The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Dr Richard Taylor MP (Independent, Wyre Forest)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/parliamentary_committees/health_committee.cfm
A list of Reports of the Committee in the present Parliament is at the back of this volume.

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Keith Neary (Second Clerk), Laura Hilder (Committee Specialist), Christine Kirkpatrick (Committee Specialist), Mr Darren Hackett, (Committee Assistant), and Rowena Macdonald (Secretary).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6182. The Committee’s email address is healthcom@parliament.uk.

Minutes of Evidence

The Health Committee took oral evidence from Rt Hon John Reid, MP, Miss Melanie Johnson, MP and Dr Fiona Adshead on Wednesday 23 February 2005. The Minutes of Evidence were published as HC 358-i on 8 April 2005 and are available on the Internet at www.parliament.uk/parliamentary_committees/health_committee.cfm.
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The Royal College of General Practitioners (WP 104)
Written evidence

Memorandum by The Green Machine (WP 01)

THE GREEN MACHINE

The Green Machine is a company which develops and sells products in its own vending machines, offering healthier alternatives to the snack foods commonly found in many vending machines, which are often high in fat, salt and added sugar. The Green Machine vending machines are mainly placed in public places such as schools. The Green Machine only stocks products that are organic and/or natural, and which are free from artificial colours, flavourings, preservatives and additives. All the products in The Green Machine are checked by the Hyperactive Children’s Support Group (HACSG) and we work closely with them when developing products.

COMMENTS

The Green Machine welcomes the committee’s attention to this White Paper and is keen to be a stakeholder in the way that the public health agenda is taken forward. It is vital that children and parents are given help in reducing the proportion of children’s diets that are made up of foods, snacks or meals that are high in fat, sugar and/or salt. It is also important that children and their parents have full information about what constitutes a balanced and healthy diet.

This submission focuses on chapter 3 of the White Paper, relating to children and young people, and considers the three points of the terms of reference of the inquiry in turn.

1. Whether the proposals will enable the Government to achieve its public health goals

One of the key policy objectives set out in the White Paper with regards to children is the target “to halt, by 2010, the year-on-year increase in obesity among children under 11” (para 10, pg 43), something we very much support. The White Paper emphasises the need to integrate services and public policy programmes, and adopt a holistic view, in order to achieve this. We have four comments relating to this:

— The “whole school approach” to children’s nutrition needs to be as inclusive as possible and incorporate food obtained by children from all sources on school premises, ie including vending machines, for nutritional guidelines to be as effective as possible. The effect of healthy school lunches could otherwise be undermined by the continued availability of unhealthy snacks. There is therefore a strong rationale for extending nutritional standards being developed for school meals to include vending machines. Therefore, we strongly support the government’s intention1 to do so, and hope that this proposal will be realised. We are unconvinced by suggestions only allowing fruit, milk, water and juice to be sold in schools, as this may well lead to children simply leave the safety of the school premises to buy unhealthy products from local convenience stores.

— In order to improve children’s health it is vital to look at the worrying rise in childhood obesity, but also at other issues which are impacted by diet, such as Attention Deficit Hyperactivity Disorder (ADHD). Our concern is that if the regulatory parameters are defined too narrowly around obesity, there is the potential for an adverse effect in other areas of public health. The Green Machine tackles this particular issue by ensuring all products are free of artificial colours, flavours, preservatives and additives.

— The Public Health White Paper indicates that the government wants to see schools actively promoting healthy food and drink and restricting the availability and promotion of other options (para 54, pg 57). We applaud this proposal and hope to see it applied to vending machines as well as school meals. This would also ensure that clear and consistent messages (para 54, pg 57) are about nutrition are not contradicted by school policies towards vending machines.

— We believe that the Food in Schools package (para 59, pg 58) which the White Paper indicates will be available from early 2005, has the potential to be a very useful resource for schools, and we welcome the inclusion of guidance on healthy vending machines in the package. The Green Machine would be happy to provide further information to assist in producing this guidance.

2. Whether the proposals are appropriate, will be effective and whether they represent value for money

We welcome the government’s proposals and specifically believe that nutritional guidelines, the promotion of healthy foods, and the existing Healthy Schools Programme and Healthy Living Blueprint are positive steps forward in improving children’s diets in the UK. The extension of school meal standards to include vending machines is, in our opinion, a complementary measure which will ensure maximum effectiveness of the government’s proposals.

1 “Subject to legislation, extending the new standards to cover food across the school day, including vending machines and tuck shops” para 57, pg 58 of the Public Health White Paper.
However, similarly there is a risk that food obtained outside the school premises will have the same effect. The Green Machine recognises the need for regulation in this area, yet it needs to be both proportionate and evidence based. For example, we are unconvinced that only allowing fruit, milk, water and juice to be sold in schools will not mean children do not simply leave the safety of the school premises to buy unhealthy products from the local convenience store. In addition, schools often receive valuable revenue from vending machines and are likely to be concerned about losing this revenue should children vote with their feet in this way.

Thus, we advocate a measured approach whereby popular snack choices are available to children but the products on offer are healthier than the standard products usually available, in terms of fat, sugar and salt content but also free from artificial additives. This approach has key benefits in terms of improving nutrition whilst keeping children on site and preserving the extra revenue which the school receives.

3. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved.

The next phase of the Healthy Schools Programme, from April 2005 (para 49, pg 55), will require a healthy school to have policies on healthy and nutritious food. We believe that this framework can deliver the government’s strategies for improving children’s diets and we look forward to the guidelines on managing healthy vending machines which we hope will help schools to work with us to provide healthier products to children throughout the school day.

The Every Child Matters programme, and the outcomes for children which the new framework for Ofsted inspections focuses on, will also help to deliver better nutrition for children through the increased emphasis on the health of children and young people—this must include looking at policies on food available throughout the school day.

Recommendations:
— Extend nutritional standards for school meals to include products from vending machines.
— Strongly encourage schools to play host only to healthier vending machines, restricting the availability of unhealthy snacks, but not limited to fruit, milk and water.
— Adopt a measured approach which still includes popular snack options, to ensure children do not turn to local convenience stores instead, and schools do not lose out on revenue.
— Highlight success stories such as in Gloucestershire through promotion of best practice and sharing of information across LEAs. 2

January 2005

Memorandum by Sustrans (WP 02)

SUMMARY

Sustrans welcomes the Public Health White Paper “Choosing health: Making healthy choices easier”. We see it as a significant step towards a future in which government funds are used to promote health and well-being right across the population, rather than treating people after they have become unwell.

We do however have real concerns about the delivery process, based on the white paper itself and what we have seen to date of the developing plans for its delivery. In a nutshell, our concerns are:
— that responsibility for delivery of the white paper as a whole may be pushed out to the local-level bodies of the NHS, to be executed through their local strategic partnerships, but without adequate support, performance management or resources from the top of the partner sectors; and
— that the physical activity element may be narrowed down to sport and recreation, and so largely devolved to the Department of Culture, Media and Sport (DCMS) and the sport sector.

We strongly urge that the other government departments whose programmes influence public health and in particular physical activity should step forward and ensure that both are central, measured objectives in all their work. These departments include:
— Department for Transport (DfT)
— Department for Education and Skills (DfES)
— Home Office (HO)
— Office of the Deputy Prime Minister (ODPM)
— Department of Trade and Industry (DTI)
— Department of Work and Pensions (DWP)

2 Dene Magna School—see Healthy Living Blueprint Objective 3: To Ensure the Food and Drink Available Across the School Day Reinforces the Healthy Lifestyle Message.
— Department for Environment, Food and Rural Affairs (DEFRA)
— Department for International Development (DFID)
— HM Treasury (HMT)
— As well as the Department of Health (DH) and DCMS.

COMMENT

1. Sustrans is a practical transport charity, which works to change the environment so that sustainable, physically active ways of travelling are more accessible. Sustrans has over 25 years experience in creating environments for physical activity, such as the National Cycle Network (NCN) programme, and changing the transport culture to make it possible, as with Safe Routes to Schools (SRS).

2. We work in partnership with the DH, DfT, DfES, ODPM and others, national and regional agencies, community groups, schools and business, and also with international bodies. Our programme helps to deliver on government’s policies and strategies in areas including public health, communities, regeneration and quality of life, and climate change.

3. Our comments below are restricted to our areas of expertise—transport, planning, physical activity and communities—in consideration both of the white paper itself and of its potential for effective implementation.

4. Over the last two years, we have worked closely with government departments and a wide range of bodies, to assist with the development of the Public Health White Paper and associated policies, such as the DfT’s excellent “Walking and cycling: an action plan”. In our view, the inter-sectoral and cross-government collaboration which informed the development of the white paper was its greatest strength; this gives reason for optimism regarding delivery.

5. Our response to the white paper itself is a positive one. It seems to build on the powerful arguments advanced both by Derek Wanless and by reports from your own committee, and to recognise two central facts:
   — that both public health and economic arguments make it imperative to move from a “national sickness service” to a health promotion service
   — and that only through a joint commitment across many sectors of government and society can the big public health issues be addressed with any real impact.

6. We are pleased to see a number of references to the importance of the environment in determining people’s levels of physical activity, in terms of transport choice and also other lifestyle choices. The white paper refers to the role of various delivery partners in creating a more activity-friendly environment, and we support this.

7. We specifically welcome the recognition of Sustrans’ flagship project, the National Cycle Network, as playing a public health role. Since we reported to your obesity inquiry, the NCN has grown by a third and usage has doubled to over 125 million walking and cycling trips per annum in 2003. The 2004 results will be published in Spring; this year the NCN will reach 10,000 miles in length, and we expect usage to grow still further.

8. The DfT has made a one-off investment this year, in a programme of links to schools from the NCN, in partnership with local authorities. We expect these new local routes to create new walking and cycling trips across the whole community, not just for the school journey. The reference to this investment in the white paper gives the impression of a multi-year programme, which could eventually address thousands of schools. We urge that DfT should continue the investment in this way, and that the other relevant departments and sectors, notably DfES, ODPM and DH, should support it.

9. You have asked contributors to consider whether the proposals within the white paper will enable the achievement of public health goals, be appropriate, be effective and be good value. Here, we find ourselves unable to respond, because in our sectors the white paper does not list sufficient detailed proposals. It lists a number of examples of interventions which, in the main, we support.

10. Our most significant concern is that the white paper does not specify how other government departments and agencies will assume their responsibilities for improving public health. This deficiency has been yet more marked in the first stages of the process towards delivery, which has disproportionately focused on the role of local NHS bodies, working through local strategic partnerships. The NHS at local level will doubtless play a very significant role in improving public health in many of its facets. However, it is most unlikely to be able to bring about significant and sustained change in areas such as the choice of active travel or the active use and enjoyment of community space, unless supported by national policies and programmes. The relevant government departments will need to create new legislation, new guidance, new performance management targets, and new or expanded financial commitments.

11. While other government departments, such as the DfT, have lead responsibility each in their own area, there is a need for clear statements of commitment as to their relationship with the DH—for example, in sharing funding flows and performance management.

12. Therefore, to address your third area of interest, while we have no qualms about the quality and authority of the existing public health infrastructure and mechanisms, we note that these pre-date the multi-disciplinary approach to public health which pertains today. To address the issues of public health today, a number of sectors must act, jointly and severally, from government down to the local level. We address below areas of activity for each.

13. ODPM, planning bodies and professionals and local government need to address the location and accessibility of services and the removal of barriers to physically active travel. People need access to key services including healthcare, shops, work, schools and social activities. The location of services where access is only easy by car promotes a sedentary lifestyle and helps to ‘lock in’ car dependence. This also worsens social exclusion.

14. Measures should be taken by the above, with DfT and the transport sector, to make the street environment safer and more pleasant for pedestrians and cyclists and a place for children to play. The development of Home Zones in residential areas and other such urban redesign should be made a priority. The perception of traffic risk is a major impediment to cycling, in particular, for many people, and our failure as a society significantly to reduce the incidence of death and injury among cyclists and pedestrians suggests that the individual risk assessment is well founded.

15. The HO and police forces should move to more complete and stringent enforcement of traffic laws, reducing the danger and—as important—the threatening nature of the road environment, which suppress walking and cycling. Illegal and inappropriate speed, drink driving and the use of mobile phones, pavement parking and a still widespread disregard of vulnerable road users combine to dissuade all but the hardest from cycling, in particular.

16. In this context we very warmly welcome the excellent new Roads Policing Strategy statement by the Association of Chief Police Officers, the DfT and the HO. We urge the three bodies to do all in their power to deliver on it, and in addition we recommend a communication programme, to address the often negative and ill-informed media treatment of measures to improve enforcement and save lives.

17. The HO and police forces should continue and redouble their offensives against other forms of anti-social behaviour, which deter many people from using public space. Please note that the public themselves identify speeding traffic as the anti-social behaviour that most affects them, and inconsiderate parking as their number two concern.

18. Since you considered similar issues in your obesity inquiry, the DfT has abandoned the targets in the National Cycling Strategy for increased cycling levels in the UK. The failure of successive administrations to commit adequate resources to their achievement has meant that the targets are now unlikely to be met. However, levels of cycling in comparable European countries are significantly higher than in the UK, and there seems no real reason to doubt that we could match them. The National Cycling Strategy Board has assembled a detailed plan to address the promotion of cycling at a national level. We recommend that the DfT should adopt and fund this programme, reintroduce national cycling targets, and performance manage its agencies and local government on their achievement, and that the remainder of the transport sector should assist.

19. Similarly for walking, we urge the DfT to set targets for walking growth, and work with the rest of the transport sector to meet them.

20. In both of these cases, the targets should be integrated with the public health targets to increase levels of physical activity.

21. The above, and particularly a planned programme to increase levels of walking, will require improvement to the current systems and methods used to measure travel choices. We are presently working with statisticians at DfT and other bodies to address this question and, we expect, to introduce more robust and accurate methodologies to monitor and evaluate walking and cycling. DfT and others should give this priority.

8 National Cycling Strategy, Department of Transport, 1996.
22. We do welcome the awareness of public health in the new Local Transport Plan guidance to local highways authorities from DfT, which states “many Local Strategic Partnerships identify public health outcomes as key local priorities and LTPs should contain evidence that authorities are reflecting such”.\(^{10}\) We agree: the LTPs should contain this evidence, and the DfT should take care to reward highway authorities which do so, and prompt those which do not.

23. We strongly welcome the commitment to build on the DfT’s Sustainable Travel Towns pilots, but recommend a much stronger follow up to these pilots than the “guidance” proposed in the white paper. The failure of the DfT and DH to ensure the inclusion of strong health promotion elements in the three pilot towns is a sad missed opportunity, which will undoubtedly mean that the beneficial outcomes identified by the Health Impact Assessment will be less than they could have been. This should now be addressed by at least one intensive “healthy travel town” intervention, involving significant change to the physical environment as well as behavioural measures, which should be co-funded by the two departments.

24. There are currently a number of incentives to unnecessary use of sedentary forms of travel, such as financial support for car use, free car parking etc. It is still, unfortunately, quite conventional for a hospital or school to provide free or subsidised car parking for staff or visitors, while offering no comparable benefit to people who travel actively. The costs of this to the business may not be identified, no management decision may ever have been taken, and no one may have considered how inequitable or unhealthy is the situation. This problem needs to be addressed, across the sectors of DfT / transport, DTI / industry, DfES / education, and of course the NHS should without delay put its own house in order.

25. In this context we strongly welcome two commitments in the white paper:

— the consultancy service to be provided to government departments by Sport England, on becoming “active workplaces”; it is most important that this should include active travel to work, and that it should be rolled out to all government buildings—national, regional and local; and

— the commitment to support the Sustainable Development Commission’s “Healthy Futures” programme, which should if fully implemented tackle the current unintentional promotion of motor travel by the NHS.

26. We recognise and admire the initiatives taken by the DfES and education sector, including those in collaboration with the DfT and transport bodies, to promote physical activity and health in schools, including active travel initiatives. We urge these partners to redouble their efforts and to expand these activity initiatives into further education.

27. The white paper contains a number of references to the importance of sport; in principle we support this, but we are concerned that physical activity and sport are often treated as though they were interchangeable terms. Sport, in fact, despite having significantly higher profile and greater resources than other forms of physical activity, accounts for less than 10% of the activity enjoyed by the one third of the UK population currently physically active (see graphic below). It may be less attractive than other activities, such as walking or gardening, to the currently sedentary,\(^{11}\) where the greatest health gain through physical activity is achievable.\(^{12}\) The contribution of the various types of activity and their relative importance should be clearly recognised and stated.

![Physical activity: it’s not just sport](image_url)

**Physical activity: it’s not just sport**

<table>
<thead>
<tr>
<th>Activity</th>
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<tr>
<td>Work</td>
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<tr>
<td>Walking</td>
<td>12%</td>
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<tr>
<td>Housework</td>
<td>9%</td>
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<tr>
<td>Gardening/DIY</td>
<td>7%</td>
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<tr>
<td>Sport</td>
<td>8%</td>
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Source: NCSRR/UCL/Health Survey for England 1998/UK Data Archive

Sport accounts for 8% of the total physical activity carried out by active adults in this country

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\(^{11}\) Active travel as physical activity promotion, Sustrans, 2004.

28. In this context therefore, we are seriously concerned by hints that the promotion of physical activity may be devolved to the DCMS and the sport sector. We strongly urge the DH and other government departments to each assume the responsibilities of their sectors for public health—both physical activity and areas such as pollution reduction.

29. In the areas of transport and physical activity, as in a number of others outside our field, there are clear shared objectives with sustainability, emissions reduction and the battle against global climate change. Climate change, in particular, carries very significant public health risks for UK residents and the rest of the world. We therefore urge that the DEFRA and environment sector should work more closely with those now active in public health to achieve on these shared agendas.

30. We are concerned that legislative and taxation avenues seem to have been under-emphasised. We would urge that the Treasury review the tax regime on motoring and fuels, which have seen the real cost of motoring fall consistently over past decades. We also recommend that consideration be given to positive fiscal incentives to healthy behaviour—for example, schemes by employers to promote active commuting.

31. In the area of regulatory impact, we welcome the commitment to “build health into all future legislation by including health as a component in regulatory impact assessment”. We trust this will include health impacts of legislation on transport and land use, traffic law, motoring and fuel taxes etc. These include traffic danger, local air pollution, accessibility of services by physically active travel modes, subsidy to sedentary modes, and so on.

32. Many of the trends in public health are international, and the UK has responsibilities with regard to public health beyond our shores. We urge that the DfID should incorporate public health impacts and measures more clearly into its work, and that the international aid and liaison sectors should give increased priority to considerations such as minimising air pollution and climate change emissions.

33. One concern we feel we should raise, across all sectors, relates to the scale of national implementation. Derek Wanless said “After many years of reviews and government policy documents, with little change on the ground, the key challenge now is delivery and implementation, not further discussion”.13 We feel that the time for local pilots and the selection of certain PCTs as “spearheads” may simply delay the delivery of the many benefits promised by the white paper, and so we urge full-scale implementation, by all relevant sectors, and a high level of investment; we believe that simple cost-benefit calculations can justify much more than the £1 billion figure currently mooted.

34. We look forward to clarification of the New Burdens Doctrine, and urge that it be made as strong and progressive as possible. Not only should local authorities be reimbursed for additional expenditure incurred in promoting public health, but those authorities which most actively take the lead should be rewarded with bonuses.

35. Across all sectors, a good example (including cycling and walking) should be set by political, administrative and business leaders.

36. Active, on-going promotion is needed of healthy and active behaviour, using promotional and media campaigns and individualised marketing interventions.

37. Intensive and transparent health impact assessment should be demanded on all transport and major land-use proposals and policies. All new projects should demonstrate real health benefits, taking into account not only their effect on pollution levels, traffic danger etc, but also their impact on the habits and lifestyle of affected people, both travellers and neighbours.

38. Sustrans wishes the committee well in its deliberations and would be happy to give oral evidence, or to provide any additional information required, in whatever form.

January 2005

Memorandum by Abbott Laboratories (WP 03)

1. This submission contains a review of the Public Health White Paper Choosing Health and has been compiled by Abbott Laboratories on the 25 January 2005 by Carole Glencorse (Dietitian), Rachel Broughton (Dietitian), Dr Lucy Cook (Medical Advisor), Len Gooblar (Government Relations & Public Affairs Manager). Carole Glencorse would appreciate the opportunity to supply supplementary oral evidence to the committee:

1.01 Abbott Laboratories is a global, broad-based health care company devoted to the discovery, development, manufacture and marketing of pharmaceuticals, nutritional, and medical products, including devices and diagnostics. The company employs approximately 70,000 people and markets its products in more than 130 countries.

1.02 We welcome the publication of the Public Health White Paper and are delighted to see that malnutrition has been considered within the document. However we would like to draw your

attention to the fact that the definition of malnutrition includes both over- and under-nutrition, and we are concerned that this document only considers the issues relating to obesity (overnutrition).

1.03 By not addressing under-nutrition it is difficult to envisage how the Government will achieve its public health goals, especially in keeping patients out of hospital,\(^{14}\) putting an increased unnecessary burden on health care at home\(^{15}\) with under-nourished patients costing in the region of £2–4 billion to care for, compared to an equal number of well-nourished patients.\(^{16}\)

**Will the proposals enable the Government to achieve its public health goals?**

2. Regrettably, no, because although the White Paper has made great moves forward with innovative thinking in many areas of healthcare, unfortunately it has missed a major contributing factor to the health of the population which in itself is detrimental to health, well-being and contributing to the quality of life that each individual strives for.

We therefore propose that undernutrition should also be considered within the paper for the following reasons:

2.01 Malnutrition (undernutrition) is a major public health issue in the UK and is estimated to affect, at any one time, at least 2 million adults. The most vulnerable are:

- the elderly;
- those with chronic diseases;
- those most recently discharged from hospital.\(^{16}\)

2.02 12% of free living elderly are at risk of being malnourished, rising to 20% for those living in an institution.\(^{17}\)

2.03 Malnutrition in patients aged 65 years or over costs £2–4 billion more annually than caring for an equal number of patients who are well nourished.\(^{16}\)

2.04 Every 1% cost reduction secondary to a decrease in interventions associated with malnutrition will save £20–40 million annually.\(^{16}\)

2.05 Patients who are malnourished on discharge from hospital are 2.5 times more likely to require health care at home;\(^{15}\) an additional burden on already over-stretched resources.

2.06 Underweight patients need 9% more prescriptions and visit their GPs more frequently (6%) than those individual with a normal Body Mass Index (BMI).\(^{18}\)

2.07 Malnourished elderly patients are more likely to be readmitted to hospital than normally nourished elderly patients.\(^{14}\)

2.08 Currently there is no effective nutritional screening programme in place that is linked to care pathways.\(^{16}\)

2.09 The National Service Framework for Older People recommends that routine nutritional screening should be undertaken and nutrition care plans implemented.\(^{19}\)

2.10 Essence of Care\(^{20}\) is a benchmarking tool for nurses and Food and Nutrition is one of the standards of care. Nutritional screening and ongoing assessment of nutritional status is recommended.

2.11 Resolution ResAP (2003)3 on food and nutritional care in hospitals\(^{21}\) also calls for nutritional risk screening to identify and prevent the causes of undernutrition, and recommends that the definition of disease-related undernutrition should be accepted and used as a clinical diagnosis.\(^{21}\)

2.12 Malnutrition also affects children and if left untreated may result in impaired cognitive development, delayed puberty as well as other potential long-term health consequences.\(^{16}\) Currently there is no standardised nutritional screening process for children.

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\(^{15}\) Chima C S, Barco K, Dewitt M L A et al. Relationship of nutritional status to length of stay, hospital costs and discharge status of patients hospitalised in the medicine service. *Journal of the American Dietetic Association* 1997; 97: 973–978.


**RECOMMENDATIONS**

3. We would like to recommend that nutritional screening of adults and children becomes standard practice in order to facilitate the early identification and treatment of undernutrition in the UK.

4. Abbott Laboratories would like to thank you for the opportunity to comment on the Public Health White Paper. We hope that you will agree that there needs to be a coordinated multidisciplinary approach to ensure undernutrition, as well as overnutrition, is appropriately identified and treated. We strongly feel that undernutrition should be considered as part of the Government's strategy on improving nutritional health.

*January 2005*

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**Memorandum by The Royal Society for the Promotion of Health (WP 04)**

**INTRODUCTION**

The Royal Society for the Promotion of Health is the UK’s largest and longest-established public health body. We were founded in 1876 by a group of reformers including Edwin Chadwick and Florence Nightingale. Since our foundation, our aim has been to promote improvement in human health through education, communication and the encouragement of scientific research. We are a multidisciplinary body, and we consulted extensively across our membership in order to prepare our response to the Choosing Health consultation in 2004.

The Royal Society for the Promotion of Health is an independent and self-financing organisation. We receive no government money and we represent no special interest. We hope our submission will be of value to the Committee in its work and will be happy to present oral evidence if called to do so.

1. **Will the proposals enable the Government to achieve its public health goals?**

   (i) We feel that the following White Paper commitments will make a particularly effective contribution towards the achievement of these goals:

   - The new cabinet subcommittee to ensure joined-up working across departments.
   - The commitment to six-monthly progress report on key indicators.
   - The proposals for developing health in the workplace.
   - The commitments to significant amounts of new money in research and innovation.
   - The financial commitment to local workforce capacity building.

   (ii) The following are unlikely to enable government to achieve its objectives:

   - More self-regulation for the food industry, particularly given that Melanie Johnson MP has already publicly taken the food industry to task over its footdragging on salt content in food, and that the Salt Manufacturers’ Association has tried to stop the Food Standards Agency’s public health awareness campaign on salt.
   - A partial smoking ban in public places. We see no clear indicator as yet of how the government will judge the effectiveness of this policy. Accepting that not all enclosed public spaces are to come under the present ban, we are not content with a blanket exemption and would prefer to see a temporary deferral which would be reviewed every three years. This would place the burden of proof onto the smoking lobby for any continuation.
   - Making “we will work closely with the Portman Group” and liberalising licensing laws the twin pillars of future alcohol policy.

   (iii) The following, which could help government achieve its goals, have been largely overlooked by the White Paper:

   - The role of the built environment in promoting healthy lifestyles, both of urban planning to reduce fear of crime and promote walking, and of “designing health into” individual buildings.
   - The Wanless Review made the case for greater investment in public health to allow for significant savings in acute and chronic NHS care. As over 65s occupy around ¾ of NHS beds it seems clear that in order to secure the “Wanless gains” a significant proportion of the investment in public health will need to be targeted at people in middle age and upwards. There are seven nice photographs of older people in the White Paper (eight if you include John Reid) and although many older people will certainly benefit from the general commitments it makes, there is almost nothing in the White Paper which is specifically targeted at older people. For this reason we have some concerns that the approach outlined in “Choosing Health” may not in fact get us off to a very sound start in terms of shifting the balance of funding from reactive to preventive health interventions.
2. Are the proposals appropriate and effective and do they represent value for money?

To a certain extent this Committee’s enquiry is posing questions which cannot yet be answered. The White Paper sets out a broad approach with a wide range of objectives, and indicates that a delivery plan is to be developed for early 2005. We believe that the Health Select Committee might be in a better position to make judgements about the appropriateness and cost-effectiveness of the government’s proposals once a delivery plan has been published.

We believe that the most cost-effective measures government can take generally involve use of its regulatory powers. Where government does not wish to use these powers it may find itself obliged to spend more money on social marketing and reactive interventions. For example there will be less positive health impact of a social marketing campaign to promote healthier eating if it is fighting for people’s attention against the “background noise” of commercial advertising for junk food.

We believe the following White Paper commitments are likely to be particularly cost-effective:

— Developing the extended schools scheme.
— Using the enormous power of the NHS as an employer, a service provider and a procurer to take a lead on sustainable development, tackling inequalities and building health literacy.
— Encouraging a greater role for health in the workplace.

3. Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

Some of what the government is proposing is completely new—for example the new cadre of health trainers, so neither infrastructure nor mechanisms exist as yet. We hope that the Committee will revisit these questions in six or nine months’ time when it will be possible to hold the government more clearly to account on these matters.

January 2005

Memorandum by British Soft Drinks Association (WP 05)

The British Soft Drinks Association (BSDA) represents the collective interests of UK manufacturers and franchisors of soft drinks, including carbonates, dilutables, still drinks, energy and sports drinks, fruit juices and bottled waters.

Response to Questions Posed by the Select Committee

1. Will the proposals enable the Government to achieve its public health goals?

Goals enumerated in the White Paper:
— The overall goal of the white Paper appears to be an improvement in the health of individuals by making healthier choices easier, based on informed choice with special responsibility for children.

Food related goals:
— by early 2006 for there to be a clear, straightforward coding system for food labels;
— developing “healthier” foods;
— funding national campaigns to promote positive health information and education;
— free fruit in schools;
— healthy vending.

Delivery is crucial and the White Paper acknowledges that the delivery plan for diet and nutrition will be included in the Action Plan on Food and Health which has not yet been published. It is therefore difficult to provide conclusive answers to the questions posed by the White Paper.

In general, achieving the Government’s goals will depend on: partnership between a number of players; providing information to which people can relate and in a way which motivates them to make the desired changes; providing support to effect changes; and taking a multifactoral approach.

The BSDA believes that its members make a positive contribution to these objectives:
— by offering a wide range of choice to meet individual needs and tastes;
— by providing essential liquid refreshment in convenient packaging with wide availability.
It supports informative labelling and believes that nutrition labelling should be clearly and meaningfully presented. It does not believe, however, that nutrition information should be over-simplified as it is important that people are able to construct balanced diets to meet individual needs and tastes. The Government will need to undertake an extensive public education campaign to ensure that consumers are able to use the information provided.

It would not wish to see action by Government which might reduce this choice or the availability of soft drinks, including fruit juices and bottled waters, as this would be detrimental to consumer choice and could be counter-productive in terms of balanced nutrition.

2. Are the proposals appropriate and will they be effective?

Government proposals to “make healthier choices easier” are not sufficiently detailed to enable BSDA to respond to the above question with precision. The planned initiatives in the White Paper require considerable discussion and development in order to be implemented.

The Government’s overall objective is to influence consumer choices and for initiatives to work and be effective in the longer term, they must inspire the commitment and confidence of all involved. The following principles therefore seem essential:

— strong coordination between Government departments;
— initiatives should be evidence-based and capable of practical implementation;
— terminology should be clearly defined and accurate;
— messages should be positive;
— clear objectives and targets should be set against which to measure action and results;
— the diversity of individual needs and nutritional requirements must be taken into account;
— education about balanced diets needs to be prioritised;
— the close involvement of parents, educators and primary health-care resources is vital.

If such principles are established and respected then a workable framework for devising initiatives could be achieved.

January 2005

Memorandum by Professor Sarah Stewart-Brown, Professor of Public Health, University of Warwick (WP 06)

I welcome the recognition implicit in this White Paper that child health underpins adult health. I also welcome the recognition that children’s emotional and social development is a key determinant of their future health and well-being, and that it plays a part in determining inequalities in health. I am, however, concerned that the potential for supporting children’s emotional and social development through cost-effective interventions is not fully realised in the text of the White Paper and more particularly in the Summary of Intelligence papers which accompanied the White Paper.

The key determinant of children’s emotional and social development and of future mental health and emotional well-being is the quality of the relationship between them and their parents. Relationships with others—for example early years workers, teachers, social workers and relatives and friends—are also important, but it is the parental relationship, particularly in infancy and the early years, which is critical. The White Paper proposes to provide additional information and support for parents. However, it is far from clear what this information and support will entail. In particular, it is not clear that it will offer parents the evidence-based programmes which are known to improve the quality of the parent-child relationship.

Will the proposals enable government to achieve its public health goals?

In the absence of support for parenting of the sort that improves relationships, it is unlikely that the government’s mental health, health related lifestyles or social inequalities targets will be achieved. The Summary of Intelligence on Mental Health paper, produced to support the White Paper, makes no mention of any intention to provide the kind of programmes which would improve parent-child relationships. It does propose a programme to support the relationships which early years workers make with children, and a programme to support parents’ involvement in learning. Both of these are important, but neither will have more than a peripheral effect on parent-child relationships.
Are the proposals appropriate, will they be effective and do they represent value for money?

The content of the information and support the government proposes to offer to parents is not clearly defined. Information is critical for public health improvement, but it is not in itself a sufficient basis for behaviour change or improvements in relationship quality. Research on parental support shows this to be widely appreciated by parents, but, on its own, also cannot be relied on to change these two aspects of parenting.

Structured programmes, provided in acceptable and accessible settings, which challenge parents in a supportive, non-judgemental atmosphere, are necessary to enable parents to change the way they relate to their children. Although more research in a UK context is needed, a wide range of systematic reviews now attest to the fact that it is possible, with relatively low-cost interventions, to improve the quality of the parent-child relationship. The sort of programmes which can be effective in this respect are those quoted in the Case Study on page 47. They are also well described in core standard two of the National Service Framework for Children, Young People and Maternity Services.

Do the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

The types of parenting programme which would increase the chances of the White Paper achieving its goals can be delivered by a range of different practitioners. Many sound programmes are also offered by the voluntary sector. It is essential that those running programmes are equipped with the necessary knowledge, skills and support to do so; some of this could be achieved through continuing professional development. The new children’s centres provide an ideal geographical location for such programmes.

January 2005

Memorandum from Action on Smoking and Health (ASH) (WP 07)

INTRODUCTION

1. Action on Smoking and Health (ASH) generally welcomes and supports the proposals in the White Paper on Public Health.

2. In particular, we welcome the proposal for legislation to end smoking in the great majority of workplaces and enclosed public places. This has the potential to be the most significant public health reform for many years, as it would both protect non-smokers from the damaging effects of secondhand smoke and encourage many smokers to quit. We consider this to be an essential step if the Government wishes to achieve its public health goals, and to represent excellent value for money in terms of health gain in relation to public expenditure.

3. However, we have serious concerns about the timescale for the proposed legislation and particularly about the proposed exemptions for pubs that do not serve prepared food and for private membership clubs. We believe that these exemptions cannot be justified on health and safety grounds, would significantly undermine the purpose of the legislation, and in particular would sharply reduce the impact of the legislation on health inequalities.

4. In publishing the White Paper, Dr John Reid committed the Government to spend “at least £1 billion in public health over the next three years.” ASH recommends that the Health Select Committee asks for an undertaking that this £1 billion represents new spending exclusively on public health, and that the Delivery Plan for the White Paper to be fully costed, including a timetable of spending over this three year period.

5. The remainder of this evidence sets out our detailed comments on the White Paper proposals on secondhand smoke, and also comments on other key issues in relation to tobacco control. A summary of recommendations is given at the end of this note.

January 2005

SUMMARY OF PUBLIC HEALTH GOALS IN RELATION TO SMOKING

(Source: http://www.hm-treasury.gov.uk/media/4B9/FE/sr04___psa___ch3.pdf)

“1. Substantially reduce mortality rates by 2010:
   — from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
   — from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole . . .

2. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.
3. Tackle the underlying determinants of ill health and health inequalities by:
   — reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less . . .”

SMOKING IN WORKPLACES AND PUBLIC PLACES

4. Paragraphs 8 and 9 of the Regulatory Impact Assessment, published with the White Paper, estimate that ending smoking in all workplaces and enclosed public places would reduce overall smoking prevalence rates by 1.7%. 0.7% of this effect is estimated to result from the direct effect of ending smoking in employees’ own place of work, and 1% from more places outside smokers’ own place of work going smoke free. This is by far the simplest and most cost effective step the Government could take to achieve its public health targets in relation to smoking. Without it, these targets will not be achieved.

5. However, the Government’s proposal to exempt some pubs and membership clubs from new legislation on smoking in workplaces and enclosed public places threatens to undermine key objectives of the White Paper—to reduce smoking prevalence rates and tackle health inequalities.

6. The White Paper makes the following statement about health risks associated with secondhand smoke: “The evidence of risk to health from exposure to second-hand smoke points towards an excess number of deaths, although debate on the precise scale of the impact continues. The consultation demonstrated clear concerns about both the health impact and discomfort felt by many in smoke-filled environments, with particular concerns about locations such as work places, where people may not have been able to choose to be in a smoke-free environment.”

7. This is an unhelpful formulation of a serious health and safety issue. The wording is both vague (for example, the evidence “points towards” excess deaths) and subjective (for example, there are “concerns” about health impacts). It is particularly unhelpful that the White Paper states that “debate on the precise scale of the impact continues”. This debate will of course continue indefinitely, because the tobacco industry and its front groups have a powerful vested interest in ensuring that it does.

8. The evidence of risk to health, and to a significant number of excess deaths, is in fact clear and overwhelming, and is well summarised in the report of the Government’s Scientific Committee on Tobacco and Health (SCOTH) published at the same time as the White Paper, and in paragraphs 5 to 9 of the Partial Regulatory Impact Assessment (RIA), published with the White Paper.

9. SCOTH’s conclusions as to risk should have been quoted in the White Paper—specifically the conclusions in paragraphs 2 and 3 of the report:
   — Paragraph 2 states that: “SCOTH concludes that there is an estimated overall 24% increased risk of lung cancer in non-smokers exposed to SHS”
   — Paragraph 3 states that: “SCOTH therefore concludes that SHS causes heart disease and that the best estimate of increased relative risk of heart disease in non-smokers exposed to SHS remains at about 25%.

Paragraph 6 of the SCOTH report concludes that “it is evident that no infant, child or adult should be exposed to SHS. This update confirms that SHS represents a substantial public health hazard”.

10. Nowhere in the White Paper is there any estimate of the numbers of employees exposed to secondhand smoke at work. Yet this estimate is relatively easy to make, and some of the essential statistics are given in paragraph 8 of the RIA. With support from the Office of National Statistics, and using data from the Government’s Labour Force Survey for 2003 and the National Statistics Omnibus Survey smoking-related behaviour and attitudes module carried out in October and November 2003, ASH has calculated that:
   — 2,182,000 people work in places with “no restrictions on smoking at all”. This is 8% of those in work in Great Britain
   — 10,366,000 people work in places where smoking takes place in “designated areas”. This is 38% of those in work.

11. Using risk factors virtually identical to those in the SCOTH report, Professor Konrad Jamrozik, formerly of Imperial College London, estimated in May 2004 that secondhand smoke in the workplace generally causes about 700 deaths each year in the UK. For comparison, the total number of fatal accidents at work from all causes in the UK in 2002–03 was reported by the Health and Safety Executive as 226. The evidence therefore supports an objective assessment (and not just a subjective reporting of “concerns”) that secondhand smoke is a large workplace health and safety risk. This is by far the most important argument justifying legislative action on secondhand smoke, and it is remarkable that the White Paper entirely fails to make it.

12. Nowhere in the White Paper is there any mention of specific occupational groups who are likely to be particularly exposed to secondhand smoke at work. Yet paragraph 5 of the SCOTH report states that “some groups, for example bar staff, are heavily exposed at their place of work”.

*ASH therefore recommends that:*

- the Government should make a clear public statement accepting the assessment of health risks from secondhand smoke set out in the SCOTH report, including SCOTH’s statement in relation to bar workers, and stating explicitly that secondhand smoke is a serious workplace health and safety risk;
- this statement should form the basis of information prepared for employers and others in the run-up to legislation;
- the Government should publish its best estimate of the number of people (a) regularly and (b) occasionally exposed to secondhand smoke in the workplace; and
- the Government should refer the conclusions of the SCOTH report to the UK Committee on Carcinogens and ask it to assess whether secondhand smoke is a workplace carcinogen.

13. Chapter 4, paragraph 76 of the White Paper states that: “we propose to regulate, with legislation where necessary, in order to ensure that:

- All enclosed public places and workplaces (other than licensed premises . . .) will be smoke free;
- Licensed premises will be treated as follows:
  - all restaurants will be smoke-free
  - all pubs and bars preparing and serving food will be smoke-free
  - other pubs and bars will be free to choose whether to allow smoking or to be smoke-free
  - in membership clubs the members will be free to choose whether to allow smoking or to be smoke-free
- smoking in the bar area will be prohibited everywhere.”

14. This proposal is poorly drafted, confused, probably unworkable and certainly undesirable. It is poorly drafted because the words “regulate, with legislation where necessary” leaves open the possibility of a return to the failed ‘voluntary approach’ in respect of smoking in pubs and bars. This will simply encourage the most backward elements in the pub trade to try to push the Government backwards from the White Paper proposal, to something closer to the failed “Public Places Charter”, introduced the last time a Labour Government backed away from effective action on this issue.

15. The proposal is confused because there is no useful line to be drawn between pubs which “prepare and serve food” and those which do not. From their public statements, Ministers appear to have only the vaguest idea how many pubs do not serve prepared food and no idea at all where such pubs are concentrated. It is also evident that no clear definition of prepared food was arrived at before the White Paper was produced.

16. Chapter 4, paragraph 79 of the White Paper suggests that between 10% and 30% of pubs will be exempted. There are about 55,000 pubs across the country, so this exemption may cover anything between 5,500 and 16,500 establishments.

17. Private clubs not admitting children could also be exempt, following a vote of members. There are 19,913 registered clubs—clubs owned by the members—in England and Wales (Source: Department for Culture, Media and Sport Statistical Bulletin Liquor Licensing, England and Wales, July 2003–June 2004).

18. Common sense suggests that many exempt pubs will be in poorer communities. These communities will have higher than average smoking prevalence rates, and will be suffering from the sharp health inequalities that the class distribution of smoking brings. Many membership clubs—for example Labour Clubs—will also be in such communities. Research undertaken by Northamptonshire Primary Care Trust and local authorities in the country shows that 54% of pubs and bars in Northamptonshire serve only drinks and would be exempt from the controls on smoking in public places. In the borough of Corby, an area where mortality rates are significantly higher than the national average, 85% of pubs and bars would be exempt (source: Northampton PCT, research published 24 January 2005).

19. Chapter 4, paragraph 77 of the White Paper notes the risk that some pubs may cease to serve prepared food in order to qualify as premises that can continue to permit smoking. This fear is dismissed with the words “we believe that the profitability of serving food will be sufficient to outweigh any perverse incentive for pub owners to choose to switch”. This assertion has been contradicted by senior figures in the pub trade, for example, Tim Clarke, chief executive of restaurant and pubs group Mitchells & Butlers has warned that: “the enforced specialisation between food and smoking risks commercially incentivising more pubs than the White Paper currently anticipates to remove food and retaining smoking throughout.”

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24 http://birmingham.icnetwork.co.uk/0150business/0200news/tn objectid = 14936209&method = full&s%e = 50002&
headline = smoking-ban-threat-to-food-in-smaller-pubs-name_page.html
20. The proposal to prohibit smoking in the “bar area” of exempted pubs would fail to provide adequate protection for employees or members of the public. Smoke drifts. Most pubs currently have any separated smoking and non-smoking areas in the same open space. Ventilation systems are expensive, hard to maintain, and as even Philip Morris has admitted, do not provide good protection from the health effects of secondhand smoke. ("While not shown to address the health effects of secondhand smoke, ventilation can help improve the air quality").

21. Chapter 4, paragraph 77 of the White Paper states that the Government intends to “consult widely” on, inter alia, “the special arrangement needed for regulating smoking in certain establishments—such as hospices, prisons and long stay residential care”. It is notable that this list does not included exempted pubs and clubs. Nowhere in the White Paper is there any commitment even to consider minimum health and safety standards for such premises. This is unacceptable.

22. Any attempt to exempt a category of workplaces from smokefree legislation would be subject to legal challenge. The date of “guilty knowledge” under the Health and Safety at Work Act 1974 (HSWA) has now passed in relation to secondhand smoke. The evidence, not least from the two SCOTH reports (1998 and 2004), is now sufficiently strong and sufficiently well known for any employer to be expected by the courts to know of the risks associated with exposure to secondhand smoke. Therefore, employees made ill by such exposure in the workplace will have a case for damages against their employer, claiming negligence and citing a breach of the HSWA as evidence. This would remain possible in respect of any premises exempted from a general prohibition on smoking. ASH has been working with the UK’s largest personal injury and trade union law firm, Thompson’s, to identify such cases, which will begin to reach the courts early in 2005.

ASH therefore recommends that:

— the Government should assess the impact on health inequalities of the proposed exemptions, and publish the results of this assessment;
— the Government should assess the impact of exempting pubs which do not serve prepared food on “binge drinking” and its wider alcohol strategy. It should consult with Alcohol Concern and other expert groups on this issue; and
— the Government should consult health and safety experts on whether proposal to restrict smoking in the “bar area” of exempted pubs would provide satisfactory protection for staff and members of the public.

23. The Government has yet to announce its intentions in relation to Wales, where a Committee of the National Assembly is due to report in May 2005 on the issue of secondhand smoke, and in relation to Northern Ireland, where all the major Parties from Sinn Fein to the Democratic Unionists have made public statements in support of smokefree legislation.

ASH therefore recommends that:

— the Government should make a clear statement of intent in relation to Wales and Northern Ireland, giving the National Assembly in Wales powers to introduce comprehensive smokefree legislation and introducing such legislation directly in Northern Ireland.

24. Chapter 4, paragraph 77 of the White Paper sets a relatively long time-table to implement smoking restrictions, as follows:

— by the end of 2006, all government departments and the NHS will be smoke-free;
— by the end of 2007, all enclosed public places and workplaces, other than licensed premises (and those specifically exempted) will, subject to legislation, be smoke-free;
— by the end of 2008 arrangements for licensed premises will be in place.

ASH believes that this timescale—around 18 months longer than is proposed in Scotland—is too long and arises mainly from the excessive complexity of the proposed legislation. A simple piece of legislation ending smoking in all workplaces would be easier and quicker to introduce, as well as being subsequently easier to publicise and enforce.

25. The RIA gives no assessment of the reduction in prevalence rates that would be achieved if the Government’s proposed exemptions were adopted, however it does assess the health benefits to non-employees ("customers") of this option as worth £150 million a year, as opposed to £350 million for the full ban. In total, the RIA assesses the net benefits of a full ban at £1,344 to £1,754 million a year, compared to £998 to £1,486 million for the Government’s preferred option.

26. Dr Reid and ministerial colleagues have sometimes suggested that the reason for the proposed exemptions is to prevent displacement of smoking from workplaces and public places to the home. A Parliamentary answer dated Monday 24 January from Public Health Minister Melanie Johnson, to a series of Written Questions on this point from David Taylor MP, shows that the Government has no research evidence to back this assertion. Evidence from other countries and jurisdictions that have introduced workplace smoking bans suggests that this concern is in fact groundless.

ASH therefore recommends that:
— Ministers should not raise unfounded concerns about displacement of smoking from workplaces to homes as a result of comprehensive smokefree legislation
— the Government should reconsider its proposed exemptions, and opt for the simplest and most effective legislative option—all workplaces and enclosed public places should be smokefree.

TOBACCO AND NICOTINE REGULATION AND HARM REDUCTION

27. Even if the Government achieves its PSA targets in relation to smoking, around one in five of the adult population will still smoke, and smoking will remain a leading cause of preventable death. As smoking prevalence rates fall, it must be assumed that remaining smokers are particularly resistant to the standard policy levers. Therefore, the Government should consider developing a harm reduction strategy in relation to remaining smokers and nicotine users. Although this is a complex matter, an effective harm reduction strategy has the potential to achieve major advances in public health. ASH believes it to be the essential next step in tobacco control policy, once legislation on secondhand smoke is in place.

28. The public health goal in relation to smoking tobacco must be to reduce the death and disease it causes. It is not simply to reduce tobacco or nicotine consumption as an end in itself. Nicotine is an addictive drug in precisely the same sense as are many illegal drugs, such as heroin and cocaine. Harm reduction strategies are an important part of work to cut the damage cause by illegal drugs; the same principle now needs to be applied to nicotine. Not all nicotine addicts will readily or quickly succeed in breaking their addiction, but all can be helped to stop consuming their drug by the dangerous and damaging means of smoking cigarettes.

29. There is now substantial experience with medicinal nicotine. It is at least 100 times less risky than smoked tobacco, and has only relatively minor negative effects on health. However, medicinal nicotine is currently only available as an aid to giving up smoking.

30. New products are therefore needed to give people access to clean forms of nicotine in a form and at a price that is attractive as an alternative to smoking. To achieve this revision of the current regulatory system is required. This is because less harmful nicotine products competitive with cigarettes are currently either not licensed for use in this country or are not being developed. Even if they were developed, they could not be promoted, because of regulatory obstacles.

31. The Royal College of Physicians, ASH and others have called for a new regulatory body to ensure uniform regulation of all products containing nicotine, based on harm reduction principles. However, we recognise that there may be alternatives to an entirely new body and would welcome the opportunity to work with the Department of Health to develop a strategy for this area.

32. Chapter 8, paragraph 8 of the White Paper states that the Government does not “think there is a case for setting up a brand new UK agency to regulate tobacco”, although it gives no reasons for this conclusion. Paragraph 8 also states that the Government does “recognise the need for more work to look at how best to regulate tobacco products” and that it intends to “develop a strategy for taking this work forward”.

33. We would suggest a three stage approach. First, the Government should consult on the principles of harm reduction in relation to tobacco and nicotine products. Secondly, it should consult on the appropriate body or bodies to regulate nicotine products, including tobacco, in accordance with harm reduction principles. Thirdly, it should implement the necessary legislative and regulatory changes, as recommended by this body or bodies. We anticipate that this process could take between four to five years.

ASH therefore recommends that:
— the Government should commit itself to developing a harm reduction strategy in relation to nicotine, and publish a timetable for consultation and consequent decisions.
Tobacco Control Strategy

34. ASH welcomes the White Paper’s recognition that public health needs to be given priority at Cabinet level and that the “Secretary of State for Health will co-ordinate action through the new Cabinet Sub Committee, set up to oversee the development and implementation of the Government’s policies to improve public health and reduce health inequalities.” (p177 para 12)

35. However, there is a need for a specific planning mechanism to help oversee the development of the new tobacco strategy and ensure that it is properly evaluated, revised and updated on a regular basis.

36. Such a mechanism is also necessary to conform to the guiding principles of the Framework Convention on Tobacco Control (FCTC) which the UK has now ratified. Under Article 5 of the FCTC there is a general obligation to: “develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with this Convention and the protocols to which it is a Party”.

37. Therefore one priority project should be setting up a Tobacco Advisory Group (TAG), with membership both from Government and civil society meeting regularly. The current Scientific Committee on Tobacco and Health (SCOTH) should be established as a technical subgroup to the TAG.

38. This group should oversee implementation of the DH’s six-pronged strategy which includes:

1. Social marketing to encourage cessation and denormalise smoking.
2. Building cessation services and strengthening local and regional action.
3. Reducing supply and availability of tobacco.
4. Enforcing the advertising ban and reducing tobacco promotion.
5. Regulating tobacco.
6. Reducing exposure to secondhand smoke.

39. In addition, there is a need for information and intelligence to inform effective implementation and development of the strategy. We are pleased to see that the Government plans to establish “a Health Information and Intelligence Task Force to lead action to develop and implement a comprehensive public health information and intelligence strategy.” (p191 para 24).

40. Public health information and intelligence on tobacco consumption and its impact is better developed than most areas of public health information. However, there are areas which can be improved. Key information on the tobacco industry should be collected and published as part of the strategy including:
   - An annual report on the tobacco market should be published. This should detail its structure, price variations within categories, calculated price-elasticities, consumption patterns by socio-economic group, ethnicity, age, sex and other demographics, market share by brand, etc.
   - A smoking module, covering knowledge, attitudes and behaviour, should be incorporated in the ONS Omnibus survey every month. The results should be made widely available, in order to be able to, for example, monitor the impact of media campaigns or price changes on smoking prevalence.
   - Existing data relating tobacco price and smoking, particularly of smuggled product, are inadequate to determine effects on consumption and cessation. New ways of studying this important policy issue need to be found.
   - A longitudinal panel survey should be established specifically to monitor smoking behaviour and its response to policy initiatives.

41. ASH is concerned that there is no commitment in the White Paper to specific funding for long-term social marketing mass media and public education campaigns. This is needed to motivate and encourage quitting and “denormalise” smoking. Such campaigns will be crucial, for example, in ensuring effective implementation of smokefree workplaces.

42. A comprehensive review and analysis of the effectiveness of the public education campaigns over the last five years is needed, to ensure that future spend is set at optimal levels and that messages are sharply defined and effectively delivered.

43. ASH has serious concerns that repeated cuts to central DH staffing, particularly among staff working on tobacco control, has left the Department’s central resources dangerously stretched. This may make implementation of the White Paper proposals, particularly legislation on secondhand smoke, more difficult and potentially less effective.

ASH therefore recommends that:

- the Government should establish a Tobacco Advisory Group to include experts from Government and civil society to oversee development of the tobacco control strategy;
- the Government should review and improve the collection of key data in relation to tobacco consumption;
— the Government should commit itself to continuing long-term mass media and public education campaigns to reduce tobacco consumption, based on comprehensive evaluation of the effectiveness of previous campaigns; and

— the Department of Health should review staffing levels in relation to tobacco control and ensure that they are sufficient to introduce the White Paper proposals and maximise the consequent public health benefits.

**Stop Smoking Services**

44. The Government’s support for Stop Smoking Services through the NHS has been a very important step forwards in tobacco control. This is rightly noted in the White Paper. Chapter 2, paragraph 15 states that the government will continue with its campaign to: “reduce smoking rates and motivate smokers in different groups to quit supported by clear and comprehensive information about health risks, reasons not to smoke, and access to NHS support to quit, including Stop Smoking Services and nicotine replacement therapy”.

45. However, there remains a need to continue to improve Stop Smoking Services, and particularly to develop the performance indicators these services are required to meet. Chapter 6, paragraph 51, of the White Paper states that: “In 2005–07, the Healthcare Commission will examine what PCTs are doing to reduce smoking prevalence among the local population, including their own staff, through tobacco control campaigns, championing smoke-free environments and provision of NHS stop smoking services. Ongoing progress will be assessed against national standards and indicators.” In addition, the White Paper promises that the Government will establish a taskforce to help increase the effectiveness and efficiency of the NHS stop smoking services.

46. However, the White Paper does not meet the criticism set out in the latest Wanless report and elsewhere on in particular the four week quit targets, which potentially give an exaggerated and misleading impression of success.

47. Smoking cessation also needs to be fully integrated as a high priority into clinical guidelines for all chronic diseases influenced by smoking in the community and in secondary care. This should include cardiovascular disease, respiratory disease, diabetes, and all others where smoking affects outcomes significantly.

*ASH therefore recommends that:*

— the Government should reframe targets for cessation services to cover both referrals and success rates (both of which are routinely collected by the Department of Health); and

— best practice guidelines should be developed and widely implemented in order to bring the level of the least successful services up to those of the most successful.

**Tax and Smuggling**

48. Chapter 8 of the White Paper, paragraph 6, states that: “The Government will continue to take tough action on tobacco smuggling. Over the past two decades, establishing and maintaining a high level of tax on cigarettes—as has been the policy of successive governments—has been shown to help reduce smoking prevalence. Cigarette duty was subject to a sustained period of real-terms increases during the 1990s, and has been held at the present high level in real terms since 2000–01. Compared to many other countries, the UK has high duties on tobacco products and high-priced cigarettes.

However, an increase in the availability of cheaper, illegally smuggled cigarettes and hand-rolling tobacco has meant that some smokers have been able to by-pass higher prices, undermining the impact of price on smoking prevalence rates and meaning that further real increases in duty would be likely to be of limited effectiveness.”

49. ASH does not accept that smuggling constitutes a reason to abandon a policy of rising taxation on tobacco products. Smuggling is a criminal activity which should be prevented through adequate enforcement. The UK Government should work to support the development of a specific international protocol with binding obligations on smuggling, to ensure that the Framework Convention on Tobacco Control (FCTC) is fully effective once it comes into force.

*ASH therefore recommends that:*

— the National Audit Office should be asked to produce and publish a report by the end of 2004 on the effectiveness of HM Customs and Excise’s current tobacco smuggling strategy and how it might be improved;
— the Government should ensure closer co-ordination between Customs and Excise, the Treasury, the Department of Health and local authority Trading Standards Officers to ensure that action on smuggling and counterfeit cigarettes is a high priority for all relevant Departments and agencies; and

— the Government should push for a smuggling protocol to be on the agenda of the first Conference of the Parties of the Framework Convention on Tobacco Control, and start work within the EU to develop such a protocol.

**CHILDREN AND YOUNG PEOPLE**

50. Chapter 3, paragraph 104 of the White Paper states that: “We propose that legislation be brought forward to create new powers to ban retailers from selling tobacco products, on a temporary or permanent basis, if they repeatedly flout the law. This complements the work already under way to improve proof of age schemes. We intend to support this measure by looking at higher fines and updated guidance for magistrates, along with education for retailers on better compliance with the under age sales law. Before introducing these measures, we will consult local authorities, the retail industry and other key stakeholders. We will support this with a communications programme for local authority enforcement.”

51. ASH supports the need for firm action against retailers who knowingly or negligently sell tobacco products to minors. Current standards of enforcement vary widely between local authorities and this is not desirable. However, it would be an error to think that this measure will be the most effective in stopping children from starting to smoke. Research shows that most teenagers begin to smoke as a “rite of passage to adulthood”. It follows that discouraging adult smoking is likely to be the best way of preventing young people from starting.

52. Chapter 2 of the White Paper also refers to the need to protect children from tobacco promotion via film & TV. The White Paper recognises that smoking in films and TV programmes may influence young people to start smoking. Paragraph 65 states: “The British Board of Film Classification has assured the Government that it does consider whether a film targeted at children and young people is actively promoting smoking. The Board’s classification guidelines are currently under consideration and one aspect of that review includes the public’s attitude to smoking in films with particular appeal to children and young people, and the potential impact on their smoking behaviour.” ASH believes that classification guidelines should state explicitly that the portrayal of smoking in films likely to be seen by children and teenagers should not glamorise the activity and this will be a relevant factor considered when the BBFC determines classifications.

53. Paragraph 66 of the White Paper notes that “there seems to have been a reduction in the portrayal of smoking on television in recent years”. It refers to Ofcom’s consultation on the new broadcasting code which is due to come into effect in 2005. The draft code contains rules about smoking in the section entitled “protecting the under-18s”. Paragraph 67 states: “The Government welcomes Ofcom’s consultation. In this consultation Ofcom has proposed tightening the rules so that smoking would be prohibited in children’s programmes, unless there is a clear educational purpose, and in programmes before the watershed, unless there is an editorial justification. Ofcom is considering the wording of these rules and whether additional rules may be required in the light of responses and evidence they receive.”

54. However, the Ofcom proposal fails to mention the portrayal of smoking in programmes likely to be seen by teenagers—the key group in this context—whether before or after the watershed. Ofcom’s proposals therefore need revision and the Government should encourage this. Again, the portrayal of smoking in such programmes should not glamorise the activity.

**ASH therefore recommends that:**

— the Government should support including the portrayal of smoking in films as a relevant factor in determining classifications. It should also support the issuing of clear guidance to TV producers about the portrayal of smoking in programmes likely to be seen by teenagers.

**SUMMARY OF RECOMMENDATIONS**

**Introduction**

— the Government should give an undertaking that the £1 billion promised by the Health Secretary represents new spending;

— the Delivery Plan for the White Paper should be fully costed, including a timetable for spending over a three to five year period.
Smoking in Workplaces and Public Places (paragraphs 5 to 26)

— the Government should make a clear public statement accepting the assessment of health risks from secondhand smoke set out in the SCOTH report, including SCOTH’s statement in relation to bar workers, and stating explicitly that secondhand smoke is a serious workplace health and safety risk;
— this statement should form the basis of information prepared for employers and others in the run-up to legislation;
— the Government should publish its best estimate of the number of people (a) regularly and (b) occasionally exposed to secondhand smoke in the workplace; and
— the Government should refer the conclusions of the SCOTH report to the UK Committee on Carcinogens and ask it to assess whether secondhand smoke is a workplace carcinogen;
— the Government should assess the impact on health inequalities of the proposed exemptions, and publish the results of this assessment;
— the Government should assess the impact of exempting pubs which do not serve prepared food on “binge drinking” and its wider alcohol strategy. It should consult with Alcohol Concern and other expert groups on this issue;
— the Government should consult health and safety experts on whether proposals to restrict smoking in the “bar area” of exempted pubs would provide satisfactory protection for staff and members of the public;
— the Government should make a clear statement of intent in relation to Wales and Northern Ireland, giving the National Assembly in Wales powers to introduce comprehensive smokefree legislation and introducing such legislation directly in Northern Ireland;
— Ministers should not raise unfounded concerns about displacement of smoking from workplaces to homes as a result of comprehensive smokefree legislation; and
— the Government should reconsider its proposed exemptions, and opt for the simplest and most effective legislative option—all workplaces and enclosed public places should be smokefree.

Tobacco and Nicotine Regulation and Harm Reduction (paras 28–34)

— the Government should commit itself to developing a harm reduction strategy in relation to nicotine, and publish a timetable for consultation and consequent decisions.

Tobacco strategy (paras 35–44)

— the Government should establish a Tobacco Advisory Group to include experts from Government and civil society to oversee development of the tobacco control strategy
— the Government should review and improve the collection of key data in relation to tobacco consumption
— the Government should commit itself to continuing long-term mass media and public education campaigns to reduce tobacco consumption, based on comprehensive evaluation of the effectiveness of previous campaigns
— the Department of Health should review staffing levels in relation to tobacco control and ensure that they are sufficient to introduce the White Paper proposals and maximise the consequent public health benefits.

Stop smoking services (paras 45–48)

— the Government should reframe targets for cessation services to cover both referrals and success rates;
— best practice guidelines should be developed and widely implemented in order to bring the level of the least successful services up to those of the most successful.

Tax and smuggling (paras 49–50)

— the National Audit Office should be asked to produce and publish a report by the end of 2004 on the effectiveness of HM Customs and Excise’s current tobacco smuggling strategy and how it might be improved.
— the Government should ensure closer co-ordination between Customs and Excise, the Treasury, the Department of Health and local authority Trading Standards Officers to ensure that action on smuggling and counterfeit cigarettes is a high priority for all relevant Departments and agencies.
— the Government should push for a smuggling protocol to be on the agenda of the first Conference of the Parties of the Framework Convention on Tobacco Control, and start work within the EU to develop such a protocol.

Children and young people (paras 51–55)

— the Government should support including the portrayal of smoking in films as a relevant factor in determining classifications. It should also support the issuing of clear guidance to TV producers about the portrayal of smoking in programmes likely to be seen by teenagers.

Further memorandum by Action on Smoking and Health (ASH) (WP O7A)

I wish to make an addition to our submission on the Government’s Public Health White Paper, with respect to the levels of staffing required to ensure effective implementation of the White Paper. In particular smokefree legislation envisaged in the White Paper will require significant policy input in order for it to be effectively developed and steered successfully through Parliament. The tobacco team at the Department of Health has been cut back from fifteen members two years ago to only five now, only three of whom are senior policy staff.

Despite requests we have not yet been able to find out whether, and how, this team will be strengthened in order to bring in the legislation. It is our understanding that in Scotland, where there are plans to introduce simple comprehensive legislation which will be easier to design and implement, the tobacco team has already been increased by four people simply to handle the legislation. In England, where it is planned that there should be exemptions to the legislation which will be complex to draft and to implement, an increase of at least this order of magnitude is required.

The timing is tight for legislation to be introduced in the timescale envisaged and work needs to be underway on this already. We would urge you to ask the Department of Health, and in particular the Deputy CMO whose area this is, Fiona Adshead, to clarify what work has been done to analyse the staffing resources needed to bring in smokefree legislation, and when and where these additional staff will be put in place.

February 2005

Memorandum by Brook Advisory Centres (WP 08)

1. Introduction

1.1 Brook, a registered charity, is the country’s leading sexual health organisation for young people, offering young women and men up to the age of 25 free and confidential sexual health advice and services.

1.2 Our evidence is therefore restricted to the plans for improving young people’s sexual health outlined in the Public Health White Paper.

2. Will the Proposals Enable the Government to Achieve its Public Health Goals?

2.1 Brook welcomes the Government’s commitment to a new sexual health campaign targeted at younger women and men. It is alarming that awareness of the importance of using condoms alongside other methods of contraception appears to have broken down since the mass media HIV campaigns of the 1980’s, particularly amongst young people. We therefore believe that a more high profile public information campaign is needed to tackle the lack of awareness about sexually transmitted infections and HIV.

2.2 The Department of Health’s proposals to ensure a broader reach of information about sexual health for young people in ways that can be accessed in complete confidence (such as websites and email) will increase their access to impartial and accurate information about how to protect their sexual health. It is evident from Brook’s own confidential on-line inquiry service provided via its website that this is an effective way of reaching young men and younger age groups who might not use telephone helplines or face-to-face services because of embarrassment or concerns about confidentiality.

2.3 However, young people also need access to confidential services in addition to information. We are particularly concerned that the Government’s proposals for information sharing databases could constitute a serious threat to young people’s confidential use of sexual health provision. Under the proposals, details of practitioners such as sexual health workers who are involved with the young person would be recorded on the database. This would potentially alert other professionals to the fact that a young person is in contact with sexual health services. The vast majority of young people taking part in a Brook consultation on this issue said that this would make them less likely to use a service. The proposals could therefore constitute a major deterrent to young people accessing preventive sexual health and contraceptive provision, undermining the Government’s aim to reduce sexually transmitted infections and teenage pregnancy rates.
2.4 We are particularly disappointed that the Government did not take the opportunity presented by the White Paper to make Sex and Relationships Education a statutory part of the national curriculum. Research shows that young people who have received good sex and relationships education, combined with access to confidential services, start having sex at a later age and are more likely to use contraception when they do become sexually active.

2.5 Brook believes that the most effective way to ensure that young people are enabled to make informed choices about their sexual health, and to therefore reduce rates of sexually transmitted infection and teenage pregnancy, is to make Sex and Relationships Education a statutory entitlement for all children within the PSHE curriculum.

2.6 There have been welcome improvements in SRE as a result of the teenage pregnancy strategy but these are by no means uniform across the country. Ofsted’s recent report on PSHE in secondary schools found some schools did not cover PSHE at all in order to give more time to subjects within the national curriculum. We believe that consistency and quality would be improved by a statutory curriculum instead of leaving it to the discretion of individual schools to define within their SRE policy what is taught, if anything.

3. Are the proposals appropriate, will they be effective and do they represent value for money?

3.1 The Health Development Agency’s review of the effectiveness of interventions aimed at reducing STIs found that there is good evidence that school-based sex education is effective in reducing adolescent sexual risk behaviour.

3.2 As long as SRE remains a non-statutory part of the curriculum, improvement in young people’s sexual health will be patchy at best. Giving young people access to more information about sexual health will have limited impact if they are not also helped to develop the skills needed to act on that information. Brook believes that young people need to be specifically helped to develop the ability to recognise and resist pressure so that they can delay intercourse until they are ready for it; to develop healthy relationships; and to negotiate and practise safer sex. This is most effectively done through comprehensive sex and relationships education in schools and other settings.

3.3 The British Association for Sexual Health and HIV estimates that diagnosing and treating sexually transmitted infections and their consequences costs the NHS around £1,000 million annually. The announcement of an additional spending of £300 million over three years to improve sexual health services and extend the national advertising campaign will clearly represent value for money if it leads to reduced rates of sexually transmitted infection. However, whether it will be sufficient to modernise and improve all services and meet the additional demands for testing and treatment which could result from the public information campaign is unclear.

4 Do the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

4.1 The main mechanism for ensuring that the proposals will be implemented is the NHS planning framework. We therefore welcome the Government’s commitment in Choosing Health to issue a “supplementary technical note” to ensure that NHS Local Delivery Plans address inequalities in sexual health but it is not clear whether this will provide sufficient leverage to promote service improvement in all areas.

4.2 Without ring fencing or a strong focus on sexual health within the planning framework, there must be concern as to how far local organisations will use the additional funding earmarked for sexual health for its intended purpose.

4.3 The proposal to deliver sexual health through a flexible multidisciplinary workforce has considerable training implications, in particular if non-specialist staff in primary care or youth work are to deliver high quality services or information.

4.4 The voluntary sector is well placed to support implementation of the proposals. Brook already provides positively evaluated confidential information to young people via a telephone helpline, website and on-line enquiry service in addition to providing sexual health services at its Centres, and producing sex and relationships education publications. We would welcome the opportunity not only to expand our own services but to share our expertise with other services through training and consultancy to improve young people’s sexual health services.

January 2005
Memorandum by Active Sheffield (WP 09)

Please find a response on the physical activity elements of the Choosing Health White Paper. The response has been drafted by the Active Sheffield Partnership, which reports to the city’s Local Strategic Partnership (Sheffield First for Health). The partnership includes key City Council departments plus all of the city’s four PCTs.

In general, we very much welcome the White Paper and feel encouraged by many of the proposals relating to physical activity. However, we have taken time to comment on some key omissions and on proposals that we feel need strengthening.

1. The Relative Importance of Physical Activity (PA)

Active Sheffield welcomes the emphasis given to PA in the Paper. However, the importance of PA within the public health debate has been historically under-estimated. It is unfortunate that the Paper has not taken the opportunity to correct this, particularly given the evidence recently presented in the CMO’s report.

PA reduces the risk of all-cause death and in particular the risks associated with England’s number one killer—CHD (accounts for 39% of all deaths). The British Heart Foundation recently published data estimating that 37% of coronary heart disease deaths can be attributable to physical inactivity, compared to “only” 19% from smoking (Britton and McPherson, 2000).

More importantly, physical inactivity is the most prevalent risk factor (Joint Health Surveys Unit, 1999; Health Survey for England, 1998). For example, 63% of men and 75% of women are not active enough to benefit their health (ONS, 1998). By comparison, “only” 28% of men and 26% of women smoke and “only” 41% of men and 33% of women have high blood pressure (British Heart Foundation, 1998).

Recent work in Canada (CFLRI, 2000) calculated the relative community impact of inactivity versus smoking, high cholesterol and hypertension ie the relative impact of inactivity on all-cause death. It concluded that the relative risk associated with low activity exceeds that of all the other factors considered.

2. Underpinning Principles

Whilst we generally welcome the idea of supporting “informed choice”, it is concerning that this is not fully complemented by the essential “underpinning principle” of key “enabling” measures that will significantly reduce barriers to physical activity—particularly for those living on low incomes. There is a danger here of de-contextualising PA from the wider environmental, cultural and social influences and instead being seen to promote a “self help” and potentially “low cost” approach. We believe that major infrastructure and environmental measures are needed to truly facilitate increased activity and these we feel are given too little emphasis in the Paper.

In summary, what is needed is a “whole systems” approach which encompasses a coherent package of measures on both the demand side (advice to individuals, marketing etc) and supply side (facilities, environmental changes and capacity building in clubs etc). Both need an investment programme to make them happen. Overall, the paper is reasonably strong on demand side proposals but fails short on the required supply side measures and fails to address some of the consequent investment issues such as the crisis in indoor sports provision (see later).

3. Over-Arching Priorities

We welcome the fact that “exercise” is included in these priorities. However, we note the reference to “over a third of people are not active enough to benefit their health”. In fact, the figure should read “almost 70% are not active enough”.

4. Marketing Health

We applaud the focus given to the importance of tackling the so-called “demand side” of health. The Canadian experience strongly suggests a “contributory” relationship between social marketing and activity levels ie impact on awareness, understanding and intent (Canadian Journal of Public Health, June 2004). However, the Paper suggests that in terms of the early focus in the marketing strategy, physical activity will feature only within the context of a wider obesity campaign. This raises a number of concerns:

— as stated above, physical activity is one of the most prevalent health risk factors and should command “its own slot” as a stand alone campaign;
— as the CMO recently confirmed, PA impacts across 20 or so chronic diseases and should not be confined to only one;
— the levels of PA required to combat obesity (60 minutes or more daily) are unsustainable for most people;
— obesity affects “only” a minority (20%—albeit growing) of the population and therefore any PA message within an obesity-led campaign is likely to meet with a “won’t happen to me” response from the vast majority of the population;
— lastly, evidence from other successful PA campaigns tell us to avoid “medicalising” the message.

On a more positive note, any campaign to promote physical activity should take into account the following key points:
— avoid words that carry “perceptual baggage” such as “sport” and “exercise”;
— focus on fun and enjoyment and employ humour wherever possible;
— associate PA with the benefits that target audiences value eg for young people valued benefits include spending time with friends, having fun, playing, gaining recognition and success;
— focus on those who are “ready to be active” as well as the least active;
— go beyond the “just-the-facts” message that typifies many public health campaigns—especially for young people (eg an hour a day or 5x30 minutes);
— promote a “can do” message and not a “must do” message;
— emphasise positive messages. Negative messages usually turn people off—“it won’t happen to me”. PA is about getting people to opt in/“starting” and make a positive choice, unlike smoking which is about opting out and stopping;
— publicise local successes of “real people” and encourage people to “join in”;
— emphasise simple, inexpensive and practical changes—“99 top tips to be everyday active” and “walk a street today”.

Finally, the social marketing campaign should extend its remit beyond simply communicating the right message(s). It should also include three other key elements—mobilisation via promotional events; informational guides which support the “call to action” with information on what, where and how to be active; influencing by engaging key “influencers” in the community such as employers, head teachers, youth leaders, GPs, faith leaders, local government etc—these are the people who influence the everyday settings in which people can be active.

5. Children and Young People

We welcome the focus given to young people. It is clearly recognised that “activity habits” are formed in the earliest years. We also applaud the emphasis given to the Healthy Schools strategy. However, we would suggest a number of improvements to the proposals:
— there is barely any mention of the critical importance of play as a source of physical activity—particularly for pre and primary school age children. Research by UCL (2004) found that children get more physical benefit from kicking a ball around in the park or playground than from PE lessons. The study concluded that the effort of unstructured play burns more calories than the average of 70 minutes a week of formal games that pupils get in school;
— we are concerned about the lack of priority given to pre-school and primary school aged children. Whilst investment in secondary schools is welcome, for too many—especially girls—the resources are coming too late;
— we need to see a greater commitment to lesson time PE given the difficulties that many children—especially those from low income families—have in accessing after school programmes;
— there needs to be much greater focus on the role of parents and the influence of the family in supporting active lifestyles. Inactivity is very much inter-generational and a schools-only approach will often not be sufficient to break this cycle;
— there needs to be greater emphasis on non-school activities ie community-based physical activity for young people. From birth to the age of 16 years, a child spends only 9 minutes of every waking hour in school. We need clear policies that encourage and support physical activity in the remaining 51 minutes!
— there is still too great an emphasis on sport and traditional team games within the school sport partnerships. Whilst this is fine for some children, we know that traditionally the majority have been “turned off”. Many young people—especially girls—are attracted by more individual-type activities such as dance, walking, cycling and aerobics;
— the focus in schools should be on health-related physical activity—which includes, but goes beyond, just sport. The role of physical education as the “spring board” for developing interest, confidence and skills in activity should be emphasised—PE should aim to truly “physically educate” young people. The Paper should recommend this more comprehensive approach to PE within schools as part of its strategy for promoting informed choice;
the support for cycling and active travel plans is welcomed. However, once again, these “tactical” measures must be coupled with more strategic proposals to tackle the wider infrastructure and environmental conditions. For example, cycle parking and lockers will remain largely irrelevant if safe, direct and segregated cycle lanes do not link the local community with its school.

6. LOCAL COMMUNITIES LEADING FOR HEALTH

We very much welcome the importance attached to the role of local government in promoting health and in particular the centrality of local authority and PCT partnerships working at the local level. We also welcome the expected flexibility offered by the new Local Area Agreements. However, we would wish to see a requirement that promoting physical activity form a key element of the work of all LSPs and LAAs.

The references to “whole town” approaches to active travel are to be supported. However, the commitment and follow-through on this appear to be rather vague. Similarly, there is mention of the forecasted 7,000 miles of new cycle lanes, but this is from already committed resources. Where is the vision of how we will move towards a European-standard provision of integrated cycle and footways?

The greater use of pedometers is to be welcomed. However, in the continuing absence of a serious strategy to promote a walk-friendly urban environment, we will continue to see a continuing decline in the numbers of people walking. We would have wished to see greater emphasis given to walking as the single most-important activity that can drive activity levels upwards. Pedometers will not overcome the real barriers to walking such as poorly lit routes, disconnected path networks, inadequate signage and benches and (perhaps most importantly) excessive and speeding traffic.

It is surprising and disappointing that no mention is made of stair climbing as a potentially significant means of increasing daily activity levels. Stair climbing requires high energy output—8–11 Kcal per minute—which is high compared to many other forms of physical activity. Even climbing two flights of stairs daily can lead to 2.7Kg weight loss in a year (Physical Activity Unit, Canada 2003). Stair climbing is an activity which is accessible to virtually all the population and can easily be built into daily routines. An international physical activity conference in 1998 concluded that the most successful exercise interventions in the past 20 years were stair-climbing initiatives (Sallis et al. 1998).

The suggested best practice guide on free swimming would be helpful. However, once again there is concern that the real issue here is not the lack of ideas within local government but instead the lack of resources to support the consequent loss of income. Given the clear health economics in support of physical activity, one has to wonder why the rationale underpinning the Government’s much-welcomed investment in free museum access does not equally apply to supporting (perhaps selectively) free access to physical activity. This is particularly the case with swimming—which is the second most popular activity and has safety as well as health benefits. An example of a cost-effective and targeted method of supporting “free swimming” might be to offer free “top up” lessons for those children who fail to achieve the minimum 25M during school swim programmes. Given that many of these children are invariably from low income families, the measure will also impact on reducing health inequalities.

Our concern about the lack of investment in key infrastructure was mentioned earlier. Sports facilities—including swimming pools and parks—are vital elements in this infrastructure. Indoor sports facilities are used more than any other setting for sports participation and yet we know that the national stock of sports centres requires around £550 million to be spent immediately. There is only passing reference (in Case Study sections) to these facilities. The White Paper Delivery Plan must identify (or commit to identifying) a feasible way forward on this facility crisis. Arguably the only sure way of making progress is to place a statutory requirement on local authorities to provide and maintain “reasonable” level of facility provision. This may then halt the downward trend in local government spend of sport (expenditure on sport by local authorities has fallen from £18 per head in 1998 to £12 in 2002). In the UK government spend on sport is only £21 per head per year compared with £112 in France. This under-investment is already adversely impacting on sports participation as the GHS 2002 clearly demonstrates.

The Paper talks about health inequalities in Chapter 1. However, it fails to develop the case for specific actions for selected target groups. There is a real danger that a strategy that largely focuses on social marketing and informed individual choice will lead to greater inequalities in terms of activity levels. Evidence from Finland and Canada suggests that targeted approaches can help to increase activity levels amongst “least active” groups. We would therefore suggest that the Paper’s current focus on young people should be complemented by an equal focus on older people. There are a number of reasons for this:
— 60% of those over 60 years are inactive;
— Sport England’s Sport Equity Index confirms that the group least likely to take part in sport is “70 + DEs”. This means that this group is 87% less likely to take part in sport than adults generally;
— there are more people over 65 than there are under 16;
— low income households feature disproportionately amongst this group;
— amongst those over 65, a significant number of deaths are attributable to falling—exercise can have a major impact on falls prevention and recovery;
many experts are of the view that no segment of the population can benefit more from exercise than the elderly (American College of Sports Medicine).

Despite this, insufficient work to encourage physical activity has been done with this growing population group.

The proposal for PCTs to work more closely with football clubs appears to be disconnected from any broader strategic theme within the Paper. This should fit within the wider social marketing strategy and must be clear about the intended message(s) and the likely audience.

7. NHS Health Trainers

An acknowledgement of the importance and complexity of behaviour change is welcomed and we would broadly support experimental work with Health Trainers. However, a number of critical issues must be considered:

— all primary care staff—including GPs—must be better engaged with the preventative agenda and in particular with physical activity. The danger in creating specialist roles (Health Trainers) is that this wider engagement is made even less likely (the “it’s not my job” syndrome!);  
— physical activity must be given equal prominence within the scope of advice available from Trainers;  
— advice to clients must include both structured (facility based) options and lifestyle (no or low cost, often home-based) options;  
— the social marketing campaign must create clear and simple physical activity messages—including audience specific messages—to be used in primary care settings;  
— the early development of the proposed Patient Activity Questionnaire is a critical pre-requisite to the success of the advisory scheme;  
— it must be recognised that there is little evidence of any long-term impact of advisory/counselling services based in primary care settings (Emmons and Rollnick, 2001). It should also be of concern that the cost of establishing such “downstream” services would not be easily sustained by absorbing them into mainstream general practice;  
— it is once again critical to emphasise that without policies that support environmental and infrastructure improvements, advice within primary care settings will have little sustained influence on patient activity levels.

In conclusion, we recommend that this proposal is taken forward with care and that wherever possible both a whole systems approach (including environmental and infrastructure changes) and strong evaluation measures are put in place at the same time.

8. A Health-promoting NHS

We clearly support the concept of the NHS moving towards a more preventative role. However, given the threat posed by inactivity (discussed earlier) it is concerning that there is little mention of physical activity in chapter 6. There is significant potential for primary care staff to positively influence physical activity levels. However, at the moment there is little incentive in terms of the current performance management systems (in primary care) for physical activity to be given priority. The current requirement for PCTs to have a physical activity policy is a start but it is not nearly enough.

A new strategic approach to fully engaging and supporting the primary care sector to promote physical activity is required. This must ensure that physical activity is part of the care pathways for medical conditions; that the promotion of physical activity is a routine part of practice consultation and that physical activity features in all relevant performance management systems.

9. Work and Health

We very much support the proposed inclusion of health within the IiP standards for 2007.

Whilst we wouldn’t disagree with the idea of tax-efficient bike purchase schemes, we must re-iterate the essential point that such “downstream” measures aimed at individuals will fail hopelessly without the “upstream” environmental measures needed to make cycling safe, convenient and enjoyable.
10. **Physical Activity Promotion Fund**

Whilst any additional funding is to be welcome, we would strongly urge that such a Fund is dovetailed with and complements existing funding for sport and physical activity. Local government is keen to see a “single pot” for sport and physical activity (drawing together the different funds) and would ideally wish this to be allocated to a local physical activity partnership (perhaps within the ‘health’ arm of the local LSP). The partnership would then be required to produce a plan (with identified projects, costings and outputs) submitted for approval before being allowed to draw down the allocation.

11. **Regional Physical Activity Co-ordinators**

There must be clarity as to the role of these posts and consultation should take place with local partners in each area to ensure that “added value” results from such appointments.

12. **The Voluntary Sector**

If the activity targets set by “Game Plan” are to be met then this will place significant pressures on the voluntary sports and physical activity clubs in the community—pressures that they are currently unable to meet. Urgent and much greater investment is needed in the infrastructure of these clubs. Whilst initiatives such as “Step into Sport”, “Club Mark” and CASC are helpful, they are not enough. Radical increases in participation will require more significant and sustained investment in the voluntary sector.

13. **Making it Happen—National Delivery**

There is a need for greater clarity about the respective roles of the DoH and DCMS/Sport England. For example, there appears to be a danger of both Sport England and DoH working in parallel on potential social marketing initiatives. There is also occasional apparent inconsistency about the scope of Sport England’s interests eg does it include walking or not?

If Sport England are to take a lead on the social marketing strategy they must take heed of the dangers of using “sport” as part of the headline messages and they must fully embrace “lifestyle” activities such as gardening, taking the stairs etc (as the recent NE pilot appears to have done).

At times Sport England claim to have a single focus on “sport” ie competitive and organised activities such as rugby, football, cricket, swimming etc. At other times, its attention ranges across “lifestyle” activities such as walking, cycling, dance etc. (ie non-organised, informal and often individually-based activity). Clarity and consistency would be helpful on this important issue. One view would be that the DoH take the lead on the lifestyle activities and Sport England lead on sports activities. Clearly there would need to be close and on-going dialogue between both organisations—particularly on issues such as the social marketing strategy.

14. **Making it Happen—Local Delivery**

Much greater co-ordination is needed of physical activity programmes and projects at the local level. Too often local government falls back on a narrow facility management role, whilst PCTs too often have little capacity or inclination towards physical activity. It is recommended that each locality is required to form a physical activity partnership involving local government, the PCTs and where possible commercial and voluntary sector agencies. This should form part of the LSP (preferably under its “health” arm) and be required to produce a local physical activity strategy and to oversee its implementation.

It is extremely unfortunate that the White Paper has not taken the chance to realign PCT boundaries with those of local authorities. This would provide a much stronger platform for joint planning and working.

15. **Conclusion**

Overall the White Paper represents a significant step forward in the public health debate. It also gives greater prominence to physical activity than has hitherto been the case. The recognition of the need for social marketing is very much welcomed, as is the importance afforded to individual behaviour change programmes.

However, the Paper places too little emphasis on key infrastructure and environmental measures that are needed to support the marketing and behaviour change programmes. It also fails to follow through the health inequalities issue with targeted programmes for the least active—especially older people.

Finally, the Paper misses the chance to articulate the truly prominent role that physical activity can play on the wider public health agenda. Inactivity poses the most pervasive public health risk in England and should therefore be treated as a “stand alone” issue in its own right, rather than its proposed status as subtext within the obesity debate.

*January 2005*
The Dairy Council welcomes this opportunity to comment on the Department of Health’s White Paper entitled “Choosing Health: Making healthy choices easier” which was published on 16 November 2004.

The Dairy Council was established in 1920 and is an independent, non-profit making organisation representing dairy farmers and processors across England, Scotland and Wales. The Dairy Council provides balanced, credible and consistent information about milk and dairy products and their role in a balanced diet. We provide evidence-based literature to health professionals, industry, consumers and the media. We believe that the White Paper provides an opportunity to deliver a change in public health policy and that it is imperative that this opportunity is seized.

The long awaited White Paper covers a range of health issues which are relevant to the work of The Dairy Council and we welcome the opportunity to work with government, to improve nutrition and promote a healthy balanced diet for all.

1. Communicating Health Messages and Marketing Health

The White Paper states that “messages about health are sometimes inconsistent or uncoordinated and out of step with the way people actually live their lives”. The Dairy Council agrees that there is a need for consistent and practical messages regarding nutrition and health that are relevant to the way people live and that are achievable. We believe it is important to offer consumers clear, consistent and simple health messages, which are scientifically based.

Consumers need to understand exactly what constitutes a correct portion size. The Dairy Council successfully conducts public health campaigns such as the 3-A-Day® campaign, which provides information regarding portion sizes for dairy products ie a small pot of yogurt, a matchbox size piece of cheese and a glass of milk. We also promote the DASH diet (Dietary Approaches to Stop Hypertension) which informs consumers about how eating three portions of low-fat dairy products, five portions of fruit and vegetables and a low salt intake can reduce high blood pressure.

The White Paper suggests developing a climate in which health could be marketed to the public. The Dairy Council has been promoting the nutrition and health benefits of milk and dairy as part of a balanced diet for 85 years. We believe that advertising can be used to encourage healthy lifestyles, particularly promoting a balanced diet. The Dairy Council successfully increased the nutritional awareness of milk through the White Stuff campaign. This campaign was run in conjunction with Britain’s farmers and dairies to encourage adults to drink milk more frequently and to remind people that milk is a credible alternative to any soft drink. The White Stuff campaign was also used successfully to promote school milk bars in secondary schools.

A further example of The Dairy Council’s efforts to communicate health messages to as many people as possible is our provision of nutrition information leaflets in English, Welsh and Punjabi and we will continue to support the dissemination of health information to all.

Evidence suggests that, in order to be successful, a social marketing campaign must be both significant, scientifically sound and sustained and therefore substantial resources are required. We would welcome the opportunity to work with the Department of Health and other interested parties to share expertise in developing such a campaign for the future.

The White Paper acknowledges that people currently obtain information about health and nutrition from a range of sources. One of these sources is the media. The Government recognises the scale of media interest in diet and health and that there is a need for information provided to the media to be accurate and accessible. As a result, from the beginning of 2005, the Department of Health will provide support for the development of a National Centre for Media and Health. The Dairy Council would encourage the Department of Health to recognise the value and excellence of the Science Media Centre, an independent venture working to promote the voices, stories and views of the scientific community when science hits the headlines, and to develop a National Centre for Media and Health which works along similar lines. The Dairy Council would be happy to work with a well run and organised centre for media and health which uses scientific evidence to promote a balanced dietary approach to health—much like the way The Dairy Council works at the moment.

2. Increasing Availability of Healthier Foods

The White Paper states “Health ministers and the FSA are leading discussions with industry to identify and implement a range of proposals to increase opportunities for people to make healthy choices in what they eat. These are aimed at increasing the availability of healthier foods including reducing the levels of salt, added sugars and fat in prepared and processed food and drink and increasing access to vegetables”. The dairy industry responded many years ago to the demand for low-fat foods with the result that semi-skimmed milk now outsells whole milk. The recent National Diet and Nutrition Survey of adults found that semi-skimmed milk was the usual milk consumed either as a drink or with cereal for the highest proportion of men and women across all age groups. Few other examples exist where a low-fat variety has been
successfully developed and now outsells the conventional product. In addition to low-fat milks, the dairy industry now also produces a wide array of low-fat yogurts, fromage frais and reduced-fat cheeses. The Dairy Council will continue to monitor new scientific research and recommend ways of developing products to offer healthier choices to consumers.

3. **Food Labelling**

The White Paper suggests that consumers find it difficult to understand current nutrition labelling and that action should be taken to simplify labelling and make it mandatory on all packaged foods. The Dairy Council welcomes that the White Paper reinforces the need for farming, industry and the Government to work together by coordinating action and promoting consistent messages and healthier food choices. The Department of Health together with the Food Standards Agency is currently developing criteria based on fat, sugar and salt contents of foods in order to outline the contribution of such a food to a healthy diet. The aim of such “signposting” of foods will enable consumers to make an informed decision about which foods they can incorporate into their diets to achieve a healthy and balanced diet.

The Dairy Council agrees that consumers need clear and accurate labelling to make healthy and informed choices; however, it is important that any new scheme is supportive of consumers and does not confuse them or demonise particular foods. For example, cheese due to its high salt content may be seen as unhealthy despite its high calcium levels.

The Dairy Council believes that in reality, it is not a particular food but the frequency of its consumption together with portion size, which is central in determining the role a food plays in a balanced diet. We feel that the existing Guideline Daily Amounts (GDAs) system could be better promoted. These values, which are currently printed on packaging of many foods, enable consumers to estimate the contribution of a particular food to their daily intake of energy, salt or fat. The GDA system could be extended to include estimates of beneficial nutrients such as calcium. Indeed GDAs in combination with portion sizes could be a valuable means of assisting consumers in making healthy food choices.

The Dairy Council is currently preparing its response to the FSA consultation document on food labelling and welcomes the opportunity to be part of new food labelling discussions.

4. **Children, Young People and Schools**

The Dairy Council welcomes the Government’s proposals on improving the diet and nutrition of children and young people.

The Dairy Council agrees that nutrition plays a key role in a healthy start to life. We welcome the Government’s initiative to provide “eligible pregnant women (including all pregnant women under 18), breastfeeding mothers and young children in low incomes families with vouchers that can be exchanged for fresh fruit and vegetables, milk and infant formula”. However, we are concerned that children attending nursery schools and day care facilities will receive either milk or fruit and not both. In our response to the Department of Health’s Healthy Start Consultation, The Dairy Council highlighted its strong concerns about the range of nutrients that children in this age group would be missing out on, if nurseries schools and day care providers are forced to make a choice between milk and fruit. Milk is a valuable source of energy, vitamins, (particularly B vitamins) and minerals, (particularly calcium) which are important for normal growth and development. Fruit also contains a variety of vitamins and minerals as well as phytosterols and dietary fibre, which are important in the diet. However, 100g of milk provides more riboflavin and calcium than 100g of apple, apricot and banana combined. To achieve a balanced diet and benefit from the nutrients both milk and fruit have to offer, The Dairy Council would encourage the Government to look at ways of providing both milk and fruit to children in nursery and day care.

The White Paper states “Health Professionals will have a more visible role in the Healthy Start scheme, providing information and support to families on breastfeeding, child nutrition and other key health issues”. The Dairy Council already supports health professionals, pregnant women and mothers by producing literature on topics such as diet during pregnancy and breastfeeding, weaning, healthy eating for the under-fives, looking after children’s teeth, nutrition and health in teenage years, and meeting calcium requirements. Consequently, The Dairy Council has extensive contact with nurseries, health visitors and other health professionals, we would encourage the Government to take advantage of our expertise and involve The Dairy Council in campaigns which educate health professionals and promote healthy diets to children and young people via nurseries and schools.

We welcome the Government’s intention to improve the nutritional quality of school meals, the provision of water and the introduction of healthy drinks to schools. The Dairy Council is involved in a number of promotional activities, targeting school-age children and young people. These groups are particularly at risk of a poor calcium intake because of erratic and unbalanced dietary habits.
In 2002, The Dairy Council became aware that head teachers in secondary schools were looking for a healthy alternative to carbonated drinks machines, but there was no automatic, easy solution. Working with the Health Education Trust, a pilot project to introduce healthy drinks vending machines into 12 secondary schools in four areas of the UK (Cumbria, Devon, Hertfordshire and Pembrokeshire) was designed. The purpose of the feasibility study, funded by the Food Standards Agency, was to investigate if vending machines selling milks, water and fruit juices could be profitable in secondary schools. At the conclusion of the study, 70,000 healthier drinks were bought from the vending machines. It was evident that given the option students frequently chose healthier options. In addition, many of the schools made profits from the machines. The Dairy Council’s experience in working with schools indicates that, if conducted in an appropriate way, both teachers and pupils will be receptive to enhanced nutrition education.

Between September 2001 and March 2002, The Dairy Council also ran a school milk campaign in 10 Local Education Authorities (Manchester, Stockport, Warwickshire, Coventry, Solihull, Birmingham, Vale of Glamorgan, Barking & Dagenham, Havering, and Redbridge). The objective of the campaign was to raise awareness of the EU subsidised school milk scheme and persuade parents that milk was important to young children. The campaign focused on dispelling the “red tape” myth surrounding the subsidy scheme and demonstrated that milk at break-time can make an important contribution to a child’s daily nutrient requirements. Target audiences included parents, teachers, health professionals, MPs, local councillors, school nurses and the dairy industry.

The Dairy Council would like to acknowledge the Government’s contribution to the subsidised school milk scheme but point out that this scheme has not been promoted in the White Paper. We would encourage the Government to continue its support for the school milk scheme which enables all school children between the ages of 5 and 11 to receive up to 250ml of whole or semi-skimmed milk each day at a subsidised price. However, currently in the UK only a minority of schools are offering this reduced price milk, despite the vast scientific evidence supporting the role of milk and dairy products in the diet of growing children. Furthermore the White Paper does not address the contribution of dairy products to the intake of important nutrients in diets of both children and adults.

5. Obesity

The White Paper highlights the fact that over the last 20 years the number of children and adults who are overweight and obese has increased significantly. Indeed, the prevalence of obesity has trebled since the 1980s and currently almost 24 million adults are either overweight or obese. If current trends continue, at least one-third of adults, one-fifth of boys and one-third of girls will be obese by 2020. Obesity is a risk factor for a number of chronic diseases such as heart disease, stroke, certain cancers, type-2 diabetes and osteoarthritis.

The Dairy Council, which represents the dairy industry on all matters relating to public health and nutrition, encourages all dairy companies to offer consumers low-fat or reduced-fat alternatives to conventional foods. In recent years the dairy industry has responded by vastly increasing the number of low-fat dairy products available to consumers.

It is interesting to note that whilst childhood obesity is on the increase, milk consumption in this age group is declining. We would suggest that more research needs to be conducted into the potential association between these factors. The Dairy Council currently recommends that primary schools offer semi-skimmed milk at break-time, even though the subsidised milk scheme offers a larger rebate for the provision of whole milk.

The Dairy Council applauds the Government’s plans to tackle the problem of obesity and looks forward to the opportunity to work with government bodies, industry, retailers and health professionals to stem the rise in obesity, particularly in children.

6. Physical Activity

The Dairy Council welcomes the promotion of increased physical activity. Societal shifts towards sedentary behaviour are concerning, particularly in light of the increasing numbers of children and adults who are overweight and obese in the UK. Physically active people have 20–30% reduced risk of premature death and up to 50% reduced risk of major chronic disease such as coronary heart disease, stroke, diabetes and cancer. A multi-faceted approach is required to combat this rise in overweight and obesity with physical activity and a balanced diet playing a key role. The Dairy Council welcomes initiatives to increase the opportunity for physical activity for all ages in a safe supportive environment.

January 2003
Memorandum by the Children’s Food Bill Campaign, co-ordinated by Sustain (WP 11)

1. SUSTAIN’S CHILDREN’S FOOD BILL CAMPAIGN

1.1 The Children’s Food Bill campaign, co-ordinated by Sustain: The alliance for better food and farming, currently supported by 125 national organisations (Annex I) [not printed]. These organisations have come together in recognition of the fact that the growing crisis in children’s diet-related health requires a multi-faceted solution which recognises the ineffectiveness of voluntary attempts to end commercial practices which encourage unhealthy food environments both in and out of school.

2. STATUS OF MEMORANDUM

2.1 This memorandum is in response to the Health Committee’s invitation to submit comments about the effectiveness of the proposals contained in the Government’s Public Health White Paper. It focuses on those proposals which refer to the regulation of marketing of food to children and which make reference to school food environments.

2.2 A draft of this response has been circulated for comment to all 125 national organisations which currently support the Children’s Food Bill.

3. SUMMARY

3.1 The Health Committee acknowledges in its Obesity Inquiry that the “epidemic” in childhood obesity is now well-documented, as are the numerous ill-effects it has on children’s physical and psychological health. The Inquiry also acknowledges that food advertising and promotion to children is intense, relentless and exploitative and influences the types of foods children eat. This “onslaught” compromises children’s health, by encouraging over consumption of energy dense foods, and also of other dietary components, such as saturated fat, sugar and salt which, independently of obesity, lead to the early onset of a range of diseases.

3.2 We welcome the Government’s recognition of the strong case for action to restrict further all forms of unhealthy food advertising and promotion to children. However, we are concerned that the Government proposals place undue reliance on voluntary codes of practice instead of introducing robust protective legislation. This weak response is in stark contrast to the pre-White Paper press reports of bans on junk food advertising, which have misled many into believing that the Government is taking effective action.

3.3 The White Paper is also full of advice for schools rather than requirements, relying again on voluntary action. However, as the Obesity Inquiry noted, children’s nutritional requirements do not vary according to where they go to school and it does not make sense for healthy food provision in schools to be a matter purely for local determination. Thus, the White Paper’s advice that schools should balance the “benefits” of food promotional activity with the ethos of a healthy school (p 36, para 57) will be interpreted differently by different schools.

3.4 An alternative approach is Sustain’s Children’s Food Bill, which was presented to Parliament by Debra Shipley MP in May 2004 and which will be re-presented during February 2005. The purpose of the Bill is to improve children’s current and future health and prevent the many diseases and conditions which are linked to their “junk” food diets. This will be achieved through a number of statutory measures—as opposed to ineffective and weak voluntary guidance—which will improve the quality of children’s food, both in and out of school, and protect them from commercial activities which promote unhealthy food and drink products.

3.5 By the end of the Parliamentary session in November, 248 MPs had signed Early Day Motion (EDM) 1256 in support of the Children’s Food Bill (Annex II) [not printed], making it the twelfth most signed EDM out of nearly 2,000 that were tabled during the session. In addition, more than 120 national organisations, including the British Medical Association and other leading medical and health charities, have confirmed their support. This wide professional and cross-party political support is matched by very strong public support for its provisions.

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26 Sustain advocates ethical and sustainable food and farming policies and practices—see: www.sustainweb.org
29 House of Commons Health Committee, “Obesity”, 10 May 2004, para 196 states, “Children are subject to an onslaught of food promotion in their daily lives, and the school environment appears to be no exception . . .”.
30 “Junk food ads banned to fight fat epidemic”, The Observer, 14 November 2004 (lead article).
31 “Junk food TV adverts to be banned”, Sunday Times, 14 November 2004 (lead article).
32 “Move to ban junk food ads for children on television”, The Independent on Sunday, 14 November 2004 (lead article).
4. **Whether the Proposals Will Enable the Government to Achieve its Public Health Goals**

4.1 In July 2004, the Government announced a new cross-departmental PSA target of “halting the year on year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.” \(^{33}\) The White Paper states an aspiration to change the balance of children’s food preferences, but for this and the PSA obesity target to be achievable and sustainable, it is essential that children’s food environments promote healthy eating from an early age.

4.2 However, the Food Standards Agency’s (FSA) 2003 systematic review describes the sharp contrast between a healthy diet and the one which is marketed to children. \(^{34}\) The FSA review also establishes that food promotion has a direct effect on children’s food preferences, purchase behaviour and consumption. The Obesity Inquiry acknowledged that the culture of ubiquitous food marketing to children, which presents unhealthy foods as positive and desirable choices, increases children’s consumption of these products and undermines attempts to encourage healthy alternatives.

4.3 Since the publication of the Obesity report, Ofcom has also published research which supports the FSA’s conclusion of the direct effect of television food advertising on children’s diets. \(^{35}\) Both the FSA and Ofcom agree that there are also significant indirect effects of advertising, which according to Ofcom have a “powerful influence” on young people’s diets.

4.4 As obesity results from an imbalance between energy intake and energy expenditure, both diet and physical activity are important in determining children’s weight. The central role played by diet in the aetiology of obesity is highlighted by a recent Department of Health report which states that burning off the calories supplied by a cheeseburger, fries and shake requires a nine-mile walk. \(^{36}\) However, it is important to emphasise that the alarming rise in childhood obesity is but one of a number of dietary issues which affect children’s health. The vast majority of children consume more saturated fat, more free sugar and more salt than the Government maximum recommended levels for adults. \(^{37}\) Quite independent of obesity, consumption of these dietary components results in premature hardening of the arteries, \(^{38}\) the formation of dental caries, \(^{12}\) and increased risk of asthma, \(^{39}\) and stroke in later life. \(^{40}\) Increased physical activity *per se* does not, therefore, make an unhealthy diet any less unhealthy.

4.5 We do not consider that the Government will be able to meet its stated obesity public health goal, nor protect children’s health from a range of other diet-related diseases, without tougher proposals than those contained within the White Paper.

5. **Whether the Proposals Are Appropriate, Will Be Effective and Whether They Represent Value for Money**

5.1 We welcome the White Paper’s formal acknowledgement of the causal link between food marketing and children’s food choices. However, having identified the problem, restated the strength of the research and noted the huge public support for protective action, the Government opts for inappropriate policies.

5.2 The efficacy of these proposed policies rely on the unknown outcome of an unnecessary further consultation on unspecified proposals which is to be undertaken by Ofcom. It also relies on the development on a meaningful voluntary code on food promotion, which will require full industry compliance. As all previous efforts to persuade the food and advertising industries to exercise social responsibility in their marketing of food to children have met with failure, the Government’s preferred option of consultation and voluntary control lacks credibility.

5.3 In July 2004, the FSA’s Board formally agreed its Action Plan on Food Promotions to Children, which introduces a range of policies to improve children’s diets. \(^{41}\) Echoing earlier calls for social responsibility by the Chief Medical Officer, \(^{42}\) the FSA acknowledges that the success of its Action Plan depends crucially upon industry adopting a responsible approach to food promotion. \(^{43}\) However, the FSA’s earlier attempts in 2000 to develop a voluntary code on the promotions of food to children were met with fierce objections from the food advertising industry. \(^{44}\) There are no indications that the current FSA Action Plan is any more likely to be welcomed by industry and lead to a reduction in children’s exposure to junk food marketing.

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\(^{34}\) Food Standards Agency, (2003), Review of research on the effects of food promotion to children, FSA, London.


\(^{40}\) MacGregor G & He F, (2003), How far should salt intake be reduced?, *Hypertension*, 42, 6, 1093–9.


\(^{43}\) Food Standards Agency Board paper 04/03/02, “Promotional Activity and Children’s Diets” (para 14).

\(^{44}\) “Code of Practice on the Promotion of Foods to Children”, FSA notes of industry meeting on 13/12/00 (unpublished).
5.4 Moreover, in its Obesity Inquiry, the Health Committee accepted that the food and advertising industry was “genuine in its desire to be part of the solution” and called upon them to, among other things, voluntarily withdraw from all television advertising of unhealthy foods to children. This recommendation has been contested by industry and, to date, not implemented.

5.5 Paradoxically, whilst agreeing that advertising can play a role in healthy eating and behavioural change, food industry representatives continue to refute arguments that unhealthy food promotions contribute towards the poor state of children’s diets.\(^4^5\) In order to shift responsibility away from an industry that aggressively markets energy dense foods to children, the food advertising industry routinely and misleadingly characterises obesity as being a problem predominantly about insufficient physical activity.\(^4^6\) The perpetual resistance from most within the food industry to acknowledge its role in the problem suggests that industry will, again, object to and then ignore the Government’s proposed voluntary controls.

5.6 The White Paper states that the Government “wants to see” schools provide food education and skills, promote healthy food, and restrict other options, but gives no indication of what—if anything—will happen if schools don’t follow this advice (p 57, para 54). Other proposals pertaining to the school food environment are similarly weak. Although a commitment is given to invest in improving nutrition in schools, no specific monetary figures are given and the option to “strongly consider introducing nutrient-based standards” for school meals (p 58, para 57), is not a commitment to do so.

5.7 As it is clear that the Government’s proposals will be ineffective, they will not help to reduce the ever-increasing burden of obesity and associated illness upon the NHS and economy. The Government states that it does not plan to consider the need for more interventions in relation to the marketing of food to children until 2007 and it does not commit itself to any specific action at that time. At current trends another 220,000 children each year may become overweight or obese,\(^4^7\) further undermining children’s health and escalating the economic burden to the country.

6. **WHETHER THE NECESSARY PUBLIC HEALTH INFRASTRUCTURE AND MECHANISMS EXIST TO ENSURE THAT PROPOSALS WILL BE IMPLEMENTED AND GOALS ACHIEVED**

6.1 The Ofcom and FSA research establishes firmly that, both directly and indirectly, food advertising affects children’s food preferences, knowledge and behaviour. An appropriate and proportionate response from the Government would therefore be to act in the best interests of children’s health by introducing legislation to remove this influence.

6.2 Instead, the White Paper offers non-specific consultation by an industry-sympathetic regulator and voluntary codes which will be developed with the food and advertising industries. The Children’s Food Bill campaign therefore maintains that the proposals in the Public Health White Paper fail to provide the necessary health infrastructure and mechanisms to safeguard children’s health. Furthermore, the White Paper does not detail any mechanism(s) for independent monitoring to assess whether the voluntary approach has “worked” by 2007.

6.3 By definition, voluntary codes do not have meaningful sanctions and companies which flout them often place themselves at a competitive advantage. This dilemma has also been highlighted recently by the Office of Fair Trading, which has recognised the anti-competitive nature of voluntary approaches.\(^4^8\) The Children’s Food Bill, or equivalent legislation, will ensure a “level playing field” for all food manufacturers, so that no company is placed at a competitive disadvantage for not marketing “junk” foods to children.

6.4 There is also concern about Ofcom’s impartiality to conduct the White Paper’s proposed consultation to tighten the rules on broadcast advertising and sponsorship of food and drink to children.\(^4^9\) In a media release in early 2004, the National Consumer Council stated that by placing commercial interests above consumer protection, Ofcom’s proposals for the future of broadcast advertising regulation lacked independence.\(^5^0\)

6.5 Following publication of Ofcom’s research into food advertising to children, Sustain wrote to the regulator to criticise some of its conclusions and its related media release, which led to inaccurate reports that it had already decided not to ban junk food advertising during children’s television. It is not surprising that such poor communication from the Government’s communication’s regulator leads many to suspect that, behind its public façade, Ofcom opposes the controls required to protect children from unhealthy food advertising.\(^5^1\)

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\(^{46}\) For example, in Carlisle D., (2002), Do children need a commercial break?, Health Development Today, 7 (March).

\(^{47}\) International Obesity Task Force estimate based on Health Survey for England 2002 figures.

\(^{48}\) “Food firms are warned obesity fight ‘is illegal’”, The Telegraph, 10 October 2004.

\(^{49}\) The Guardian Editorial on 17 November 2004 describes how following the publication of the White Paper, Ofcom claimed a ban was not necessary. The Editorial concludes that “Even the regulator seems to have been captured.”


\(^{51}\) See for instance Media Release issued by Debra Shipley MP on 16 November 2004, which criticises the Government for inappropriately asking Ofcom to consult on food advertising to children.
6.6 Enactment of the Children’s Food Bill would result in the introduction of statutory regulations prohibiting the marketing to children of unhealthy foods, using criteria defined by the FSA. This includes foods which may not be exclusively children’s foods, for instance crisps, sugary soft drinks and chocolate bars, but which are aggressively marketed to them. This will bring to an end the many commercial activities, including all forms of advertising, which promote unhealthy foods to children.

6.7 The Bill will make manufacturers producing foods for the children’s market legally obliged to comply with the FSA specified thresholds (eg for maximum levels of fat, saturated fat, sugar, salt, additives and contaminants). The result will be substantial improvements in the quality of children’s food. Improving the quality of the foods children eat will benefit the health of children living in poverty in particular, as they have the poorest quality diets and suffer disproportionately from diet-related diseases.52

6.8 The Children’s Food Bill also requires mandatory nutrient and compositional standards for all school meals, an end to the sale of unhealthy foods and drinks from school vending machines, and food education and practical food skills (such as those needed choose, grow and prepare healthy food) for all schoolchildren. Moreover, the Bill requires Government to promote healthy foods to children (such as fruit and vegetables), thereby providing a multi-faceted solution to the crisis in children’s diet-related health.

6.9 We recommend that the Health Committee:
   — acknowledges that the Government’s Public Health White Paper is insufficiently robust to guarantee improvements in children’s health; and
   — calls upon the Government to adopt the Children’s Food Bill, or equivalent protective legislation, at the earliest opportunity.

6.10 Sustain’s Children’s Food Bill Campaign would welcome the opportunity to give oral evidence to the Health Committee.

January 2005

Memorandum by Manchester Health Inequalities Partnership (WP 12)

1. INTRODUCTION

1.1 The Manchester Health Inequalities Partnership (HIQP) is one of the seven Thematic Partnerships that comprise the city’s Local Strategic Partnership. It includes representatives from several departments of the City Council, the three Manchester PCTs, the Community Network for Manchester, the NHS acute sector, and local universities.

1.2 This document sets out some brief comments on Choosing Health: Making healthy choices easier. In the time available it has not been possible to prepare a comprehensive response: this paper simply sets out some of the key points made by the HIQP in its consideration of the White Paper.

1.3 The White Paper’s priorities for action closely mirrors the key local public health priorities set by the HIQP; consequently the comments set out below are largely structured around these priorities rather than around the chapter headings.

2. OVERALL PERSPECTIVE

2.1 In many ways the White Paper is disappointing. Its dogged insistence on focusing on choice rather than the socioeconomic determinants of health runs counter to the HIQP’s recommendation in its response to the consultation, although it is true that to some extent such determinants are addressed by other areas of government policy. In addition, the proposals are weak in many areas where the HIQP was urging bravery and radicalism. However, there are some parts of it that are very welcome.

3. SPECIFIC PRIORITY AREAS OF WORK

3.1 Tackling tobacco. The proposals around smoke free public places are woefully inadequate. They do not go far enough and the timescales for implementing the proposals are absurdly long. There is some evidence to suggest that in Manchester they may in fact contribute to a widening of health inequalities within the city, as the city centre and gastropubs go smoke free, and the local pubs in more deprived communities stop serving food. The creation of “drinking only” establishments may also go counter to the drive towards a more Continental drinking culture, and so encourage binge drinking. We believe that these proposals will widen social health inequalities, so run counter to the government’s public health priorities. They are therefore not appropriate; they will not be effective; and nor will they represent value for money. The Regulatory Impact Assessment published alongside the White Paper illustrated that the net economic

benefit from completely smoke free public places is significantly greater than from the proposed policy position. We strongly recommend that the Committee should urge Government to reconsider this policy and implement a total workplace smoking ban by summer 2006.

3.2 Food and health. The commitment to fund more community food initiatives is welcome, although details are sketchy; the advertising restrictions are welcome though not sufficient; but it is disappointing that the government has failed to be more robust in challenging and regulating the food industry, and there is no indication of new resources coming to local areas to support developments. We believe that voluntary approaches to advertising restrictions and product development will have little impact: it would be considerably more effective in meeting public health goals for the government to act now to tighten regulation of the food industry.

3.3 Physical activity. The White Paper is generally weak on promoting physical activity; it is to be hoped that the promised Physical Activity Action Plan will be an improvement. More guidance is promised, and investment in schools sport and PE, but there is little sense of a coherent strategy. In particular, the government has shied away from the area that seems most likely to be effective in increasing levels of physical activity: using whatever measures necessary to get people out of their cars for most journeys. A range of anti-car and pro-alternative measures will be needed, including ones that impact on people financially, to increase active travel and help people build activity into everyday life.

3.4 Accidents. Unsurprisingly when the prevailing dogma is one of choice, the White Paper has almost nothing to say about accident prevention at all; it is not even one of the key priorities for action. RoSPA will be commissioned to establish an accreditation scheme to sustain best practice, and there is to be a national standard for cycle training—but no new resources to run more classes, which is the problem in Manchester. There is nothing on reducing traffic speeds nor any new investment in home safety, education programmes, or falls prevention services. Given that accidents are the leading cause of death among young people, we believe that this is a missed opportunity. Government should act to review national speed limits such that most roads in built up areas have a 20 mph limit: this probably saves lives, even over short timescales, and is known to be extremely cost effective.

3.5 Sexual health and teenage pregnancy. It is possible that sexual health services will see the biggest change as a result of the White Paper, with new resources promised and hints about changes to the way sexual health services are delivered. Little is said about teenage pregnancy, short of a commitment to “support[ing] Teenage Pregnancy Partnership Boards to strengthen delivery of their strategy in neighbourhoods with high teenage conception rates.” There is little about prevention. In particular, insisting that adequate sex and relationships education is provided in all schools (they can currently largely opt out) will be essential. The government has always shied away from this, and does so again in the White Paper.

3.6 Alcohol. Overall, investment in treatment appears strong, but there is little to excite those interested in prevention: no regulation of high volume vertical drinking, nothing (other than education campaigns) to encourage more responsible drinking, and a tobacco policy that may make things worse. We strongly believe that the government should make the promotion of public health a key objective of licensing policy, and that current licensing proposals should be reviewed accordingly. Current policy seems very likely to run counter to attempts to reduce binge drinking and general levels of alcohol consumption, with all the health consequences of this.

4. OTHER COMMENTS

4.1 PCT funding. PCT funding is mentioned briefly and inadequately: “We shall continue and if possible accelerate distribution towards need” (emphasis added). Manchester has been campaigning for PCTs to reach their target allocations by 2010: at the current pace of change it could take some PCTs more than 20 years to reach the level of funding identified as their “fair share” of NHS resources. Most of the “losers” are in deprived areas, and most of the “winners” in more prosperous areas: hardly helpful in achieving reductions in health inequalities.

4.2 Health trainers. We welcome the idea behind health trainers, but whether these will emerge as a significant and valuable part of the workforce will ultimately depend on whether they are adequately resourced and trained to provide the intensity and type of support required. What is not needed is a group of volunteers trained to tell people where the nearest leisure centre is. What is needed is people with the skills and the time to work closely with individuals and families, identifying on a one to one basis what it is that is preventing them from choosing a healthy lifestyle, and supporting them to address whatever issues need to be dealt with. This may initially apparently have little to do with health—it may be about dealing with debt, or low self-confidence, or lack of skills. However, without these factors being addressed no amount of signposting people to services or “persuading” them to change their lifestyle is going to be helpful or sustainable.
5. CONCLUSION

5.1 The White Paper contains one or two key initiatives that, if adequately funded, could be interesting and innovative ways of encouraging individuals to change their behaviour patterns in ways that will be beneficial to their health. However, on many occasions it shies away from taking the sort of radical action we urged when responding to the consultation. It also tends to assume that those other areas of government policy that deal with the main determinants of health are acting in a health positive way, rather than challenging them to do better.

5.2 For most of the strategies associated with the local public health priorities there is little in the way of innovation. Ultimately what was touted during the consultation phase as being “the most exciting opportunity for public health in 20 years” has ended up being disappointingly thin on radical social changes to improve health and reduce inequalities.

January 2005

Memorandum by the British Geriatrics Society (WP 13)

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners and scientists engaged in research of age-related disease.

Geriatric Medicine is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

The BGS welcomes the opportunity to respond to the White Paper and makes the following points:

1. The BGS welcomes the aspiration of the White Paper to move towards health promotion as a complimentary strategy to disease management, but is disappointed by the focus on children and the working population, with a lack of reference to older people, particularly those approaching retirement. Older people stand to gain as much from a health promotion approach as younger people and their relative absence from this paper will prevent the government achieving its public health goals.

2. The BGS would hope that increased expenditure on health promotion where evidence of cost effectiveness is weak, would not be at the expense of proven interventions for health problems of older people including comprehensive geriatric assessment and rehabilitation which are evidence based.

3. The Society believes cessation of smoking to be an important health promotion measure to reduce the incidence of chronic chest disease, ischaemic heart disease, cardiovascular and peripheral vascular diseases and would urge that the proposed ban on smoking in public places is implemented without exceptions in line with other countries including Scotland and Ireland.

4. The Society welcomes measures to tackle the problems of obesity and poor nutrition. However, there is evidence that increased exercise is beneficial at all ages and not just an issue for the young, which should be highlighted. In addition, older people may suffer from problems of under nutrition and poor dietary balance emphasising the need for greater awareness and education surrounding nutritional issues in older people. The issues may be exacerbated by concurrent disease, low incomes and social isolation.

5. The Society also welcomes measures to moderate the consumption of alcohol in society. Again, this is not purely an issue for the young. In many areas, high alcohol intake throughout life has been a cultural feature leading to increasing evidence of liver disease and mental health problems among older people, exacerbated in the post retirement period.

6. The Society is concerned that mental health is insufficiently represented in the White Paper. There is an emphasis on work related stress, but levels of stress, depression and anxiety among spouses and carers of people with chronic disease are very high and often under-recognised. Vulnerable older people living alone suffer from the same issues.

7. The Society welcomes the recognition of the impact of inequalities in the White Paper. There is a lack of equity in health care resourcing which is particularly evident in services for vulnerable and older people, but also inequity of access due to disability or disengagement. Current concerns over the value of pensions and financial security may exacerbate these issues and the Society would urge that attention be paid to these areas.
8. The Society acknowledges the important role of community matrons (advanced nurse practitioners) in health promotion and chronic disease management. However, the role of these professionals seems to be disease specific and may not address the multiple co-morbidities special to older people. The role of health trainers appears unevaluated at this point.

January 2005

Memorandum by Heart of Mersey (WP 14)

Thank you for the opportunity to respond and give evidence to the Health Committee on the Government’s Public Health White Paper.

Heart of Mersey (HoM)* welcomes the White Paper “Choosing Health: Making healthy choices easier” as an important start to a Governmental commitment to “promote physical and mental wellbeing and prevent illness”.

In Merseyside, we have particularly high levels of coronary heart disease (CHD) in some of the most socially and economically disadvantaged communities in England. HoM is a combined response across this region to address the causes of CHD. As a regional intervention programme HoM can pool resources to address coronary heart disease prevention. For example, HoM is able to develop research to support its interventions, to work towards ensuring healthier food is available to our local population and to support more smoke-free public places.

HoM is able therefore to make its own contribution to some of the priorities highlighted in the White Paper.

In general, HoM sees the White Paper as making an important start on key public health issues but feels that too many of its actions focus on the individual.

Our brief responses to your specific questions are detailed below:

1. WHETHER THE PROPOSALS WILL ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS

We feel that there are serious limitations in the proposals.

Firstly in regard to food.

Heart of Mersey has recently published a Food and Health Strategy for Greater Merseyside.53 The strategy identifies the role HoM can play in “upstream” interventions such as in food procurement, in work with the food industry including caterers and in contract specifications. In addition HoM seeks to involve our local community through promotional campaigns.

However, we are unable to influence the Common Agricultural Policy (CAP) where so many key decisions are made in food subsidies and support for farmers. Heart of Mersey urges that a major reform of the CAP is required in which food production is clearly related to the health needs of the consumer.

There is a huge contrast between allocations in the CAP budget and the dietary targets of the World Health Organisation (WHO) and the Food and Agricultural Organisation (FAO) and illustrate the urgent need for reform. In particular there should be a switch from animal-based to plant-based production and towards more sustainable production.

Whilst a major omission in the White Paper, HoM believes that it is essential that this “European” dimension is considered in the planned Food and Health Action Plan.

We congratulate the Government on the moves it has already made towards clearer food labelling and controlling the marketing on “junk” food to young people. However HoM believes that more regulation is required if we are to be successful in controlling some of the advertising excesses of the food industry and we fully support the Children’s Food Bill and its commitment towards better food and a healthier future.

Further, HoM believes that national legislation is required to support a reduction in salt, fat and sugar in all processed food products manufactured and sold in the UK.

Finally, in supporting the public sector to carry out its role as a corporate citizen, HoM urges the Government to develop nutrient-based guidelines for public sector procurement.

Secondly, concerning tobacco.

Heart of Mersey organised a coalition of Greater Merseyside Local Authorities and NHS Trusts to write to the Rt Hon John Reid just prior to the publication of the White Paper supporting the case for national legislation to prohibit smoking in enclosed workplaces.

We are therefore pleased that tobacco has received a high profile in the White Paper and support the Government’s continuing action to further curtail the advertising and production of tobacco products. HoM believes this has helped to reduce the prevalence of smoking and supports those smokers who have

given up. However HoM is concerned that the proposed legislation on smokefree legislation is half-hearted and potentially ineffective. We believe that the evidence on the detrimental health effects of secondhand smoke is unequivocal.

As in many other areas, there is a clear mandate for public places to be smoke free: according to the Big Smoke Debate—North West, over 85% of North West residents would prefer smoke free public places.

There are major differences in smoking habits across Greater Merseyside with rates of over 50% in some of our more disadvantaged neighbourhoods.

HoM believes that by permitting those public houses not serving food to allow smoking, this will have a disproportionate effect in our poorest areas and will encourage greater health inequalities. We urge a reconsideration of the wording of the new legislation towards a clear and unambiguous message towards the pub and hospitality trade.

In the meantime HoM strongly supports Liverpool City Council’s Private Bill (section 239 of the Local Government Act 1972) to protect workers from second hand tobacco smoke by prohibiting smoking in enclosed workplaces.

2. WHETHER THE PROPOSALS ARE APPROPRIATE, WILL BE EFFECTIVE AND WHETHER THEY REPRESENT VALUE FOR MONEY

HoM will develop social marketing campaigns with our partners supported by our phoneline and website to engage our local communities to create more informed choices. However, this needs to be supported by Government campaigns promoting healthier food choices and a smoke-free environment.

As previously noted, national legislation is necessary in certain situations. Tobacco is a good example. Voluntary agreements simply do not work. In many cases, people are very clear on the healthiest choice. For example most people feel strongly about food in schools but legislation will be necessary to require food companies to produce healthier processed foods (with less hidden fats, sugar and salt) and at the same time advertising targeting children must be restricted.

If individual and informed choices are not supported we run the real risk of increasing inequalities as it is always those from the most disadvantaged areas (including large areas of Merseyside) who find it hardest to make the changes towards a healthier lifestyle.

It is difficult to say if the proposals represent value for money. However, studies have shown that investment in reducing risk factors (such as promoting a healthier diet to reduce serum cholesterol) for coronary heart disease is a much cheaper and more effective method of reducing the disease than cardiological treatments.54

3. WHETHER THE NECESSARY PUBLIC HEALTH INFRASTRUCTURE AND MECHANISMS EXIST TO ENSURE THAT PROPOSALS WILL BE IMPLEMENTED AND GOALS ACHIEVED

HoM believes that it is essential that adequate funding is provided to support the work described in the White Paper. Some should be allocated to national social marketing campaigns linked to local and regional programmes such as Heart of Mersey:

We are pleased that the Government has promised to provide more funding to strengthen the evidence base for the White Paper.

We hope that funding will also be made available to organisations such as Heart of Mersey who are making a concerted effort towards preventing the biggest killer—coronary heart disease—of the population of Greater Merseyside.

* Please note:

Heart of Mersey is a coronary heart disease prevention programme funded primarily by the 10 primary care trusts and six local authorities of Greater Merseyside. Its Management Board includes representatives from:

— Chief Executives and Directors of Public Health from the Merseyside Primary Care Trusts;
— Chief Executives of the Merseyside local authorities;
— The Merseyside Councils for Voluntary Service;
— cardiac patients;
— Merseyside Public Protection Officers;
— University of Liverpool; and
— the host organisations of Sefton Borough Council and the Sefton Primary Care Trusts.

Heart of Mersey is a non-governmental organisation currently seeking charitable status.

January 2005

Memorandum by the British Heart Foundation (WP 15)

1. The British Heart Foundation (BHF) is leading the battle against heart and circulatory disease—the UK’s biggest killer. The Charity is a major funder and authority in cardiovascular research, education and care. The BHF relies predominantly on voluntary donations to meet its aims. In order to increase income and maximise the impact of its work, the BHF also works with other organisations to combat premature death and disability from cardiovascular disease.

2. Rather than commenting generally on the overall document, the BHF would like to highlight three key areas where we believe the proposals can be strengthened to help the Government to achieve its public health goals. Overall we believe that the Government’s Public Health White Paper provides a solid platform for transforming the NHS from a disease focused system to a health promoting system.

SMOKING

3. The BHF commend the Government for its measures to further restrict tobacco advertising and support smokers to quit.

4. The BHF strongly recommends that the Government implement a full ban on smoking in indoor areas including pubs.

5. We do not believe that the partial ban on smoking will help the Government achieve its goals. We believe the proposed legislation is inappropriate, unfair and illogical. Inappropriate because it is virtually unenforceable and littered with inconsistencies.

6. Unfair because it condemns workers in pubs that don’t serve food to an occupational health risk that is not tolerated for any other workers. The Government’s own Scientific Committee on Tobacco and Health identifies bar staff as the occupational group most at risk from secondhand smoke. Once the principal is agreed that smokefree environments protect the health of workers, all employees must be protected—including the thousands of bar workers who will not be covered under the White Paper’s proposals.

7. Illogical because it will increase the inequalities that the White Paper aims to reduce. Smoking rates among manual workers are 50% higher than non-manual workers (BHF, 2004, Coronary Heart Disease Statistics, page 87). Drink only pubs tend to be situated in poorer communities. The policy as it stands will also encourage more pubs to stop serving food and go “drink only”—this could seriously undermine the Government’s alcohol policy.

8. The Wanless Report (2004) suggests that “a workplace smoking ban in England might reduce smoking prevalence by around four percentage points—equivalent to a reduction from the present 27% prevalence rate to 23% if a comprehensive workplace ban were introduced”. Evidence from jurisdictions who have introduced a full ban suggests that a ban also acts as a trigger for people to reduce the amount of cigarettes they smoke.

9. The BHF strongly recommends that the timescale for the introduction of the legislation be brought forward. The proposed length of the timescale leading up to a ban is a reflection of the need for difficult negotiations between central Government, local authorities and businesses ahead of implementing a policy which is littered with inconsistencies. On the other hand, a full, clear ban on smoking in all enclosed public places would take less than four years to fully implement.

PHYSICAL ACTIVITY

10. Whilst the BHF welcomes the White Paper’s promotion of sport, we are concerned that physical activity and sport are often treated as though they are interchangeable terms. The greatest gain in improving population physical activity levels will come from active living initiatives, not sport initiatives.

11. The BHF recommends that the physical activity delivery plan should have an equal emphasis on non-sport physical activity strategies.

LOCAL HEALTH INFORMATION

12. The BHF welcomes the White Paper’s recommendation to develop a standard set of local health information that can be linked to other local data sets. There is a need for accurate data on coronary heart disease rates, risk factors and risk conditions at the local level.

13. The BHF recommends that the Government consult with stakeholders on the data to be included in the standard set of local health information.
CORPORATE PARTNERSHIPS

14. The BHF notes the White Paper’s emphasis on voluntary codes of practice with industry, particularly the food, broadcasting and advertising sectors.

15. We have concern with the lack of detail on the Government’s expectations of these voluntary codes, timeframes and consequences of non-compliance.

16. The BHF recommends the Government produce a detailed plan on industry codes which covers the issues of expectations, timeframes and consequences of non-compliance.

CHILDHOOD OBESITY

17. The BHF is particularly concerned with the emphasis on voluntary codes of practice with regard to childhood obesity. Obesity is an increasing threat to the health and well-being of our children. Between 1984 and 1994 the prevalence of obesity in English primary school children increased by 140% (Chinn and Rona, 2001, BMJ 322). Nothing suggests that this trend has slowed in the last 10 years.

18. Sustain warns that every year that the legislation is delayed, an estimated 40,000 children will become obese.

19. Childhood obesity is too important an issue to leave to more consultation and voluntary industry codes. The BHF believes the time is right for comprehensive legislation to ensure that children’s food is healthy.

20. The Children’s Food Bill (www.childrensfoodbill.org.uk) proposes legislation to end junk food advertising to children, stop junk food vending in schools and provide healthy school meals. The BHF recommends that this Bill become law at the earliest possible date.

SCHOOLS

21. While we recognise the Government’s efforts towards ensuring all children have access to at least two hours of high quality PE and school sport every week, the BHF recommends that the aspiration should be for school children to participate in three hours per week of physical activity.

22. The BHF recommends that children should have their Body Mass Index measured annually at school, with poor results being followed up by specialised support services. The Government’s timeframe on providing clusters of schools with a shared school nurse by 2010 seems very long—and we are unconvinced that a shared school nurse between large clusters of schools will satisfy demand.

CONCLUSION

23. The BHF wishes the Committee well in its consideration of submissions and would be happy to give oral evidence or to provide additional evidence as requested.

January 2005

Memorandum by Child Health Advocacy Network (CHANT) (WP 16)

CHANT is a network of leading professional and non-governmental organisations who work to improve children’s health. CHANT works collaboratively to promote the mental, emotional and physical health of all children, particularly those living in poverty and vulnerable circumstances.

CHANT welcomes the recognition implicit in this White Paper that child health underpins adult health. It also welcomes the recognition that children’s emotional and social development is not only an important aspect of their well-being during childhood, but also a key determinant of their future health and well-being, and plays a part in determining inequalities in health. Members are, however, concerned that the potential for supporting children’s emotional and social development through cost-effective interventions is not fully realised in the text of the White Paper and more particularly in the Summary of Intelligence papers which accompanied the White Paper.

The key determinant of children’s emotional and social development and of future mental health and emotional well-being is the quality of the relationship between them and their parents. Relationships with others—for example early years workers, teachers, social workers and relatives and friends—are also important, but it is the parental relationship, particularly in infancy and the early years, which is critical and which in turn is a key influence on the nature and quality of the other relationships which children will form in their future lives. The White Paper proposes to provide additional information and support for parents. However, it is far from clear what this information and support will entail. In particular, it is not clear that it will offer parents the evidence-based programmes which are known to improve the quality of the parent-child relationship.
Will the proposals enable government to achieve its public health goals?

In the absence of support for parenting of the sort that improves relationships, it is unlikely that the Government’s mental health, health related lifestyles or social inequalities targets will be achieved. The Summary of Intelligence on Mental Health paper, produced to support the White Paper, makes no mention of any intention to provide the kind of programmes which would improve parent-child relationships. It does propose a programme to support the relationships which early years workers make with children, and a programme to support parents’ involvement in learning. We acknowledge that both of these are important, but neither will have more than a peripheral effect on parent-child relationships.

Are the proposals appropriate, will they be effective and do they represent value for money?

The content of the information and support the Government proposes to offer to parents is not clearly defined. Information is critical for public health improvement, but it is not in itself a sufficient basis for behaviour change or improvements in relationship quality. Research on parental support shows this to be widely appreciated by parents, but, on its own, it cannot be relied on to change these two aspects of parenting.

Structured programmes, provided in acceptable and accessible settings, which challenge parents in a supportive, non-judgemental atmosphere, are necessary to enable parents to change the way they relate to their children. Voluntary sector experience suggests that providing such programmes as part of a variety of family support activities, such as cooking skills and benefits advice, can increase the likelihood of parental engagement. The provision of a good créche facility can also make an important difference to whether parents commit themselves to attending a programme.

Although more research in a UK context is needed, a wide range of systematic reviews now attest to the fact that it is possible, with relatively low-cost interventions, to improve the quality of the parent-child relationship. The sort of programmes which can be effective in this respect are those quoted in the Case Study on page 47. They are also well described in core standard 2 of the National Service Framework for Children, Young People and Maternity Services.

Do the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

The types of parenting programme which would increase the chances of the White Paper achieving its goals can be delivered by a range of different practitioners. Many sound programmes are offered by the voluntary sector. It is essential that those running programmes are equipped with the necessary knowledge, skills and support to do so; some of this could be achieved through continuing professional development. The new children’s centres provide an ideal geographical location for such programmes, though there is a strong possibility that they will not reach all the parents who would benefit from such programmes.

January 2005

Memorandum by The Obesity Awareness and Solutions Trust (WP 17)

TOAST

The Obesity Awareness and Solutions Trust (TOAST) is a national charity (Reg No 1088049), primarily a patient advocacy group, committed to ensuring that people whose lives are directly affected by obesity have a voice which enables them to have an impact on policy, treatments and services. TOAST also aims to expand and develop frontline action to prevent and solve the problem of obesity.

TOAST works closely with academia, patient groups, the medical profession, consumers, local government and a wide range of industries, to raise awareness of and seek solutions for the treatment and prevention of obesity. It also seeks to share its experience and expertise in dialogue with policy makers and regulators on a national level, decisively to confront the obesity epidemic and to challenge discrimination and stigma.

SUMMARY

TOAST welcomes the general principles of the government’s public health white paper and believes that in part the initiatives will influence the future health of the nation. However, key to TOASTs concerns is the complex and multifaceted nature of obesity, which has not been given strong enough recognition. The initiatives and underpinning principles of the paper largely concentrate on food and exercise, omitting issues relating to why food behaviours and patterns develop in the first place; food and the fat are still largely being treated as the problem, TOAST would see them as being a symptom of a whole set of other factors including: socioeconomic, psychosocial and psychological.
Will the proposals enable the Government to achieve its public health goals?

With two thirds of the population of England either overweight or obese and an increase of 400% over the last 25 years, obesity, under current trends will soon surpass smoking as the greatest cause of premature loss of life. The government will therefore have to be rigid in its implementation of the white paper and also recognise the wider causes of obesity, which are related to social circumstances, access to healthy food, local referral services, availability of appropriate services, and personal issues such as self-confidence and self esteem.

Are the proposals appropriate, effective and good value for money?

The proposals are appropriate so far as they cross a broad spectrum of issues and reflective initiatives which begin to address the complexity of obesity; however the lack of focus on drivers behind obesity has not been sufficiently addressed. Obese people are a vulnerable group and should be recognised as such, issues such as social stigma, and lack of access to treatment need to be acknowledged and remedied.

TOAST welcome the review of treatments for obese patients, however the effectiveness of this could well be undermined as it is not due to be produced by the National Institute for Clinical Excellence until 2007, and with the current morbidity rate for obesity related diseases at 30,000 per year this seems over due.

The real value of the public white paper will be seen as the number of overweight and obese halt and then begin to decrease. The reality that one in three children are now categorised as overweight and one in nine obese must be addressed proactively, and the delivery paper will hopefully demonstrate appropriately an effective implementation to a problem which if trends continue will cost the NHS a quarter of it’s budget just to treat type 2 diabetes.

Do the necessary public health infrastructures and mechanisms exist to ensure that proposals are implemented and goals achieved?

The healthcare framework is in place however the knowledge base of healthcare professionals needs to be assessed in terms of identifying causes of obesity and recognising it is often a symptom of an underlying problem, rather than just a problem in itself. Continuing professional development courses on obesity need to be developed and best practice disseminated around PCTs.

January 2005

Memorandum by Organon Laboratories (WP 18)

Organon Laboratories Ltd. is a research-based pharmaceutical company with a long-standing interest in contraception and pregnancy, having developed and produced a wide range of contraceptive products over a great many years. We therefore read with interest the Government White Paper, Choosing Health: Making Healthy Choices Easier.

We are grateful for the opportunity to submit evidence to the above inquiry and have a number of observations to make which I have set out below. We would like to stress that they are restricted to the sexual health content of the White Paper and are made on a corporate basis on behalf of Organon Laboratories Ltd.

1. Whether the Proposals will Enable the Government to Achieve its Public Health Goals

1.1 Organon believes that the combination of broadening the reach of information on sexual health and the commitment to modernisation of sexual health services proposed in the White Paper will be key in achieving the Government’s goals. The expansion of information in ways that meet the needs of young people will increase their knowledge, but will also raise their expectations of sexual health services.

1.2 It is therefore important to ensure that sexual health services are configured so that expectations raised through better information provision can be met, which implies that not only will the combination of the two elements be important but so will the co-ordination between them. We believe that the proposed audit of contraception services in 2005 should provide a solid basis for this to happen.

1.3 The White Paper highlights two major components in sexual health: the rise in STI rates and the high teenage pregnancy rate. The two are clearly linked; for example information on both can (and should) be communicated simultaneously. Likewise health care professionals (HCPs) can provide services that will address both simultaneously. However, it is important that both components and their different needs are dealt with; considering one or the other will not automatically deal with both.
1.4 There are differences in the methods by which the different needs of effective contraception and protection from STIs are satisfied. For STIs, the important role of condoms and other barrier contraception is clear, but studies show that these are not the most effective means of contraception, and in any case the selection of a suitable method of contraception may be based on additional factors.

1.5 One of the most important of these factors is the degree to which the way the chosen contraceptive method is used suits the user. No single method is ideal for everyone and so whilst it is important to stress the use of condoms for protection against STIs, it is equally important to encourage the additional use of a method of contraception that the user finds easy to use and which provides a more effective means of preventing pregnancy.

1.6 The White Paper proposes the development of a new national campaign targeted at younger men and women to ensure that they understand the real risk of unprotected sex and persuade them to the benefits of using condoms to avoid the risk of STIs or unplanned pregnancy. Organon would urge the Government to design the campaign so that it promotes the combined use of condoms (primarily for protection against STIs) together with other forms of contraception to prevent unplanned pregnancy more effectively. The combined use of condoms and other forms of contraception was first promoted in the mid 1980s through the term “double-dutch”—implying the use of both.

1.7 The importance of selecting a method that suits the needs of the individual user also means that it is important to have a full range of contraceptive methods and services available. The reference to this in the White Paper, relating to the audit of contraception services in 2005, is particularly encouraging. The selection of a contraceptive method that is easiest for the user increases the likelihood of the appropriate use of the method and thus its effectiveness.

1.8 Availability of, and access to, a full range of contraceptive methods is therefore important in minimising pregnancy rates in any age group, including teenagers. To meet the Government’s public health goals in this area, people need to be aware of the wide choice that is available to them, so health education programmes will need to reflect this. Organon urges the Government to ensure such programmes should not only explain each method, but should encourage people to consider if or how each method would fit into their lifestyle.

2. Whether the Proposals are Appropriate, will be Effective and Whether they Represent Value for Money

2.1 Organon believes that the proposals in the White Paper to take a proactive approach to information on sexual health across a broad range of outlets and media are highly appropriate. Indeed, we would encourage this to be taken even further. Greater consistency of messages across all sources of information will, we believe, be important.

2.2 Organon believes that it is important to have information available across the full range of media and presented in different styles. Clearly there are some areas where more information is needed, for example the White Paper proposals to produce targeted information for specific groups are very helpful. But there may be ways in which existing information can be made more effective. We would like the Government to encourage ideas to improve accessibility of information across all media.

2.3 If people cannot find the information they need, the reason may be that, though it exists, it is not sufficiently accessible. The proposal to provide advice on sexual health in settings where young people go is particularly important, therefore. A similar consideration also applies to a medium of communication that is growing in importance—the Internet.

2.4 The White Paper refers to a MORI study in 2003 showing that the Internet is used as a source of health information more frequently than “traditional” media such as television, books, magazines and newspapers. This is supported by a study published in 2001 in the United States of America, which reported that 75% of young people that use the Internet go online for health information, of whom 44% have sought information on sexual health.55

2.5 The White Paper also mentions confidentiality as an important factor and this may be an important perceived advantage of using the Internet. A 2004 paper from the UK reports that access to the Internet in the home is common and that 22% of computers in the home are located in a young person’s bedroom56 which provides a high degree of privacy. The same paper, however, highlights the risk of gaining access to websites containing adult material when using the Internet to look for information on sexual health—it says that 57% of 9-19 year olds in the UK who use the Internet at least once a week have reported coming into contact with pornography online. Those seeking health information are more likely to encounter it.

55 Generation Rx.com: How Young People Use the Internet for Health Information. Rideout, V; Kaiser Family Foundation; December 2001.
56 UK Children Go Online. Livingstone, S and Bober, M; Department of Media and Communications, London School of Economics and Political Science; July 2004.
2.6 Since the Internet is growing in importance as an information source, Organon would like to suggest that the Government encourage initiatives to improve access to UK informative websites on sexual health that will encourage more people to use them and protect them (particularly young people) from accidentally entering pornographic sites. This suggestion may require a different approach to the Internet by taking a strategic view of all information provided from all informative UK sites.

2.7 With a greater degree of coordination to facilitate easier and more prominent access from general search engines such as Google, the already excellent individual websites provided by a range of organisations including Government departments and non-government organisations could become an even more effective and valuable resource. The key advantage of this would be that people may be more likely to use this to inform themselves before consulting a health care professional or to reinforce their understanding following such a meeting. This, in turn, would help to relieve the pressure on HCPs, who are in the difficult position of having to provide greater amounts of information within the already constrained time available in an average consultation.

3. Whether the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure that Proposals will be Implemented and Goals Achieved

3.1 As the White Paper implies, there seems to be a need to provide sexual health information and services in settings where young people go, i.e. outside the surgery. The amount of information involved in covering all methods of contraception is too much for HCPs to convey in the time available in a typical consultation and beyond the ability of users to absorb such a lot of information. Yet, it is very important that users are able to make a choice of method that is informed by knowledge of everything that is available. This suggests the need for information and advice sources outside the normal consultation of which the Internet is one possibility. Organon would like to suggest that the Government encourage other innovative ideas to provide information for users outside the consultation and co-ordinated in such a way as to support the needs of HCPs, even where some additional funding may be required.

3.2 As already mentioned in 1.7, there is a need to ensure that a wide range of contraceptive methods is available to maximise the overall effectiveness of a contraceptive service by matching the lifestyle needs of users to appropriate contraceptive methods. Each method should therefore be equally accessible in order to ensure that the user’s needs are the main factors in their choice of contraception. Organon would like to encourage the Government to ensure the optimum accessibility of all methods of contraception through the existing infrastructure and mechanisms, and to address any issues where access could be improved.

3.3 Organon has experience of one example that illustrates the point made in 3.3 above. Women choosing to use long-acting methods, such as the contraceptive injection, the intrauterine system (IUS) or the contraceptive implant, that need to be applied by HCPs should ideally be able to have them at the time of their initial consultation (unless there are medical reasons for doing otherwise). However, women choosing the contraceptive implant cannot have it fitted at the first consultation if they go to a GP surgery. They must first take a prescription from the surgery to the pharmacist to obtain the item. They must then later return to the surgery for it to be fitted, because the implant is not covered by section 44.5 of the Red Book (the Statement of Fees and Allowances for General Practitioners). Unlike any other method of contraception, for those who have chosen this, there is thus a delay in obtaining their contraception and a potential additional risk of a person failing to return with the implant and remaining at risk of unplanned pregnancy.

3.4 As the Health Select Committee stated in the recommendations of its 2003 report, there is a crisis in the sexual health of this country. Its specific inclusion in the White Paper is a significant boost to the perceived priority of sexual health, but this priority needs to be constantly reinforced throughout implementation of the recommendations. This does not appear to be matched by incentives for HCPs to take up the recommendations through the GP contract, where sexual health and contraception are relatively low on the priorities. Organon urges the Government to consider the addition of some such incentives as an effective way of rewarding the implementation of the White Paper proposals.

We very much hope that our points will be taken into consideration and we thank you once again for the opportunity to comment.

January 2005

Memorandum by The Health Foundation (WP 19)

1. Executive Summary

1.1 The Health Foundation welcomed the long-awaited publication of The Public Health White Paper, which rightly places real emphasis on the need to improve public health. However, we are concerned that while the White Paper sets out specific challenges to the health service to deliver improvements in this important area, insufficient consideration has been given about how exactly these challenges will be met. This is particularly the case when it comes to GPs, who in our view will be key to delivery of improved public
health. Recent research indicates that GPs in the UK are least actively engaged in promoting better health compared to their peers in comparable countries. Government policy will have to address these shortcomings, as well as addressing the role of patient engagement in improving public health.

2. THE ROLE OF PRIMARY CARE IN DELIVERING THE GOVERNMENT’S PUBLIC HEALTH AGENDA

2.1 The Government’s Public Health White Paper sets out specific challenges to the health service to deliver improvements in public health. In particular, it refers to the role of health professionals in educating and equipping patients to improve their personal behaviours and to manage chronic or long-term medical conditions (Public Health White Paper, Choosing Health, chapter 6).

2.2 Consistent with the Wanless report’s “fully engaged scenario” (HMT Treasury, 2002), effective health promotion and disease management are critical components for matching demand to supply in healthcare, whilst at the same time improving the nation’s health. The success of the Government’s public health strategy will therefore depend on the extent to which primary care health services promote and maximize patient engagement.

2.3 A highly functioning primary care system would actively encourage patients to adopt healthy behaviours and to self-diagnose and treat minor ailments, involve patients in treatment decisions, and support them in the active self-management of chronic diseases and other long-term medical conditions (Coulter and Rozansky (2004) BMJ: 329:1197–1198). This approach would also fulfil the Government’s policies around choice, responsiveness and equity.

3. CURRENT PATIENT EXPERIENCES IN PRIMARY CARE: FINDINGS FROM THE 2004 COMMONWEALTH FUND INTERNATIONAL HEALTH POLICY SURVEY

3.1 The Health Foundation recently analysed the results of a major international study comparing patients’ experiences in primary care in order to establish how well the current primary care system promotes better health, disease management and patient engagement. The seventh in an annual series, the 2004 Commonwealth Fund International Health Policy Survey gauged public experiences with primary healthcare systems in Australia, Canada, New Zealand, the UK and the USA. The survey effectively benchmarks British patients’ experiences against those of their counterparts in the other countries (Schoen et al, Health Affairs (2004) 10.1377/hlthaff.w4.487).

3.2 A mixed picture emerges from our analysis of the survey data. Whilst British patients face the fewest hurdles to access primary care, and are generally satisfied with the status quo, patient-centred care is not the norm, and there are indications that primary healthcare is still delivered in a paternalistic fashion. Compared to the other countries in the survey, the UK performed the worst in relation to advice about prevention, information about medicines, shared decision-making, patients’ access to records and self-management of chronic disease. These are specific aspects of primary care provision that require attention if the full potential of a primary care led service to improve public health can be realised.

3.3 The survey shows that NHS patients are the least likely to have a conversation with their GP about weight, nutrition and exercise—in the survey, only one in four UK patients (27%) reported discussing health behaviours with their GPs. The same small proportion reported that their GP had initiated a discussion about their emotional well being.

3.4 Compared to patient responses from other nations, Canada and the USA especially, this means that opportunities to promote healthier lifestyles, reduce the risk of preventable diseases, and support good mental health are currently being missed on a significant scale. (See Table 1, below.)

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Source: Commonwealth Fund International Health Policy Survey, 2004

3.5 The survey also reviewed the extent to which patients were engaged in treatment decisions, and how well their preferences and concerns were identified and acted upon by their GPs. Doctor-patient communications and interactions are important for all patients, but especially for people with chronic conditions. Evidence from other studies shows that better patient engagement and self-management of
chronic conditions improves the patient experience, and even leads to better health outcomes, more appropriate and efficient use of healthcare services. (Coulter, The Autonomous Patient, Nuffield Trust (2002)).

3.6 The survey findings suggest that patient engagement is not the norm in the UK. Only one in four (27%) reported that their doctors always tell them about treatment choices and ask for their ideas and opinions, compared with 41% in New Zealand and 43% in Australia. (See Table 2, below.)

Table 2

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</table>

*Source: Commonwealth Fund International Health Policy Survey, 2004

4. POLICY ISSUES

4.1 In relation to public health, there seems to be quite a gap between where we are now, and the sort of health service the Government would like to see. The findings from the Commonwealth Fund Survey suggest that, for the UK, we are far behind other countries in using primary care services to improve public health.

4.2 The Public Health White Paper suggests that a very wide range of professionals and community members could have a part to play in promoting healthy lifestyles. But it has very little to say about the specific role GPs should play. While the varied NHS workforce can undoubtedly contribute to better public health, The Health Foundation thinks the place to start is primary care.

4.3 Government policy for public health should also address shortfalls in the provision of primary care. The Government has just finished negotiating a new GP contract, which hopefully provides adequate incentives for GPs and primary care staff to undertake more health promotion work. It is surprising, however, that the Public Health White Paper has so little to say about the vital role of primary care professionals in improving public health.

4.4 Does the GP contract contain the right incentives to improve the performance of primary care? Whilst there are incentives to provide better advice on nutrition, smoking prevention, and blood pressure checks, it does little to encourage patient engagement. The Public Health White Paper does not address the role of patient engagement in improving public health.

January 2005

Memorandum by The National Childbirth Trust (WP 20)

INTRODUCTION

1. The National Childbirth Trust (NCT) is the largest and best-known childbirth charity in Europe reaching over 300,000 parents. For almost 50 years, it has offered wide-ranging information and support across the UK and locally through its network of over 350 branches. Consulted by decision makers on all aspects of pregnancy, birth and early parenting, the NCT works hard for improved maternity care and better services and facilities for new parents. The NCT currently has over 59,000 members.

1.1 The NCT welcomes the opportunity to contribute to an inquiry by the Health Committee into the Government’s Public Health White Paper.

1.2 In this submission, the NCT will comment on aspects of the Public Health White Paper, which relate to pregnancy, birth, breastfeeding and early parenthood. The NCT has primarily focused on Chapter Three (Children and young people: starting on the right path) as this section has most relevance to our work.
NCT Response to the Government’s Public Health White Paper

2. “Good maternity services support parents, both mothers and fathers, before and during pregnancy and after their child is born. Midwives provide advice about health and targeted care to mothers, fathers and their families. They have an important role in promoting health—helping pregnant women to stop smoking, improving nutrition and rates of breastfeeding, promoting mental health and building social support”. (Chapter 3, page 52, Point 36).

2.1 The NCT welcomes the Government’s commitment to improving maternity services and to providing parents with support before and during pregnancy and after their child is born. The Public Health White Paper’s emphasis on the role of midwives in providing advice to families is particularly welcome. Midwives can play a key role in delivering the Government’s public health goals, such as improving uptake of antenatal care and rates of breastfeeding, and leading smoking cessation programmes amongst pregnant women.

2.2 The NCT feels that the proposals outlined above are an appropriate and effective method of delivering improvements in maternity services. Midwives have unrivalled access to pregnant women and new mothers throughout pregnancy, birth and the postnatal period and are therefore in a crucial position to get to know women and their families, appreciate the stresses and concerns they face, and provide care and health advice which is tailored to their individual needs and circumstances.

2.3 The NCT is concerned however, that the current crisis in midwifery recruitment and retention may hinder the ability of midwives to promote the Government’s public health goals and to deliver support and advice to parents. The RCM Annual Staffing Survey 2004 reveals that long-term vacancy rates (those lasting three months or longer) have increased to 68% of the total number of vacancies (up from 53%). The survey also reveals that 81% of Heads of Midwifery in England have stated they are experiencing some level of staffing shortage.57

2.4 Such high levels of midwife shortages mean that women and their families will be denied the care and support they need throughout their pregnancy, birth and postnatal period. The NCT urges the Government to do more to tackle the recruitment and retention crisis in the midwifery profession, including funding more posts so that Birth rate Plus recommended levels of staffing can be achieved. New and innovative ways of working could be introduced into the profession in order attract more midwives and keep them motivated. Opportunities here could include carrying a caseload, providing care for home births and working in midwife-led birth centres. At present there are new opportunities to develop roles previously carried out by junior doctors, with funding attached, but there is no equivalent funding for new posts for the development of normal midwifery care. As Children’s Centres develop, their success in providing support to parents during the transition to parenthood will be partly dependent upon there being sufficient midwives employed in the NHS to ensure that there are midwives available to work in the centres, develop outreach initiatives and links with social services which are enabling for parents and not solely based on a conservative approach to child protection.

2.5 Ongoing midwifery shortages could also have a negative effect on the Government’s breastfeeding initiation targets, particularly amongst women from socially disadvantaged backgrounds. Peer support groups, which are often initiated and supported by midwives, are vital to giving women from disadvantaged communities the opportunity and confidence to breastfeed their baby. Support for breastfeeding could be improved through greater Government financial support for the establishment of peer support groups. The NCT would also like to see pre-registration training for all health professionals who are in contact with new mothers include knowledge about the physiology of breastfeeding, the health benefits of breastmilk and the need for a woman-centred approach to providing support. Post-registration training must also cover these areas for all relevant health professionals so that parents do not continue to receive inaccurate and inconsistent information. Within GP appraisal and practice accreditation schemes, for instance, inclusion of up to date, evidence based information on breastfeeding and prescribing during lactation should be mandatory.

3. “From 2005, we will provide eligible pregnant women (including all pregnant women under 18, breastfeeding mothers and young children in low income families) with vouchers that can be exchanged for fresh fruit and vegetables, milk and infant formula through a new scheme—Healthy Start. The scheme will be backed by a new communications campaign to help these families improve their diets and wider health, and make effective use of the vouchers. Infant formula milk will no longer be available from healthcare premises, which will reduce its promotion in the NHS.” (Chapter 3, page 53, Point 38)

3.1 The NCT welcomes the principles behind the Healthy Start initiative, which aim to increase pregnant women’s and mothers’ access to fresh fruit, vegetables and milk. The announcement that infant formula milk will no longer be available from healthcare premises thereby reducing its promotion in the NHS is particularly welcome. The NCT feels that the latter action will better enable the Government to achieve its public health goal of increasing breastfeeding initiation and duration rates in England: midwives and health professionals should be able to focus more of their time on supporting good nutrition practices and

promoting breastfeeding to pregnant women and new mothers. However, it is well recognised that additional staff will be required to enable the necessary training on nutrition and breastfeeding support for this already hard-pressed group of professionals.

3.2 While the NCT welcomes any initiative to promote healthier eating amongst pregnant women and new mothers, we are concerned that the low monetary value of the Healthy Start voucher significantly limits the amount of healthy produce that can be purchased. Currently, the Healthy Start voucher has a proposed monetary value of just £2.80 for pregnant women and children over 12 months. The NCT would like to see a significant increase in the value of the voucher or an increase in benefits for pregnant women; this would enable pregnant women and new mothers to buy more fresh fruit, vegetables and milk and to make real and sustained improvements to their diets. In addition, the NCT would urge the Government to equalise benefit rates for unemployed pregnant women aged between 16 and 24.

4. “Further action will include the review of Infant Formula and Follow on Formula Regulations (1995) with a view to further restrict the advertisement of infant formula. We will continue to press for amendments to the EU Directive on infant formula and follow on formula.” (Chapter 3, page 53, Point 39)

4.1 The NCT welcomes the Government’s announcement that it will review the Infant Formula and Follow on Formula Regulations (1995) with the view to further restricting the advertisement of infant formula. The announcement that the Government will press for amendments to the EU Directive on infant formula and follow on formula is also welcome. The NCT has consistently campaigned for further restrictions on the advertisement of infant formula because of the negative implications of formula feeding for public health. Research shows that formula fed babies are five times more likely to admitted to hospital with gastro-enteritis in their first year, twice as likely to develop eczema, wheezing and ear infections and five times more likely to have a urinary tract infection than babies who are breastfed for at least four months. Research also suggests that on average, children who are formula fed as babies have higher blood pressure, a greater risk of developing obesity and childhood diabetes and lower scores in intelligence tests. Restrictions on the advertisement of infant formula would help the Government achieve its public health goals of increasing breastfeeding rates while also tackling childhood obesity.

4.2 While the NCT welcomes further “amendments” to the EU Directive on infant formula and follow on formula, we would encourage the Government to take more decisive action to deliver its public health goals on breastfeeding. The NCT urges the Government to fully implement the Global Strategy on Infant and Young Child Nutrition, and the Blueprint for Action for the protection, promotion and support for breastfeeding in Europe, both of which call for full implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Resolutions. UK governments have consistently supported the Resolutions on the International Code at an international level, but failed to provide the protection and support for breastfeeding provided by these Resolutions in the UK. We see no reason why mothers and babies in this country should continue to be suffer biased and misleading information, inadequate support for breastfeeding in public places and within the legal system, lack of facilities when women return to work and poor access to evidence based information.

4.3 Although the majority of women in this country want to breastfeed, more than one third change to formula milk in the first six weeks and nine out of 10 of these women would have liked to breastfeed for longer. This is an indication of the lack of support evident in the health service and the wider society. Although babies from disadvantaged families may be particularly susceptible to the infections and diseases made more likely by formula feeding, their mothers are least likely to start breastfeeding and continue for shorter periods. Improving breastfeeding rates, particularly among this group of women, would therefore have a significant impact on their children’s short term and long-term health with fewer visits to their GP58 as well as the advantages referred to in 4.1 above.

5. “Our goal is to halve child poverty by 2010 and eradicate it by 2020. This will be achieved by a combination of hard work by people and the opportunities created by government. The Child Poverty Review reinforced the importance of commitment across a wide range of public services to improving poor children’s life chances and tackling cycles of deprivation. This includes initiatives that improve health outcomes for children, such as:

- Supporting parents (Chapter 3, page 43, Point 5)

“A key aspect of this work will be to support parents during pregnancy and in the very early years of parenting to break the cycle of inequalities between generations. The strategy to support parents in these early stages includes:

- Continued support from maternity services and health visitors;
- Improvements to public support on nutrition in the early years;
- Improved support for learning and development in the early years;

5.1 The NCT welcomes the Public Health White Paper’s emphasis on tackling poverty by providing greater information, support and advice to parents. Parents from disadvantaged groups and communities may find it more difficult to access or maintain contact with traditional maternity services, which could mean that they miss out on care leading to them and their babies experiencing poorer outcomes and further disadvantage. Wider access to antenatal and postnatal services, as indicated in the Public Health White Paper, would help meet the needs of socially excluded and disadvantaged families.

5.2 Without a clearer definition of what “supporting parents” constitutes, it is difficult to assess whether the Government’s proposals will be appropriate, effective or represent value for money. Nevertheless, the NCT welcomes the Government’s proposals to roll out Children’s Centres across England, which will provide integrated services in one location. Proposals to create 2,500 children’s centres by 2008 and 3,500 centres by 2010 could make significant headway in tackling poverty in this country.

5.3 We believe that Children’s Centres should:
- Provide antenatal and postnatal support—including reaching out to fathers and hard-to-reach groups.
- Offer facilitated mutual support.
- Provide access to trained breast-feeding counsellors.
- Encourage and facilitate user-involvement.
- Disseminate parent-centred, evidence-based information.

The NCT has expertise in these areas and also offers training for professionals in a parent-focused approach, supporting breastfeeding, parent-led birth preparation classes, running groups for young parents, and running “bumps and babies” and “early days” groups.

January 2005

Memorandum by the Socialist Health Association (WP 21)

1. The Socialist Health Association promotes health and well-being, social justice and the eradication of inequalities through the application of socialist principles to society and government. It is a voluntary group that is affiliated to the Labour Party and seeks to influence the Party’s policies to reflect socialist principles.

2. The Association welcomes the opportunity to give evidence to the Health Select Committee on the Government’s public health White Paper—Choosing Health: making healthy choices easier on:
- Whether the proposals will enable the Government to achieve its public health goals;
- Whether the proposals are appropriate, will be effective and whether they represent value for money;
- Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved.

3. By and large the Association welcomes the Government’s proposals. However, it notes that the White Paper focuses predominantly on one domain of public health—people’s individual lifestyles. It does not address the important underlying determinants of health—such as income, educational attainment, housing and social networks. It is also weak on the prevention and health protection domains that add so much to the public’s health through effective immunisation and population screening.

4. The SHA wishes to draw attention in particular to the following concerns:

4.1 It is not appropriate to treat health as a consumer good. The more privileged in society have easier and greater access to consumer goods. If health is to be a consumer good, then it is likely the health inequalities will widen, and the overall health of the population will decrease. The rich and healthy are known to adopt healthy lifestyles more quickly than more disadvantaged groups. For example, smoking prevalence is now 10–15% in social classes 1 and 2 and 40% in social class 5. And the gap in life expectancy between rich and poor is increasing.

4.2 Putting the Department of Health in charge of achieving the Government’s public health goals is not advisable. Instead, the SHA stresses the need for a cross-government Cabinet Minister for Public Health with the authority to engage with all departments of government. The Department of Health has the responsibility to improve health care. Improving health is the responsibility of all arms of government and the leadership must be in place to ensure that they all play their part.
4.3 The role of local authorities must be greatly strengthened. Indeed we believe they should have the lead responsibility to tackle health inequalities, so the proposal to use the national PSA targets and local area agreements more rigorously is welcome. The SHA also strongly supports the appointment of Joint Directors of Public Health working to both PCTs and local authorities. This would “join up” scarce public health capacity and provide leadership for the Local Strategic Partnerships that should be in the forefront of the attack on health inequalities.

4.4 It is welcome that the NHS is to become an exemplar employer, but this duty should be extended to all statutory bodies and they should all work to achieve clear national standards.

4.5 The ban on smoking in all enclosed public places should be unconditional. The current proposals will impact adversely on those least able to choose health—employees and customers in bars and pubs located in disadvantaged areas of the country. There is no difference in the health risks from breathing environmental tobacco smoke whether the person is eating or drinking.

4.6 It is unlikely that voluntary agreements with the food and drinks industries will succeed. The damaging consequences of high consumption of coloured fizzy drinks and processed foods, such as obesity and diabetes, are well known; as are the adverse consequences of alcohol abuse that include violence, crime, drink driving and social disorder. The food and drinks industries have already had sufficient time in which to improve their products and amend their marketing strategies but have failed to do so. There is thus no alternative, in our view, to much stronger regulation in the fields of both alcohol and processed food. Restricted advertising, clearer labelling and with alcohol a sustained programme to try to combat the epidemic of binge drinking, must be on the agenda.

4.7 Children need more protections and support than are outlined in the white paper; for example, the proposal to roll out the Healthy Schools initiative to all schools should be brought forward and made mandatory for all schools as quickly as possible.

4.8 There is little in the White Paper about improving mental health and well-being. Mental well-being is an important factor in health inequalities and chronic mental illness leads to poor quality of life. Local government and PCTs have a key role in promoting well-being that is currently restricted by insufficient resources and capacity.

4.9 Some of the proposed innovations—such as Spearhead PCTs and health trainers—do not have a firm evidence base. Data show that there are more poor and disadvantaged people outside the Spearhead PCT areas than within them and work based solely on spatial and geographical areas will not address the issue of inequality systematically or sufficiently. Health trainers are not evidence based and this initiative risks wasting resources. It is important to pilot such proposals to ensure that they can fulfil their aims and do not have unanticipated outcomes that widen rather than narrow health inequalities.

4.10 Finally, the SHA believes that government must do much more to raise the level of debate about quite how unhealthy UK society is, utilising a range of marketing strategies.

5. The Chair of the Socialist Health Association, Dr Paul Walker, will be pleased to attend the Committee hearing and provide further detail on these issues to the Committee.

6. This is a corporate response prepared by the Executive of the Socialist Health Association.

January 2005

Memorandum by the London School of Hygiene and Tropical Medicine (WP 22)

We welcome the increased focus on public health reflected in the White Paper—“Choosing Health: Making healthy choices easier”, from the Department of Health for England. Nevertheless, we believe that there are a number of opportunities to improve health that are not adequately addressed by the White Paper.

As an academic institution our contributions to UK public health include: improving the evidence base underlying health policies; strengthening capacity to address research questions; ensuring that research evidence is appropriately used to influence policy and practice and training the public health workforce.

We believe that there are important philosophical questions about the balance between individual choice and government action that first need to be resolved in order to develop coherent and effective national policies to improve public health. In the introduction to the document, the Health Secretary makes the point that “people can not be instructed to follow a healthy lifestyle in a democratic society”. However, the White Paper also points out that expenditure on marketing by the food industry, much of it promoting products that are high in fat, sugar and salt, is one hundred times greater than what is spent by the Government to promote healthy eating.

This highlights the asymmetry of information to which the public is exposed. If unhealthy eating is to be reduced additional steps will need to be taken but this will require that there is clarity about precisely what the role of government should be. Behaviour change is a complex process and it seems unlikely that the labelling of food alone will promote the necessary changes. It also remains to be seen whether the voluntary codes to regulate the promotion of food to children will work. There are a number of examples where the evidence from research indicates that personal choice alone cannot deliver the potential health benefits and where greater Government action is necessary. These include the fortification of food with folic acid and increasing the rate of progress on reduction of the salt content of foods.

In our view the Government has yet to make the case for what we believe to be necessary actions, although we recognise that this would require that it faces down potential criticisms of "nanny statism"; a course that may risk adverse comments by some sections of the media.

We also have concerns that the primary care trusts which have the biggest challenges in terms of reducing health inequalities are currently under-funded against their weighted capitation target. There is a pressing need to match the stated intentions of the Government with the resources being made available.

The White Paper presents a range of case studies outlining apparently successful initiatives to improve health but insufficient information is given to determine whether they have had the desired impact and whether they are likely to be generalisable. It is only through undertaking rigorous research that we can have confidence that the policies will have the desired affect. Although expansion of training in public health is mentioned there is nothing on developing capacity in academic public health. The proposed increase in research funding is welcome but there is a need to develop a multi-disciplinary research environment that will make it possible to address complex issues surrounding improvements in public health.

It will also be important to develop capacity to facilitate the translation of research into policy and practice including that from other countries. This might be undertaken for example by the development of centres of excellence focusing on synthesizing and promoting the uptake of research in areas such as nutrition, alcohol, or tobacco policy. The Research Assessment Exercise must recognise appropriately those researchers who focus on topics that are policy relevant and the impact of research on policy and practice should be assessed in a transparent and reproducible fashion by the relevant sub panels, namely those on epidemiology and public health and health services research.

There also needs to be a greater receptivity by the NHS to introducing innovations on an experimental basis, where possible using randomised designs in order to compare intervention and control groups. Currently, pressures to demonstrate action and lack of research capacity often combine to result in a failure to evaluate innovations. This in turn leads to a waste of resources and an inability to learn reproducible lessons about successes and failures which can then be shared more widely within the NHS.

Unfortunately bureaucratic obstacles to research, particularly in the processes of ethical approval and research governance are making it increasingly difficult to undertake many studies that can provide the evidence to underpin public health policy and practice. A recent example from researchers at LSHTM concerned a study on weight management for the reduction of obesity which necessitated contacting 77 PCTs around the country. The researchers encountered different procedures for obtaining approval from research governance leads in PCTs including a diversity of application forms and inconsistent requirements for honorary NHS contracts for research staff.

Finally, because many determinants of health are outside the control of the Department of Health, we would like to see a public health research agenda that spans Government Departments encompassing sectors such as transport, housing, criminal justice, education and social policy. This will necessitate the development of collaboration between public health academics and researchers from other sectors and will need to be driven by new funding mechanisms and high level support across Government.

These comments are not the official policy of LSHTM but represent the views of a number of senior academic staff in public health.

January 2005

Memorandum by Groundwork (WP 23)

Groundwork welcomes the opportunity to submit written evidence to the Health Select Committee’s inquiry on the Public Health White Paper. This submission provides information on Groundwork’s activities and provides comments on the specific proposals in the White Paper and the broader debate on public health.
1. Groundwork is a federation of 50 locally owned Groundwork Trusts in England, Wales and Northern Ireland, between them working with over 100 local authorities to deliver “joined-up” solutions to the challenges faced by our most deprived communities.

1.2 Groundwork has 23 years’ experience of engaging and involving communities in practical projects to improve quality of life and promote sustainable development.

1.3 Each Groundwork Trust is a partnership between the public, private and voluntary sectors, with its own board of trustees. The work of the Trusts is supported by the national and regional offices of Groundwork UK and Groundwork Wales. Groundwork works closely with the Government and devolved assemblies, local authorities, RDAs and businesses. Groundwork also receives support from the European Union, the National Lottery, the landfill tax credit scheme, private sponsors and charitable foundations.

1.4 Groundwork’s projects are organised into local, regional or national programmes embracing six themes: communities, land, employment, education, youth and business. Groundwork recognises that people, places and prosperity are inextricably linked and therefore aims to design projects that bring benefits for all three at once. We believe this integrated approach is vital if we are to bring about sustainable development.

2. The Public Health White Paper states that there are “unacceptable differences in people’s experience of health between different areas and between different groups of people within the same area”. It proposes a number of measures including investment an new initiatives to promote local action on public health and partnerships between the public and voluntary sectors to help extend the opportunities for people to choose healthier lifestyles. Over the past twenty years Groundwork has been working on a wide range of projects at the heart of communities aimed at creating better environments for people to live in and providing services in the community to provide support, skills and education to help people develop and improve their own quality of life.

2.1 There are two key ways in which people can be helped to lead a more active and healthy lifestyle. The first is providing the facilities and infrastructure to allow them to do so, be it a decent public transport system, with adequate facilities for cycling and pedestrians, or safe and attractive public parks and play areas. The second is giving people the education, knowledge and confidence to make the personal choice to lead a healthy lifestyle. Groundwork’s activities focus on addressing both of these issues in the context of the country’s poorest neighbourhoods—tackling inequality at its roots.

2.2 Groundwork undertakes setting-based approaches, working in informal public spaces, parks and places where people live. We try to connect people with the importance of the environment for health, not just as a setting for interventions, but in its own right—making places safer, cleaner and greener. As a result, there are an increasing number of people within the Groundwork Federation with health expertise. Groundwork also brings significant amounts of resource into the health sector through accessing non-NHS funding sources for projects that contribute to public health and well being.

2.3 Groundwork’s activity impacts on health in a number of ways by:

(i) Encouraging exercise
The most accessible forms of exercise—cycling, walking and enjoying the open air—are at the heart of many Groundwork regeneration projects. In areas of high density housing, play spaces or “kick about” areas may be the solution and increasingly these are being developed to offer coaching facilities as a way of encouraging long-term use. Other regeneration projects will provide a new route to work, a safe footpath to school or more formal facilities for weekend sport.
Those recovering from medical problems or undergoing treatment also benefit from improved physical surroundings. Groundwork has developed partnerships with primary care trusts and local health groups across the country to deliver therapeutic activities, often linking with GP referrals for “exercise on prescription”.

(ii) Health through horticulture
The environment can be a powerful remedy for helping people recover from ill health or helping others cope with a long-term disability. Working with specialist local partners, Groundwork is making a real difference both to people’s health and their quality of life.

(iii) Making homes safe and healthy
Groundwork has developed a wide variety of local partnerships to address the health and welfare issues that are caused by unfit housing and poor quality living environments.

(iv) Creating a healthier workplace
Groundwork has been working in commercial and industrial environments for many years. Supporting healthy workplace practice reduces the risk of accidents and the associated personal and financial costs. Health and risk lessons learned in the workplace are also taken home by employees.
(v) Education and healthy food

With Groundwork’s support, many people are now growing their own food while others are benefiting from local community facilities serving up healthy meals. This approach offers a range of outcomes. Older people are given the opportunity of exercising or passing on almost forgotten skills. People with no means of accessing land for their own allotment are given their own space and young people are discovering that good food doesn’t have to come from a supermarket or takeaway.

Groundwork also works in schools to pass on the healthy eating message to tomorrow’s decision-makers as part of the national curriculum through its network of education specialists.

(vi) Reaching out to young people

Young people can often be the most difficult group to reach with a health message and their relationship with their local environment can have a major impact on their physical and mental well-being.

Groundwork has a track record of reaching out to the most marginalised young people and engaging them in activities which help them understand the health consequences of their actions while providing facilities that help them stay well and safe.

THE WHITE PAPER—“CHOOSING HEALTH”

3.1 Groundwork fundamentally supports the central tenet of the White Paper—that Government should provide the framework within which individuals can make informed choices about their personal health and lifestyle. We are now keen that the actions and initiatives set out in the White Paper will be fulfilled so that that people living in our most deprived communities have access to the same facilities, education and support that will allow them to make those choices as everyone else.

3.2 The White Paper takes an important step further forward in providing people with the opportunities and infrastructure they need to adopt healthier lifestyles. We firmly believe that a sustainable community is, by definition, a healthy community, and that the key challenges we need to address continue to revolve around tackling inequalities. Improving the health and well-being of residents in those areas has always been a central component of our holistic approach to regeneration and local sustainable development.

3.3 “Choosing Health” outlines proposals for establishing a network of community health trainers to offer support to people in making decisions about their health and lifestyle. We welcome this initiative and believe it will be an effective way of seeking to promote good health at community level. Groundwork has an extensive network of links with community organisations within the most deprived neighbourhoods and we are keen to work with the Government to help support the delivery of this initiative.

3.4 The White Paper sets out the importance of Children’s Trusts to the planning and delivery of health services to young people. We support this initiative and the introduction of Children’s Centres at heart of communities. We are keen however that these arrangements ensure that service delivery at a local level is co-ordinated and works with existing projects and initiatives for young people, and with the involvement of the local community. We would also like to see a consideration of the provision of decent open space for young people as part of the planning and co-ordination of service for young people by Children’s Trusts. This is key to any public health strategy for young people and is essential to improving health outcomes for those living in the most deprived communities.

PUBLIC HEALTH—WHAT WE ASK OF GOVERNMENT

4. The NHS is a precious national institution that should both be preserved and supported, but the current burdens placed on it will jeopardise its long-term survival, unless Government policy undergoes a radical refocus. We believe that there is a crucial need to move the UK’s health debate away from an over-concentration on NHS acute facilities and towards a focus on the long-term solutions and strategy for the public health and well-being of the population. By tackling health inequalities in a sustainable way, the burden on the NHS will be alleviated for the long term, providing better health for the population, and for the nation’s finances.

4.1 Improving public health is also essential if we are to achieve social justice. It is self-evident that the poorest communities live in the worst areas. This is reinforced by Environment Agency research which demonstrates that there are five times as many industrial sites in wards containing the most deprived 10% of the population, and seven times as many emission sources, than inwards with the least deprived 10%.60

4.2 By improving health and well-being in our poorest areas, it will be possible to deliver a multitude of other outcomes that lead to the long-term regeneration of an area. Groundwork believes that by tackling the quality of local environments and infrastructures we can build the framework for the long-term well being of the nation.

4.3 What we would like to see:

(i) A change in the nature of the debate

The White Paper should be followed by a series of immediate, but sustainable, changes to the way in which the health debate and approach to health policy is framed.

The current NHS funding regime prioritises acute care disproportionately in comparison to health prevention and inequalities initiatives and there is consequently a lack of power and clout for public health within the NHS.

In addition, the primary care sector is not taking the long-term agenda seriously, mainly due to the emphasis placed on achieving central targets and the short-term nature of funding streams.

(ii) Assistance for the environmental sector in evidencing the health benefits of their activities.

As mentioned above, the link between environment and public health is for many people intuitive and self-evident. More needs to be done, however, in order for the environment to be taken seriously as a determinant of health.

The environmental delivery sector needs support in order to fully evidence the impact and value of the links between environment and public health, and to identify good practice. Evidence synthesis, evaluation and dissemination are therefore important, and Government should be providing support for this, especially by funding qualitative and quantitative evaluation of the health outcomes from programmes and initiatives.

(iii) Supporting both the health and the environmental sector to work more closely together, in particular by encouraging collaboration and providing training, leading to an increased understanding of needs, priorities and what works.

The health and environmental sectors have a real potential to deliver major quality of life improvements, but this will be done only in partnership and by sharing lessons and learning. Effective partnerships must be build at all levels to maximise this very real potential.

for those in NHS and other public health functions to have secondment and learning opportunities within the regeneration and environment aspects of public health are also important. This will drive cultural sharing and the development of the distributed leadership necessary to join up programmes effectively.

The attached Annex gives examples of Groundwork projects which are focused on improving public health.

January 2005

Annex

GROUNDWORK IN ACTION FOR HEALTH—CASE STUDIES

PATHWAYS TO EMPLOYMENT—PATHWAYS TO HEALTH

Employment is important as a means of supporting lifelong health. People who experience the worst inequalities in health, and worst health outcomes, are often those who are unemployed or who find pathways into employment most difficult to access. Groundwork runs Intermediate Labour Market or other employment projects in 26 of our Trusts. These programmes provide people with sustainable ways into employment and have direct health outcomes from improving activity and income to providing important settings for addressing a range of health challenges faced by this population. Advice, support and referral on mental health, parenting, drugs and alcohol, smoking, diet and sexual health are all to be found in Groundwork employment programmes. A national study of our ILM programmes will be reporting shortly.

There are specific partnerships with local health economies too. Groundwork East London operates a Transitional Employment Programme, in partnership with Homerton Hospital. The programme recruits lone parents and asylum seekers to train for NHS positions such as ward clerks, housekeepers, reception and manual roles. Not only does this scheme help the NHS create a sustainable workforce, but it helps to bridge the gap between the service user and the service provider and supports some of the most deprived Communities in East London. It has a 100% success rate.

The scheme is now being rolled out into Newham and Tower Hamlets, doubling its size. Groundwork East London has also been invited to run a similar pilot with the local PCT and a scheme with Homerton Hospital’s community nursery to provide trained staff and increase links with the local community.

Encouraging Exercise

Groundwork Leeds worked with the South Leeds Elderly Group, comprising a dozen men from the city’s Pakistani, Bangladeshi and Indian communities. The members had already decided they needed to take more exercise but were having difficulty finding somewhere they felt safe to walk, run or cycle. Groundwork Leeds introduced the group to Rothwell Country Park, created on the site of an abandoned colliery as part of Groundwork’s millennium Changing Places programme. Groundwork’s project officers encouraged the men to take part in guided rambles, which built their confidence and fired their enthusiasm—to such an extent that they are now a regular sight striding across Ilkley Moor.

Groundwork West Cumbria has delivered a large number of cycle paths in the area, with a particular focus on linking local towns with Sellafield, the biggest employer in West Cumbria. This has been achieved by working in partnership with local SRB programmes and community health workers.

The Wandle Trail in London was created by Groundwork Merton in conjunction with a range of partners and follows a 14 mile course through some of south London’s most attractive parks and open spaces. The route encourages walkers and cyclists to use the trail for short or long distance trips. Many parts are now wheelchair accessible and this work, together with safety improvements, is ongoing.

The Wandle Trail now not only contributes to local health generation and the environmental regeneration strategies in the participating boroughs of Sutton, Merton and Wandsworth, but also links into the national cycle network.

This partnership involving the three boroughs, Sustrans, the Environment Agency and many different voluntary organisations has allowed for a balanced approach to encouraging greater use of the trail. Groundwork Merton promotes cycling and walking along the trail whilst continuing to work with partners to improve the biodiversity of the Wandle corridor.

Health Through Horticulture

Groundwork West Durham’s Greenways to Better Health programme works in partnership with local groups and organisations, specifically targeting older people, people with disabilities and those with health problems. The aim is to increase local people’s interest in the environment at the same time as improving their health. In addition to organising “doorstep walks”, the Trust has helped create raised beds, sensory gardens and community allotments.

Groundwork Thames Valley recently received funding from the Healthy Living Initiative to work with New Deal participants to make physical improvements to residential hostels. The programme uses common ground and public space to engage hostel residents and New Dealers to improve the physical environment and undertake health promotion activities at the same time. The health outcomes address mental health, accidents and falls, working with older people and improving mental health.

In addition, Groundwork Thames Valley is running horticultural therapy at a Study Centre in Hillingdon, funded by Hillingdon PCT, in conjunction with their trained horticultural therapist.

Safe and Healthy Homes

When research revealed that 23% of the population of the East Midlands—742,000 people—were subjected to fuel poverty, Groundwork Ashfield and Mansfield developed an initiative to help. With the backing of the local authorities and a number of other partners, a package of measures was identified to support the most needy households.

EnProve, a training company owned by the Trust, employs local people to carry out a broad range of home improvement schemes that can mean a healthier living environment. Recent work has included small-scale repairs, energy insulation, security upgrades and the installation of accident prevention measures.

Projects are now running in three areas. Over 1,000 homes have benefited from insulation work and a further 800 houses have had child safety measures installed. One scheme carried out with the Nottingham Health Authority to help those in cold, damp houses has also won a National Energy Foundation HENRY (Home Energy Rater of the Year) award.

Memorandum by the Royal College of Physicians (WP 24)

The Royal College of Physicians is grateful for the opportunity to comment on the terms of reference for the above inquiry and attach our comments. For your information I am also enclosing a copy of the College’s original submission to the Choosing Health? consultation.

The College has at its core aim the promotion of the highest standards of medical practice in order to improve health and healthcare. To this purpose it defines and monitors programmes of education and training for physicians at all stages of their careers as well as providing professional advice and support for
career grade physicians and those in training. The College has approximately 11,000 Fellows worldwide—
of whom approximately 8,900 are in the United Kingdom—and nearly 7,300 Collegiate Members. The Fellows are senior members of the medical profession, usually hospital consultants or physicians working in university departments of medicine.

In formulating our comments we have received advice from the Chairs of our Alcohol Committee, our Nutrition Committee, our Tobacco Advisory Group and our Joint Specialty Committee for Genito-Urinary Medicine. The College would be happy to contribute to the oral evidence sessions if that would be helpful.

Yours sincerely

Professor Carol M Black CBE, PRCP
President

1.1 The Royal College of Physicians (RCP) welcomes the Health Committee’s Inquiry into the Government’s Public Health White Paper, as it did the White Paper itself and the extensive consultation undertaken by the Government to collect the views of a wide range of audiences.

1.2 The College has played a leading role in addressing public health concerns for much of the past 50 years, most notably in the area of tobacco control. Its work has, and continues to be, informed by the experience and expertise of our Fellows and Members who deal with the consequences of unhealthy behaviour.

1.3 We broadly welcome the White Paper’s recommendations and proposals on addressing health inequalities, sexual health and obesity that build on much of the work of the College with its partners and we are committed to working with the Government on implementing its proposals and improving the health of the public. However we feel that the White Paper does not go far enough in tackling the two biggest causes of premature death in this country—smoking and alcohol misuse. We are disappointed that it fails to put in place a total ban on smoking in all public places and workplaces, or adequately address the issue of problem drinking. In these areas we will continue to press the case for the recommendations to be strengthened.

1.4 The White Paper does not meet our two benchmark standards of tougher regulation and cross-government co-operation at Cabinet level as set out in our response to the Choosing Health? Consultation—this is likely to have an adverse effect on implementation.

1.5 In addition, the pre-occupation with intellectual arguments is in danger of distracting attention away from proactive interventions that will help to, at the very least, stem a public health problem that is in danger of spiralling out of control.

**WHETHER THE PROPOSALS WILL ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS**

**Alcohol**

2.1 We welcome plans to invest in improvements to services to help the NHS tackle alcohol problems at an early stage. However it is crucial that there is investment in research and monitoring. No one yet knows or understands fully why we have the binge culture, what to do about it, how to change it, or whether education programmes work. Any initiatives will therefore have to be carefully assessed in a rigorous and scientific way.

**Obesity**

2.2 The Government has avoided making targets for the reduction of obesity in adulthood, which is disappointing, and has merely indicated that for children the objective is to halt the year on year increase in prevalence by 2010. We are uncertain whether this more simplistic target will be achievable without a stronger regulatory framework that engages the food and advertising industries at an earlier stage. We completely support the proposal for a close partnership with industry; however, we anticipate that legislation will be necessary to bring about change. The RCP believes that the proposed introduction of regulations in 2007 will be too late to achieve the childhood target and will allow “drift” from the original good intentions.

2.3 We are unconvinced that the suggested cross-Governmental approach is actually happening—the publication of the White Paper does not appear to have changed the “silo” approach by Government departments and there has been no public pronouncements about the Cabinet sub-committee described in the White Paper.

2.4 The achievement of the public health goals is heavily dependent upon the delivery plans, which have yet to be published.
Tobacco

2.5 The proposals to increase access and uptake of smoking cessation services will help, and the more widely their use can be encouraged, the greater this effect will be. Provision of cessation services needs to become second nature for all healthcare workers in order that support is delivered as routine to all smokers who want to quit.

2.6 The proposal to ban smoking in most but not all workplaces will have an important effect on smoking prevalence, but this effect will not be maximal and will be least effective in the deprived communities that most need them. The proposed timescale for introduction of smokefree policies is unnecessary long.

2.7 The promises on spending on health promotion are without substance in terms of budget or stated aims. High profile, sustained and varied campaigns are effective but need a substantial budget. We believe low-key activity will not achieve much.

Sexual health

2.8 It is likely that through the high profile public health advertising campaign there will be greater awareness of STIs and HIV infection. A similar campaign in the 1980s in retrospect seems to have been effective in reducing the transmission of HIV and other sexually transmitted infections, this campaign is therefore to be welcomed. This campaign will put increased demands on already hard-pressed GU Medicine/HIV services; it is going to be impossible for the Government to put in place effective remedial action for these services before this campaign is launched.

2.9 There has been no co-ordinated organisation of community services to make up for any shortfall and the current system of commissioning for sexual health services through primary care trusts (PCTs) is producing a very patchy and unsatisfactory system throughout the country which will make it impossible for an effective public health response to the current problems.

2.10 The introduction of a nationwide chlamydia trachomatis screening for appropriate groups may be a major step to cutting the transmission and the morbidity associated with this serious public health problem and is to be applauded.

Whether the Proposals are Appropriate, Will be Effective and Whether They Represent Value for Money

Alcohol

3.1 We are concerned that Ofcom does not go nearly far enough in limitations on broadcast advertising of alcohol. In France there is a complete ban on broadcast advertising of alcohol and this has withstood legal challenge by the industry.

3.2 We question the validity of running an information campaign in partnership with the industry-funded Portman Group rather than independent bodies such as Medical Royal Colleges and Alcohol Concern.

Obesity

3.3 The Government concedes that the limited evidence-base on population-wide strategies to prevent and treat overweight and obesity and, quite rightly, calls for commissioned research. Such research must draw on experiences from elsewhere, most particularly USA and Australia and include a full economic analysis. We cannot wait for the outcome of such research and need action now.

3.4 The RCP is concerned that the desire to devolve actions down to a local level reduces the opportunity for a national health promotion campaign that could (and should be) hard-hitting. The devolution of action largely to a local level has the potential danger of widening rather than narrowing social inequalities.

3.5 The White Paper includes no cost-benefit analysis but merely refers to Sir Derek Wanless’ report. Such an analysis is essential to ensure that resources that are saved for the longer term by effective preventive measures are clearly identified and utilised at a national and local level. The Government promises additional resource to PCTs from 2006 to strengthen primary care capacity to prevent weight and tackle obesity—such resource (financial and human) is needed now.

Tobacco

3.6 The tobacco control policies outlined in the White Paper are appropriate, should be effective and represent value for money if implemented with vigour. The likely effectiveness of the White Paper policies is in approximate direct proportion to the rigour with which they are implemented. The proposal to make some but not all public places smokefree will be less effective than early implementation of full smokefree policy; the effectiveness of price rises is directly proportional to their magnitude; low profile and dull health promotion campaigns are less effective than interesting or challenging high profile ones.

3.7 The absence of a commitment to reform nicotine regulation is a major missed opportunity.
### Sexual Health

3.8 STIs/HIV have now been recognised as a major public health problem. For a public health campaign to be successful it would require:
- public education on sexual health leading to behaviour change;
- provision of wherewithal to provide protection ie free access to barrier methods of contraception and reduction of partner rate change;
- a substantial investment in new and expanded premises especially in genito urinary medicine;
- 48 hour access to services in genito urinary medicine;
- a community network of high quality services made up of appropriately trained, supervised and co-ordinated personnel; and
- a clear programme for implementation of NAATS testing in all GU Medicine clinics and in the community.

3.9 The proposals the Government make are entirely appropriate in respect of the need for investment in services. The question is will the response be adequate to address the current shortfall? The Health Select Committee has itself pointed out the woeful state of many genito urinary medicine departments and the inadequate expansion of consultant numbers in genito urinary medicine and there has been little progress in implementing the 2001 National Sexual Health and HIV Strategy for England.

3.10 It is hard to see the investment of £130 million allocated to modernisation of genito urinary medicine will have sufficient impact to meet the demands that will be placed on services. It is essential that any new monies are carefully allocated and monitored as to the appropriateness of their use.

### Whether the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure That Proposals Will Be Implemented and Goals Achieved

#### Alcohol

4.1 In our 2001 report, *Alcohol: can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals*, the RCP has already given strong arguments for dedicated alcohol healthcare workers in all acute Trusts and evidence exists for their cost-effectiveness, so we need to press on. Also in the same report we called for a National Institute for Alcohol Research akin to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in the United States. We are concerned that the Government has taken up neither proposal.

4.2 Relaxation of licensing laws runs contrary to the spirit and intent of the White Paper. It highlights the indecision within Government as to the underlying philosophy behind its approach to public health.

4.3 Those of us working at the front door of hospitals wonder how long must we wait for convincing evidence of results from voluntary social responsibility scheme of the industry before tougher statutory measures are taken. It represents further delay during which the health crisis related to alcohol misuse could get worse.

#### Obesity

4.4 There is very little expertise across the NHS in the prevention and management of obesity. Most particularly, this has not been regarded as a priority at a PCT level and there is very limited public health and general practice experience for applying effective measures. The situation in secondary care is little different and the shortage of staff trained in obesity management is extremely serious.

4.5 A priority must be the immediate establishment of training programmes for all health professionals who work in every location of the NHS. The White Paper’s suggestion that this will be picked up by the new NHS Competency Framework seriously under-estimates the complexity of the task and the current paucity of knowledge and skills—the White Paper makes no mention about who will draw up and deliver this framework. There is a danger that all of the opportunities for tackling obesity created by the White Paper will founder unless there is an immediate and substantial programme of education and training—this should include not only health professionals but also the public.

#### Tobacco

4.6 For smoking cessation interventions the rate-limiting step in many cases is the lack of priority given to smoking prevention by many healthcare professionals. Resolving this is a major undertaking that will require a great deal of investment in training and the introduction of appropriate incentives. When demand rises as a result, services will need to expand to meet it.
4.7 The necessary regulatory system and resources are not currently in place for nicotine regulation. The UK needs to establish a nicotine regulation authority to oversee all aspects of production, marketing, taxation, safety and monitoring of all nicotine products, with the remit to minimise the use of smoked tobacco as the primary source of nicotine in our society. The pragmatic aim of the regulation authority should be to minimise the harm caused by smoking.

4.8 Effective tobacco control policy requires coordinated, cross-departmental activity; the White Paper does not clearly state whether and how this will be achieved for tobacco.

4.9 There is a need for research and development particularly in cessation service implementation, and this needs funding support.

4.10 Monitoring of smoking trends in the UK is piecemeal and slow. It is important to establish more regular and quickly available monitoring systems so that the impact of policy change can be assessed in a timely manner.

Sexual health

4.11 A serious problem is developing for sexual health services for the successful implementation of the White Paper proposals. As sexual health/HIV has not been identified as a national priority for action, and the GP contract does not give any priority to this area, the current contracting system through PCTs and the devolution of care to inadequately trained personnel in the community is of serious concern. Urgent consideration needs to be given to both providing training and governance for those who wish to provide sexual health services.

4.12 The infrastructure for implementing the chlamydia trachomatis programme does not currently exist and will need to be urgently addressed if even the goal of 2008 is to be achieved.

4.13 There is an excellent case to be made for treating STIs and HIV without the above contract system with resources being put into a strategy that provides for a network of sexual health/HIV services overseen on a national basis. This would ensure a coordinated response to the public health crisis and ensure fair provision of services.

January 2005

Annex

The Royal College of Physicians welcomes the opportunity to respond to the “Choosing Health?” consultation. Our response focuses on four key public health issues: smoking, alcohol, obesity and sexual health.

The College has played a leading role in addressing public health concerns for much of the past 50 years, most notably in the area of tobacco control. Its work has, and continues to be, informed by the experience and expertise of our Fellows and Members who deal with the consequences of unhealthy behaviour, often seeing patients who are suffering from the combined effects of smoking, alcohol misuse, obesity and sexual disease.

We note that much of the current debate about public health has focused on the pros and cons of “government intervention” versus “individual responsibility”. While we support the notion of freedom of choice, it is clear to us that the serious medical consequences of smoking, obesity, excessive alcohol and sexually transmitted disease requires decisive leadership and action by Government and can only be successfully achieved through:

— regulation or legislation, as history has compellingly demonstrated in the case of smoking and tobacco control; and
— cabinet-level cross-departmental co-ordination of policy development and implementation on public health issues.

Smoking, alcohol, obesity and sexual health have much in common with each other in terms of the challenges facing Government, industry, health professionals and society. In particular:

— All disproportionately affect the vulnerable in society, the young, the deprived and the disadvantaged.
— All require more socially responsible approaches to the advertising, marketing and promotion of products, which, if used at all in the case of tobacco, or unwisely in the case of alcohol and diet, cause ill-health and premature death.
— Premature death and ill-health from the above causes are preventable, and could be significantly reduced by public education and health promotion to encourage healthy behaviours.
— All form a substantial cost to society, not just through the costs to the NHS, but also in terms of wider costs to society such as lost production, costs to social services, and reductions in quality of life.
— All have implications for the training and education of health professionals and their practice.
In our response the College identifies clear actions and measures that should be taken to address these challenges. Our response also incorporates the views of the College’s Patient and Carer Network.

**RCP Patient and Carer Network**

“Government should not be afraid to regulate.”

We hope that the forthcoming White Paper will incorporate many of our recommendations as part of a coherent and long-term programme of policy and practice. But, above all, we urge Ministers to embrace the need for tougher regulation and cross-departmental co-ordination as levers for achieving real change. If they do, it will be the clearest signal yet that the Government is serious about tackling our nation’s ailing public health.

**TOBACCO**

**LONG-TERM OBJECTIVES**

The long term objective of public health policy and practice in relation to smoking in Britain should be to achieve a smokefree society.

In practical terms, with strong leadership and commitment, and with creative use of alternative nicotine products, this could realistically be achieved in 20 years.

**MEDIUM-TERM OBJECTIVES**

To achieve a fully smokefree society we propose measures to:

- Reduce the prevalence of smoking as quickly as possible, by
  - maximising cessation rates among established smokers;
  - minimising the uptake of smoking by young people;
- Maximise the use of alternative, safer sources of nicotine by established smokers who are unable or unwilling to quit.

**What is the context of these objectives?**

1. **The size of the problem**
   - There are currently about 13 million smokers in Britain.
   - Smoking currently kills around 114,000 Britons each year, far more than any other avoidable cause.
   - Smokers who die in middle age as a result of their smoking lose on average 21 years of life.
   - Smoking causes a vast burden of premature illness amongst smokers and non-smokers, including young children.
   - Smoking exacerbates poverty and deprivation.
   - Smoking contributes to social inequalities in health in Britain more than any other identified factor.

2. **Smoking as an addictive behaviour**
   - Smoking is a powerfully addictive behaviour, and most adults continue to smoke because they are addicted to nicotine rather than from choice.
   - Most smokers become addicted to nicotine during or before adolescence, and once addicted find it very difficult to stop smoking.
   - Hence, two-thirds of all smokers would prefer to be non-smokers but only a very small proportion (currently only about one in every 70) succeeds in quitting each year.
   - Nicotine is not itself a significantly harmful drug; it is the tar that accompanies nicotine in cigarette smoke that accounts for most of the harmful health effects of smoking.
   - Nicotine addiction per se has none of the adverse societal effects associated with addiction to alcohol or illicit drugs; it is tobacco smoking as a source of nicotine that is harmful.

3. **Implications for health policy**
   - Therefore, whilst quitting smoking is the ideal course of action and should be promoted as the best outcome for all smokers, it is also important to address the needs of the substantial proportion of smokers unable or unwilling to quit in the short to medium term.
— For these smokers, switching to a safe source of nicotine offers almost all of the health benefits of smoking cessation with minimal risk.
— Effective prevention of the current burden of ill-health and mortality caused by smoking therefore requires three courses of action:
  1. Measures to prevent uptake of smoking by young people.
  2. Measures to encourage complete cessation in current smokers able to quit.
  3. Replacement of smoked tobacco products by alternative safer nicotine sources for those unable or unwilling to overcome their nicotine addiction.

What policies are available?
The following measures have been shown to be effective in relation to the above three areas, either in their own right or as part of an effective overall policy in reducing smoking prevalence in other countries:
— Comprehensive, total smokefree policies in all public and workplaces.
— Progressive increases in the real price of smoked tobacco products, combined with effective measures to tackle smuggling and “faghouse” distribution.
— Strong and sustained health promotion programmes.
— Complete prohibition of all advertising and promotion of smoked tobacco products.
— Systematic implementation of smoking cessation services and encouragement of use.
— Promotion of safer forms of nicotine delivery as an alternative to smoked tobacco.

Likely Time Course of the Effects of Different Policy Approaches

1. Policies that reduce uptake of smoking:
— Minimal effect on major diseases (cancer, heart) over next 20 years.
— Substantial reduction in risk of major diseases from 20 years onwards.
— Substantial and rapid reduction of peer group and role model smoking norms.
— Immediate reduction of passive smoke exposure to others.
— Immediate reduction of parental role modelling of smoking and passive smoke exposure (pre- and post-natal) to own children.

2. Policies that increase smoking cessation:
— Immediate reduction in risk of most major smoking-related diseases.
— Immediate reduction in health service use and improved productivity.
— Immediate reduction in smoking role models and societal norms.
— Immediate reduction in all passive smoking exposure.

3. Policies that reduce the harm caused by nicotine addiction:
— Immediate reduction in risk of most major disease.
— Immediate reduction in health service use and improved productivity.
— Immediate reduction in smoking role models and societal norms.
— Immediate reduction in all passive smoking exposure.

What Should UK Policy be on Smoking?

1. Reduce the drivers to smoke in everyday life

There is strong evidence that the main driver to uptake of smoking by young people is the prevalence of smoking among adults, and the resultant perception of smoking as a positive adult behaviour. Policy should therefore be directed primarily at areas (2) and (3) above.

The following general policies help to make smoking generally undesirable and/or unacceptable, and thus create an environment in which smokers are more likely to try to quit, and young people less likely to want to experiment with cigarettes and become regular smokers:
— Make all work and public places completely smokefree.
— Strengthen the current advertising ban by complete prohibition of all sponsorship, brand stretching, product placement and point-of-sale promotion of cigarettes.
— Strong and sustained publicity/advertising campaigns targeted at all sections of society and all aspects of smoking, including passive smoking.
— Progressive and substantial increases in the price of cigarettes (in conjunction with changes in the availability of alternative nicotine products, and controls on smuggling, see below).
— Prohibit all point of sale promotion and display of cigarettes and smoking tobacco products (make cigarettes an under-the-counter product).
— Impose plain generic packaging on all smoking products.
— Act quickly to close any loopholes or unforeseen exclusions to the above.

2. Maximise the uptake of effective smoking cessation interventions

Effective methods of cessation exist and are available in the UK for all smokers to use; however, the proportion of smokers accessing cessation services, the proportion of doctors trained in and actually delivering cessation interventions, and the proportion of consultations with smokers in which smoking is addressed remains low. We therefore propose:

— Powerful, pervasive and sustained advertising and promotion campaigns at national and local level to make smokers aware of cessation methods, their basic principles and success rates, and the availability of local services.
— Encouragement of the training of all doctors and other relevant health professionals in the clinical practice of delivering smoking cessation interventions.
— Application of strong incentives and/or contractual drivers to implement evidence-based clinical cessation practice guidelines in routine primary and secondary medical care, dentistry and other health care provision to ensure that:
  — Smoking status is ascertained and brief advice to quit delivered at all clinical consultations.
  — All smokers who are motivated to quit are provided with the highest level of cessation support they are willing to accept, without delay.
  — All smokers making quit attempts are followed up, and encouraged to try again if they fail.
— Provide the necessary funding resources to ensure that staff are trained and appropriate services are available for all smokers ready to try to quit.

3. Minimise uptake of smoking

Most smokers start to smoke in their teenage years, and all of the available evidence indicates that young people are less likely to experiment with and/or persist with smoking if smoking is perceived in society as an undesirable and/or unacceptable behaviour.

Therefore the above measures to denormalise smoking, and encourage cessation in adults, are also likely to have a substantial effect on the uptake of smoking and should be the first priority in preventing smoking in young people.

Additional policies that are likely to be effective include:

— Protecting children and young people from exposure to positive smoking role models, brand placement or other incentives to smoke in feature films by making these characteristics criteria for 18 classification in all new films.
— Applying a similar guideline to all new TV programmes in relation to transmission before or after the 9 pm watershed.
— Implement fully smokefree policies in all schools and colleges.
— Providing cessation services at school for young smokers.

Consideration should also be given to tightening controls at the point of sale of cigarettes:

— Requiring proof of age at point of sale for all purchasers who look under 25, and impose severe penalties on retailers who do not comply.
— Effective policing of point of sale regulations, backed up by a strong likelihood of severe penalties for individuals supplying cigarettes to underage smokers by whatever means (such as responsibility for vending machines).
— Licensing of tobacco retailers to provide the opportunity to withdraw licences from those allowing underage sales.
4. Encourage the use of safer sources of nicotine

Medicinal nicotine products are safe and should be strongly encouraged as an alternative regular source of nicotine. Some smokeless tobacco products (such as snus, which is widely used in Sweden) can also provide nicotine in a formulation that is a proven acceptable alternative to cigarettes for many smokers, and although more harmful than medicinal nicotine is much less harmful than cigarettes. The following policies are therefore likely to reduce significantly the harm caused by nicotine addiction:

— Encourage switching from smoked tobacco to medicinal nicotine, by:
  — Promotion of medicinal nicotine as an alternative regular source of nicotine, rather than a cessation product.
  — Packaging and promotion of medicinal nicotine in daily packs, to compete directly with cigarettes at the point of sale.
  — Pricing of medicinal nicotine to give strong market advantage relative to smoked tobacco.
  — Providing the necessary assurances and commercial confidence for manufacturers to invest heavily in the development of new and more effective medicinal nicotine products.

— Regulation of selected smokeless tobacco products to provide an interim alternative nicotine source to smoked tobacco and medicinal nicotine:
  — Define safety standards for a limited range of smokeless products to be introduced as a social experiment, initially limited in test region(s) of the UK.
  — Permit promotion of smokeless products to existing smokers under strict controls.
  — Regulate and monitor the promotion and sale of smokeless products.
  — Ensure that pricing of products is positioned between that of cigarettes and medicinal nicotine.
  — Apply the same age restrictions on sale of smokeless products as cigarettes.
  — Aim to phase out the use of smokeless products as and when this can be achieved without significant switching back to smoked tobacco.

5. Other supporting policy

The following are all areas important to the support and implementation of effective measures to reduce smoking:

— Monitoring smoking behaviour: It is essential that the effect of the above policy initiatives is closely monitored, and changes made to deal quickly with failings, loopholes, unforeseen adverse effects, and new circumstances. It is also essential to collect detailed and regular information on smoking behaviour, access to cigarettes (through legal and illegal sources), use of alternative nicotine products and various other characteristics routinely, regularly and quickly.

— Smuggling: Price, packaging and underage sale measures are seriously undermined by illicit market in smuggled tobacco products. Prevention of smuggling will require substantial further investment in police and Customs and Excise activity against smoking. Given the past record of tobacco industry complicity in smuggling it would be reasonable to impose strong penalties on the manufacturers of products that appear on the illicit market, and to require manufacturers to implement control measures to allow the supply chain of illicit products to be traced.

— Protecting children: Passive smoke exposure at home is a major cause of childhood illness and mortality. Children have a right to a clean atmosphere at home, and specifically to freedom from exposure to tobacco smoke toxins and smoking role models in parents and siblings. Innovative measures are required to specifically target and prevent passive smoking in the home.

— National floor standards for protection against passive smoke: Experience in other countries indicates that smokefree policies are effective in the great majority of environments. However, in special cases (such as mental health establishments or penal institutions) where more time may be necessary to establish smokefree policies successfully, it would be appropriate to apply a national floor standard to limit the extent of passive smoke exposure permissible for inmates and staff.

— Cross-departmental coordination of tobacco policy in government: It is essential that a suitable political framework is established to implement, monitor and coordinate all aspects of tobacco control policy.
6. Establish a nicotine regulation authority

The above measures need coordinated supervision and monitoring if they are to be successful. Smoked tobacco products are extremely dangerous but are currently exempt from food, drug and consumer protection legislation; medicinal nicotine is extremely safe but is subject to tight medicines control legislation; smokeless products are much safer than cigarettes but are prohibited on health grounds. We suggest that the regulation of all nicotine products is brought under the control of a single authority with a remit and budget to:

- Take responsibility for all aspects of nicotine use in the UK.
- Implement and monitor the progress of all of the above policy initiatives.
- Adapt and respond to new developments and maximise the speed and effectiveness of new implementation.
- Establish standards for novel nicotine products.
- Co-ordinate the actions of the various government departments relevant to implementing the above policy.
- In particular, monitor the impact of opening the market to medicinal and approved smokeless products, and deal with any inconsistencies and unforeseen adverse impacts.
- Control and supervise marketing activities of tobacco companies.
- Commission research to address areas of uncertainty in established practice, new developments in practice, and in policy response.

**Importance of Balancing Cessation and Harm Reduction Policy**

- Smoking prevalence in the UK is currently about 26%, and is falling by about 0.4% per year.
- At this rate therefore, even if sustained, it will take 65 years to eradicate smoking from the UK.
- We suggest that with strong policy implementation it may be possible to increase cessation to achieve a 1% year-on-year reduction in prevalence in the shorter term, possibly more when adult prevalence trends start to translate into a reduction in uptake of smoking by young people.
- However, in the longer term this rate may not be sustainable, as the remaining population of smokers increasingly comprises those who find it especially difficult to quit.
- Hence it is important to begin to address the needs of this group early, by encouraging alternative nicotine use.
- We would suggest a target of achieving a similar rate of switching to alternative nicotine sources to that of complete cessation.
- The combined effect of these measures would then be to reduce smoking prevalence by up to two percentage points per year.
- On this model, achieving a smokefree society in the UK over a 20 year period is a challenging but achievable and realistic option.

**OVERWEIGHT AND OBESITY**

**LONG TERM OBJECTIVE**

To achieve a leaner, fitter and healthier nation and in this way reduce the prevalence of obesity in England/UK to less than 10% of the adult population and less than 5% of children and younger people.

**MEDIUM TERM OBJECTIVE**

To enable people of every age, and from every social background, to make informed choices about their eating and to become more physically active by better information, education and health promotion and through an environment that encourages activity.

*What is the context of these objectives?*

1. The size of the problem

Obesity is a disorder in which excess body fat has accumulated to an extent that health may be adversely affected.

Overweight and obesity are now so common among the world’s population that they are beginning to replace under-nutrition and infectious diseases as the most significant contributors to ill health. The National Audit Office estimated for England that each year 30,000 excess deaths result from obesity,
constituting 6% of all deaths. Moreover, many of these people die prematurely (National Audit Office
Tackling obesity in England, 2001). However, despite the compelling evidence, many people, including
doctors, continue to consider obesity as a self-inflicted condition of little medical significance.

There has been a rapid increase in the prevalence of overweight and obesity in all age groups across the
UK over the last 20 years. For example, according to the latest Health Survey for England (Joint Health
Surveys Unit, 2002), between 1993 and 2002 the proportion of overweight and obese adults rose from
62% to 70% among men, and from 56% to 63% among women. So, over two-thirds of men and nearly
two-thirds of women were either overweight or obese in 2002. The proportion who were categorised as obese
increased from 13% of men in 1993 to 22% in 2002, and from 16% of women in 1993 to 23% in 2002. Obesity
now affects over one in five adults in the UK.

Overweight young people have a 50% chance of being overweight adults, and children of overweight
dads have twice the risk of being overweight compared to those with healthy weight parents. Obese
10- to 14-year-olds with at least one obese parent have a 79% chance of becoming obese adults (Whitaker
et al Predicting obesity in young adulthood from childhood and parental obesity, New England Journal of
Medicine, 1997). Furthermore, parental obesity more than doubles the risk of adult obesity in obese and
non-obese children under 10 years.

If current trends continue, at least one-third of adults, one-fifth of boys and one-third of girls will be obese
by 2020. These forward projections from existing data are conservative. If the rapid acceleration in
childhood obesity in the last decade is taken into account, the predicted prevalence in children for 2020 will
be in excess of 50%.

2. Health consequences

The health consequences of overweight and obesity are wide-ranging and serious, from type 2 diabetes,
to the risk of coronary heart disease. At present, overweight and obesity may be more common in older age
groups but the increase in the proportion of overweight and obese children is of major medical concern. The
medical complications from overweight and obesity may become evident throughout life but are likely to
occur much earlier because of the increasing fatness of children and young people. As well as exacerbating
many health problems, increasing degrees of fatness shorten life.

3. Implications for health policy

To prevent obesity, the nation has to consume less energy and be more physically active. Most people,
especially those prone to overweight, are well aware of these basic principles but, for various reasons, find
it difficult to follow them. The challenge, in tipping the balance towards a trimmer and slimmer nation, is

to help people overcome the many barriers to a healthier lifestyle.

4. Target groups

Although everyone needs to watch their weight, the national programme to tackle obesity is likely to be
more effective if initiatives are targeted at those individuals, families and communities most prone to
overweight, or for whom being overweight poses a higher risk to health. National and local initiatives should
therefore target the following three priority groups, with particular attention to individuals, families and
communities who may be disadvantaged in terms of age, gender, income, language, culture, ethnicity,
ability/disability, or geographical location:

— All children and young people: healthy eating and an active lifestyle should be promoted to prevent
the onset of overweight and to develop healthy habits for life.

— Children and young people who are overweight or obese: weight control should be promoted and
the risks associated with overweight and obesity reduced. Priority should be given to those for
whom obesity would confer extra risk of ill health (eg children with diabetes, or musculoskeletal
problems), and to those suffering adverse consequences (eg bullying and low self-esteem).

— Adults with a tendency to become overweight or obese: weight control should be promoted and
the risks associated with overweight and obesity reduced. Priority should be given to those at
particular risk of obesity (eg through a family predisposition, pregnant women), or for whom
obesity would confer extra risk of ill health (eg people with high blood pressure, diabetes,
depression, musculoskeletal problems).

What policies are available?

In our report “Storing up problems: the medical case for a slimmer nation” (Royal College of Physicians,
2004), the College made the following policy recommendations:

— A cross-governmental task force should be established at Cabinet level to develop national
strategies for tackling the threat from overweight and obesity, and to oversee the implementation
of these strategies.
— Government should mount a sustained public education campaign to improve people’s understanding of the benefits of healthy-eating and active living, and to motivate people to eat a healthier diet and adopt a more active lifestyle.

— New standards in nutritional content, food labeling and food marketing and promotion should be agreed jointly by the food industry and the Food Standards Agency. Incentives to encourage the production, promotion and sale of healthier foods should be introduced.

— Population-wide initiatives should be implemented at local level to tackle obesity. Public services should take the lead by promoting healthy eating and increased physical activity in public places and institutions, such as schools and hospitals.

— The prevention and management of overweight and obesity should be included in all NHS policies and clinical care strategies. Appropriate training programmes for doctors, nurses and other health professionals should be established.

— There should be further funded research to improve understanding of the societal and cultural factors behind the epidemic of overweight and obesity, and the development and implementation of effective prevention and treatments.

What should UK policy be on obesity?

1. National level co-ordination

There is evidence from around the world that centrally coordinated, multi-agency, strategic approaches to tackling obesity are more likely to achieve substantial and sustained results. Such approaches are often contained within broader health improvement strategies.

In England, the Government White Paper on health improvement, “Saving lives: our healthier nation” (1999), sets targets for reducing the impact of such major killers as coronary heart disease (CHD), strokes and cancers. Saving lives proposes action at three levels: individual, community and government (national).

Central and local government should take a more active role in making it easier for people to access better community spaces, gyms, exercise activities, local authorities, town and country planners etc, could support small corner shops, rural businesses, to stay open to provide employment, accessibility etc. They could be encouraged by being given incentives to sell fresh fruit and vegetables, healthy food and snacks, therefore families would be given the opportunity to walk to shops/or cycle instead of using cars, buses etc to shop further from their homes.

Government has also developed disease-focused plans to prevent and treat major diseases such as CHD, stroke, diabetes and cancer. For example, there are national service frameworks (NSFs) to tackle cancers, mental health, CHD, diabetes, health problems in older people (including stroke and falls), and children’s health. Each of these will have a major impact on overweight/obesity in various ways, and the CHD NSF specifies reducing obesity as a designated priority with stated objectives and milestones.

And there are specific plans to improve the national diet or increase physical activity and sport such as England’s “Game plan” and its recent physical activity strategy and food and health action plan. The UK-wide Food Standards Agency (FSA) is also doing much to promote healthy eating by encouraging the food industry to improve the nutritional quality of processed and convenience foods, to promote healthier alternatives and to develop simple nutritional labeling.

To succeed in tackling the time bomb of obesity the Government needs a cross-governmental, “joined-up”, high-level strategy which gathers together all these elements and welds them into a coherent, whole-system approach to the prevention and treatment of overweight and obesity.

2. Public education and social marketing

In the developed world, there are a number of national public education campaigns that have succeeded in raising awareness of the issues and promoting healthier eating and more active living, the most notable example being Finland’s North Karelia Project. Multimedia public education approaches have proved effective in reducing weight gain in two large-scale community-based programmes in the USA.

As part of its strategy, central government should mount a promotional campaign to motivate the public to eat a healthy, balanced diet and adopt a more active lifestyle. The campaign should be directed at everyone, whatever their background, but should particularly aim to engage children, young people, and people who are disadvantaged or from those ethnic groups at greatest risk from increasing fatness.

People’s choice of food and drink depends greatly on such factors as price and availability, as well as flavour, quality, convenience and nutritional value. The food industry, from farm gate to consumer’s plate, has a key role to play in determining what foods are consumed and in what quantity or balance.
The dominant force in this chain is likely to be the supermarkets, which can strongly influence primary producers as well as consumers. Ideally, consumers should be presented with a wide choice of foods from which they can select a healthy balance for the family table at prices the poorest can afford. Theoretically, the contents of the family shopping trolley should correspond to nationally recommended dietary intakes.

Much work is currently being undertaken in partnership with the food industry to try to shift consumer demand away from high fat, high sugar, high-calorie products, towards healthier alternatives. However, greater effort is needed to achieve a healthier national diet and, in particular, to increase consumption of fresh fruit and vegetables. This should go beyond simply engaging the food industry in initiatives, and should instead aim for joint working towards good practice as part of the food and advertising industries' corporate social responsibility.

As people become more aware of the health consequences of what they eat and drink, so it becomes increasingly important for them to have useful nutritional information about each food item. This should include guidance on calorie content. However, it is essential that this is given in an easily understandable form, such as simple symbols indicating “high”, “medium” and “low” calorie content. As far as possible, this should be in accordance with the latest European Union nutritional labeling proposals.

3. Promoting “active transport”

Any national strategy must contain a strong element promoting “active transport”, ie discouraging the unnecessary use of cars, and encouraging walking and cycling. This might involve initiatives regarding town planning, building specifications, road taxation, VAT on bikes, etc. Safety of walkers and cyclists is a key issue. The need for policies, which promote and support active transport has already been recognised by the Government.

4. Promoting leisure-time physical activity

Much is already being done to promote leisure-time physical activity and sport. All four UK countries have well-funded non-governmental organisations (NGOs) which promote such sport and leisure activities. All four have comprehensive strategies in place, with clearly identified priority target groups. However, there is still much to be done, particularly in terms of joining up with local strategic partnerships for health and well-being. A key gap is the lack of strong and effective links between the leisure and health sectors.

**RCP Patient and Carer Network suggestions**

- Having shorter journeys to work.
- More time should be allotted in school to health and home.
- Free supplies of fruit for all school-aged children to support the five a day campaign.
- Support for workplaces to provide sporting facilities, reduced entrance costs to sports clubs, teams etc.
- Provide greatly-reduced entrance costs to sports clubs etc for unwaged members of the public.
- Encourage canteens in schools, colleges, universities, workplaces, all public places to provide healthy choices on their menus.
- Access to fresh food—out of town supermarkets may deprive the poor and elderly access and generate traffic/transport issues and means fewer people walking to shops (same for argument for locating pharmacies in supermarkets, restricts choice for those without access).
- Supporting services in rural areas ie sports clubs, aimed at different ages groups, regular bus services providing regular access to these venues in nearby towns to help alleviate social isolation, causing ill health etc.
- Encourage workplaces to introduce flexible working times—to allow parents to walk their children to school before commencing work. Central government to support and encourage more “walk to school” initiatives, safer cycling routes etc.

5. Promoting healthy schools

There is evidence to support a multifaceted approach to promoting healthy eating and physical activity in the schools setting, including: curricular and non-curricular education; healthy food and drink choices in school meals, tuckshops and vending machines; and sport, active pursuits and active travel to and from school.

For many years, school catering suffered from inadequate budgets and an absence of statutory nutritional standards. In 2001, national nutritional standards were re-introduced and catering budgets were made the responsibility of school governors. Hopefully, these changes will result in healthier choices for all schoolchildren. In particular, there should always be an attractive choice of fresh fruit on offer in school dining rooms.
In England, the National School Fruit Scheme, offering every child in England aged four to six a free piece of fruit each school day, has been successfully piloted and will be fully operational nationwide from 2004. The Government has also recently launched its “Food in schools” programme, jointly run by the Department of Health and Department for Education and Skills, which will involve over 500 schools in eight pilot projects around the country, looking at a range of initiatives from breakfast clubs and lunchboxes to healthier vending machines, fruit tuckshops, and after-school cookery classes.

Pressure on the school curriculum has been blamed for the gradual erosion of teaching time devoted to sports, active games and physical education. There has also been a trend toward selling off school playing fields in order to help balance hard-pressed education budgets. These issues are being actively addressed and the trends reversed. There is now a minimum standard of two hours of moderate physical activity in school time per week. Very large capital sums, from such sources as the New Opportunities Fund, are being invested in schools’ sport and physical education facilities and equipment, focusing on the more deprived areas of the country.

In England, the National Healthy School Standard aims to encourage schools to develop a “whole school” approach to health and to consider diet and physical activity (along with sex and relationships, drugs and alcohol, tobacco and citizenship) in all aspects of school life. It is part of the Healthy Schools Programme, led jointly by the Department for Education and Skills and the Department of Health. Similar initiatives exist in other UK countries.

However, it is up to the individual school to decide its Healthy School priorities, and in many cases education in sex and relationships, drugs and alcohol takes precedence over attention to diet and physical activity.

One aspect of the whole school approach is to ensure that healthy eating messages are consistent across the classroom, dining room, tuckshop and vending machine. The tuckshop and vending machine, in particular, should not promote sugary or fatty snacks or sugared drinks. School governors should consider banning these items from the tuckshop or vending machine. At the same time, they should ensure the easy availability of plain drinking water. In Scotland, the provision of water and fruit juice in school vending machines is now mandatory and advertisements on the front of the machines promoting sugar-sweetened drinks and fatty or sugary snacks are banned. It is important that these school-based initiatives are sustained and built upon, involving parents and local communities.

6. NHS priorities, planning and performance

Recent NHS priorities and planning guidance continues to focus on health services and pays scant attention to tackling obesity or promoting healthy eating and active living. Any references to these aspects tend to be inferred in longer-term targets concerning CHD and cancer, with an emphasis on adults. The urgency of the problem among children and young people is barely acknowledged. It is most important that the prevention and management of overweight and obesity, prioritising children and young people, be given greater prominence in future priority-setting and planning for the NHS and social care.

With regard to adults, an important opportunity now exists with the implementation of the new General Medical Services (GMS) contract. The contract’s Quality and Outcomes Framework is designed to raise organisational and clinical standards in primary care, with an emphasis on teamworking and nurse-led chronic disease management. Within it is a requirement to record accurate data in a standardised electronic format. This should greatly improve risk management of CHD, stroke, hypertension and diabetes, including the risks associated with overweight and obesity. Along with other initiatives such as the Expert Patients Programme and the Electronic Patient Record, this is expected to contribute greatly to an improved service for managing overweight/obesity, and for monitoring the implementation and effectiveness of programmes to prevent and treat obesity.

However, there remains a lack of coordination in terms of workforce planning. As more and more overweight patients are assessed as being at risk of cardiovascular disease or diabetes, so this will put a greater strain on local community dietitians and exercise referral services. It is essential that workforce planners factor these trends into their calculations, and provide for extra community dietitians and physical activity coordinators as necessary. All NHS trusts should ensure that the management of overweight and obesity is integrated into all relevant clinical programmes.

The NHS Expert Patient’s Programme should be extended to include sessions for children and young people with a more positive attitude to good health and prevention. This would make a contribution to reducing the number of obese and overweight children and young people.

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7. Prevention programmes at local level

Sustained change can only be brought about by working in a “whole system” way across the various sectors locally. Local strategic partnerships (or local community planning partnerships or equivalent) should be urged to develop local action plans to tackle obesity as a priority within their community strategy.
to promote well-being in their population. In England, a requirement along these lines is included in the Coronary Heart Disease NSF. The Faculty of Public Health has also published a toolkit to help local teams develop and implement action plans to tackle obesity.

Action to prevent obesity at local level will require a co-ordinated approach involving a range of partner organisations, notably:

- Community services, such as health visiting and community child health services, eg school nursing.
- Schools and local education authorities.
- Leisure services.
- Local authority planning departments and parks departments.
- Police and community safety partnerships.
- Primary care organisations and general practices.
- Hospitals and community health services.
- Community groups and voluntary bodies.
- Local food retailers and caterers.
- Local employers.
- Local media.

A practical framework for local programmes could be that offered by the so-called “healthy settings” approach, which focuses interventions in a number of key settings to develop a co-ordinated programme for obesity prevention. There are many possible settings to develop: from home to hospital, from park to prison, and from community group to club or pub. Each provides a particular opportunity to influence people’s eating, drinking and physical activity habits. A simple range of settings for preventing obesity might include:

- home and pre-school;
- school;
- workplace;
- community group;
- leisure facility;
- retail outlet;
- media;
- GP surgery, health centre or clinic; and
- wider population.

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“There exists a large evidence base on major inequalities . . . The major gap is the inability of agencies and areas to work together for the benefit of individuals and families.”

**ALCOHOL**

**Long-term objective**

The long-term objective of public health policy in relation to alcohol use should be to minimise the damage to health through its misuse.

**What is the context for this objective?**

- Alcohol consumption has more than doubled in the UK since 1960, and is rising at a time when it is falling in many parts of continental Europe, such as France and Italy.
- The rise in consumption closely mirrors affordability.
- Almost one in three adult men and nearly one in five women now exceed the recommended guidelines of 21 and 14 units per week respectively.
- Alcohol is second only to tobacco as the main cause of preventable premature death in the UK.
- There has been a three- to 10-fold increase in deaths from cirrhosis in the last 35 years.
- Many of these people are not dependent on alcohol and can stop drinking when damage to health becomes apparent, but often this is too late.
- The increase in both drinking and harm is most marked in younger age groups.
— The cost to the NHS is about £1.7 billion.
— Alcohol is responsible for about a third of Accident and Emergency (A&E) attendances, rising to 70% during the night, and about 150,000 hospital admissions each year.
— While moderate consumption of alcohol has a beneficial effect on cardiovascular disease, as a nation we are consuming well in excess of this. Countries that have reduced their per capita consumption, such as Spain and Canada, have seen a fall in cardiovascular mortality as well as in those diseases one would expect from alcohol misuse.

It could be argued that policy in the alcohol arena has been set by the Government strategy, launched through the Cabinet Office in March this year (Alcohol Harm Reduction Strategy for England, Cabinet Office, 2004). While we welcome this strategy, we believe it does not go nearly far enough in the field of health, both in disease prevention and treatment. For instance:
— There is undue dependence on voluntary action by the drinks industry.
— There is no clear plan with proper outcome targets for any partnership with industry.
— There are calls for pilot schemes for brief interventions when the evidence from pilot studies is already available.
— There is undue emphasis on auditing existing alcohol treatment services rather than properly funding and extending them.
— The strengths, such as the emphasis on earlier detection and prevention of harm, are not backed up by funding.
— The opportunity to use the new GP contract to develop primary care targets has been missed.
— The opportunities to use presentations to A&E departments and acute hospital wards are not developed.
— There is no requirement on acute hospital trusts or PCTs to give development of a coherent alcohol strategy any priority and no targets to drive progress.
— Little or no attention is given the measures that are of proven benefit in reducing harm—price and access. While the Government fears electoral repercussions of such levers, it misses an opportunity to engage the population in proper and responsible debate.

What policy measures are available?

These fall into the categories of education, research, availability of alcohol, marketing, enforcement, detection of hazardous drinking and treatment.

Education
— General Public.
— Product labelling.
— Health care workers (PCT, acute hospital, med students and nurses).

Research
— Proper funding streams for basic and health service research.

Availability
— Price.
— Numbers of outlets.
— Licensing hours.
— Cheap imports.
— Age controls.

Marketing
— Advertising.
— Promotional approaches (students, happy hours).

Enforcement
— Drink-driving limits.
— Under-age purchase and drinking.
Detection of Hazardous Drinking Patterns

- GP well man/woman clinics.
- Occupational health screening.
- Alcohol-related attendances—eg A&E departments.
- Coincidental attendances to primary or secondary care.

Treatment facilities for alcohol dependence

*What should UK policy be on alcohol?*

1. Making the polluter pay

The issue of government levers and, in particular, taxes, and how they might be used to influence key areas is explored in “Securing Good Health for the Whole Population” (Wanless February 2004). We particularly welcome the concept as outlined in para 8.28 that “the product or unhealthy ingredient be taxed”. The government alcohol strategy itself highlights that the alcohol industry must share responsibility for tackling the harm associated with alcohol misuse (Chapter 7, Pages 75–80, *Alcohol Harm Reduction Strategy for England*).

The evidence drawn together by the Cabinet Office Strategy Unit to inform policy includes the fact that 25% of the adult population of the UK are currently drinking alcohol at levels which may cause harm (interim analytical report p 142), and that 2.9 million people show evidence of alcohol dependence (interim rep p 38). In the final strategy (p 18, fig 2.4) the Government estimates direct costs to the NHS at £1.4–1.7 billion and to society from crime and in the workplace at up to £7.3 billion and £6.4 billion respectively. The damage to children and families is beyond quantitation.

At present the alcohol industry contributes nothing to these costs yet has an annual turnover in excess of £30 billion. This is fundamentally wrong. The “polluter” should pay a proportion of the cost, and we propose that a levy of the turnover of the alcohol industry should go towards remedying some of the health and social harm caused by alcohol. The government has accepted in part this argument and has called for a voluntary donation by the industry to an independent fund designed to tackle alcohol related harm, but has set no guidelines for the level of this donation nor made specific proposals as to how the funding should be used.

We propose a contribution by the alcohol industry of 1% of turnover—representing a tiny fraction to both consumers and to the industry as a whole but with the potential to counteract some of the immense harm caused by alcohol to society in England. The funds would amount to less than 20% of the costs to the NHS, but set against the funds currently available for education, prevention and treatment of alcohol related harm could make a real difference. Government estimates that at present less than £100 million is spent on specialist alcohol services and education—with less than £24 million of this provided via the NHS and the remainder by the voluntary sector (interim analytical report p 47).

This funding must be administered by an independent body to promote significant amelioration of alcohol related health and social costs. Priorities would include: acting as a catalyst for the development and identification of good practice; start up funding to build the capacity of specialist services; education and training of health workers; targeting information and promoting culture change.

We suggest that the alcohol industry be given an opportunity to contribute this 1% levy voluntarily, but agree with government that additional steps including legislation should be taken after a defined interval if the industry does not take on its share of responsibility under voluntary arrangements.

2. Establishing a coherent strategy for the identification and management of harmful and hazardous drinkers presenting to hospital services

In view of the magnitude of the burden placed by alcohol on hospital services (estimated at 2–12% of total NHS expenditure on hospitals) it is vital that these services have in place appropriate strategies for the early identification and management of harmful and hazardous drinkers. These include both the initial management of alcohol withdrawal in dependent patients, as well as management strategies directed at abnormal drinking behaviour that causes admission or, in the case of coincidental hazardous drinkers, that may lead to alcohol-related admissions in the future. Strategic Health Authorities would seem ideally placed to co-ordinate the development of such a strategy since this will include the activities of acute hospital trusts, as well as mental health trusts.

Targets and time-scales

- Each Strategic Health Authority to have in place a coherent strategy for the detection and management of harmful and hazardous drinkers presenting to hospitals within its remit—strategy in place by the end of 2005.
— The appointment of a national lead ("Tsar") to help change the culture in secondary care regarding the attitude of health care workers to patients with alcohol related problems—achieved by end of 2005.

— Each Strategic Health Authority to appoint a steering group consisting of a senior member of medical staff and nursing staff, a senior psychiatric colleague with an interest in the management of alcohol problems, along with senior managerial personnel to devise and implement the alcohol strategy—achieved by end of 2005.

— Each Acute Trust to have in place at least one dedicated alcohol health worker responsible for:
  (a) the implementation of screening strategies;
  (b) detoxification of dependent drinkers;
  (c) administering brief interventions in hazardous drinkers;
  (d) referral of patients for ongoing support where necessary;
  (e) provision of links with liaison/specialist alcohol psychiatry; and
  (f) education for other health care workers in the Trust.

These targets should be achieved by end 2006.

3. Reduction of Alcohol Related Illnesses

There is a clear relationship between per capita alcohol consumption and the prevalence of illnesses/diseases where alcohol is a direct cause. These diseases include those where alcohol is a necessary and sufficient cause of a presenting condition, such as acute alcohol intoxication and alcoholic liver disease, and also cases where alcohol is a sufficient but not necessary cause, for example pancreatitis and epileptic seizures. Based on the experience in other countries (e.g. Spain and Canada) we believe that any "sensible" national alcohol strategy should have at its core, an aim to reduce per capita consumption, and that an achievable target for this aim should be a reduction in diseases where alcohol is a direct cause. In diseases where alcohol is a sufficient but not necessary cause, the target should be to reduce the "attributable" proportion of that disease related to alcohol. Specific targets should include:

— Reduction in admissions due to acute intoxication.
— Reduction in the death rate from alcoholic liver disease (see increase documented in Chief Medical Officer of England's report, 2000).
— Reduction in admissions to accident and emergency departments directly or indirectly related to alcohol excess.
— Reduction in suicide rate.
— Reduction in road casualties due to drink driving. These fell steadily from 1990 (20,400) to 14,980 in 1993 but they have shown a steady increase since then reaching 20,140 in 2002.

These targets should be achievable by 2010.

4. Enhancement of Primary Care Services

The new General Medical Services contract could allow for Locally Enhanced Services to support the management of moderate alcohol problems in general practice. The status of a National Enhanced Service would do much to promote a more robust approach in primary care.

SEXUAL HEALTH

LONG-TERM OBJECTIVES

To provide a safe environment in which the population can enjoy the sexual behaviour of their choice, resulting in low levels of sexually transmitted diseases and unwanted pregnancies comparable to or better than any in western Europe.

MEDIUM-TERM OBJECTIVES

— To ensure all children have high quality effective sex and relationship education.
— Provide adequate education on sexual health to all relevant health care and educational personnel at undergraduate and postgraduate levels.
— Raise the age of at which coitarche occurs.
— Increase the number of persons using condoms at first intercourse (coitarche), on partner change, oral sex by gay men.
— Reduce the number of partner changes.
— Ensure appropriate access to high quality integrated sexual health services.
— Implement screening programmes for C trachomatis for all at risk groups for women and men.
— Implement vaccine programmes for hepatitis B and human papillomavirus.
— Protect vulnerable persons from sexual abuse.
— Promote an environment in which sexual health issues can be openly discussed without fear, embarrassment or prejudice.

**What is the context of these objectives?**

1. **The size of the problem:**
   — Falling age at coitarche.
   — Unacceptably high numbers of persons have unprotected sexual intercourse at coitarche and with non regular partners.
   — Increasing number of partners.
   — Increasing number of persons having same sex contact.
   — Among highest levels of teenage pregnancies in Europe.
   — High rate of termination of pregnancy.
   — Increasing number of serious sexually transmitted infections (STIs) eg chlamydia trachomatis, syphilis and HIV. Between 1992 and 2002 in England, Wales and Northern Ireland reports of chlamydia rose by 139%, gonorrhoea 106% and syphilis 870%. The largest increase was in the under 25 year old age group (Health Protection Agency).
   — Mild to severe erectile dysfunction (ED) affects 52% of men between the ages of 40 and 70 with 10% being severely affected.

2. **Factors affecting sexual behaviour**
   There are many influences on sexual behaviour and it is only possible to focus on the major ones which may be amenable to modification. Change can be difficult once a pattern of sexual behaviour has been established.
   — The family is the ideal place for young persons to receive sex and relationship education (SRE) but is often not able to deliver the necessary knowledge and skills.
   — Education has an important bearing on sexual behaviour and risk avoidance.
   — Peer group pressure can result in both positive and negative influences.
   — Prejudice can lead to fear, embarrassment and covert sexual behaviour.
   — Religions commonly set only one standard of behaviour.
   — Cultural influence can lead to differing patterns of sexual behaviour.
   — Media/advertising has become highly sexualised.
   — Role models can influence sexual attitudes.
   — Alcohol/drugs lead to disinhibition and risk taking.
   — Sexuality can influence behaviour patterns and vulnerability.

3. **Services available to deal with sexual health**
   **Specialist**
   — Family planning services are chronically short of doctors and nurses and not funded to carry out infection screens.
   — Genito Urinary Medicine (GUM) clinics are overwhelmed with ever increasing numbers of new patients and demands for sexual health checks.
   — Psychosexual services are totally inadequate.
   — Termination of pregnancy services have patchy availability throughout the country.
   **Non Specialist**
   — Primary care medical and nursing services have had inconsistent involvement with sexual health issues often not regarding them as priorities.
Schools and further education colleges

— Whilst good SRE programmes exist they may start too late or be inhibited by Boards of Governors, parental or religious pressures.

— Youth services have increasingly become involved with sexual health and should be utilised especially for peer group education.

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“Start sex education early, stop being so prudish.”

4. Implications for health policy

Policy measures which could influence harm reduction are:

— Raise age at coitarche.
— Reduction of partner change rate.
— Use of barrier protection.
— Effective use of contraceptive services.
— Effective use of contraception.
— Effective use of an access to sexual health services.
— Improve information and education at all levels in society.
— Implementation of effective vaccine programmes.

WHAT POLICIES ARE AVAILABLE?

Government has made a number of initiatives (ie National Strategy for Sexual Health and HIV, Department of Health, 2001) which if fully implemented could make a very significant contribution to sexual health. Policies tailored to maximise damage limitation are:

— Providing access to high quality integrated services.
— The promotion of safer sexual practices.
— Ensuring SRE for all young persons.
— Influencing the media to improve the sexual health message.
— Conducting programmes of public information campaigns.
— Conducting relevant research into sexual behaviour and the effectiveness of SRE.
— Engaging those commercial interests that influence sexual behaviour eg alcohol, entertainment.
— Implementation of appropriate screening programmes.

LIKELY TIME EFFECTS OF IMPROVED POLICY APPROACHES

The time course to show effects of policies is unpredictable but improvement should be monitored with 5 yearly target setting.

1. Policies that reduce risk taking behaviour

— Increase of knowledge and relationship skills.
— Substantial increase in use of effective barrier protection and contraception.
— Increasing age at onset of sexual activity.
— Substantial reduction in partner exchange rates.
— Control of alcohol and drug misuse.

2. Policies that promote society/personal responsibility

— Involvement of schools, religions, special interest groups in realistic goals of SRE.
— Involvement of the media in shared sexual health goals.
— Substantial changes in role models sexual behaviour.
— Involvement of the alcohol industry in social marketing.
3. **Policies that reduce harm caused by sexual ill health**

- Increasing age at onset of sexual activity.
- Reduction in poverty and loss of opportunity attendant to teenage/unwanted pregnancy.
- Substantial reduction in major complications such as sub fertility, ectopic pregnancy, genital tract cancers over 10–20 years.
- Substantial reduction in serious morbidity and mortality secondary to HIV disease 10–20 years.
- Substantial reduction in need for expensive antiretroviral therapies (ART) 10–20 years.
- Substantial reduction of psychosexual problems secondary to relationship breakdowns.

**WHAT SHOULD UK POLICIES be on SEXUAL HEALTH?**

1. **Reduce the drivers to unsafe sexual behaviour**

- Promote personal responsibility for own and partners sexual health through SRE.
- Reduce prejudice, fear and embarrassment associated with sexual health issues especially STIs/ HIV through education, media, information campaigns.
- Agree standards for media’s portrayal of sexual behaviour and health including incorporation of topical sexual health issues into soaps, dramas, etc.
- Normalise sexual behaviour as a serious public health issue.
- Strict enforcement of alcohol misuse policies especially underage drinking.
- Monitor use of other drugs and their relationship to unsafe sexual behaviour.
- Engage with influential sections of society—special interest groups etc to set common realistic goals for achievable targets.

2. **Maximise the uptake of sexual health seeking behaviour**

- Promote peer group education, which has been shown to be the most effective way of influencing young persons’ sexual behaviour.
- A programme of sexual health education campaigns on issues such as the impact of unplanned/ teenage parenthood in terms of poverty, reduction in opportunity etc.
- Use advertising and education to inform people about the risks of sexual ill health in their lives and empower them to seek appropriate help and advice.
- Educate the public on the dangers of asymptomatic STIs especially C trachomatis and HIV. Promoting the uptake of specific screening programmes such as that currently being rolled out for C trachomatis.
- Target groups with particular sexual health problems/needs for information/harm reduction campaigns: gay men; Afro-Caribbeans, immigrants and their partners.
- Set targets for appropriate age for first sexual intercourse as well as condom usage at sexual intercourse and at partner change.
- Set targets for partner change reduction. This is a more powerful driver for reduction of certain STIs than the use of condoms.
- Provide high quality, easily accessible sexual health services.
- Promote innovative sites for delivery of sexual health services eg youth services.
- Provide resources to improve access to services. The GUM specialty has a target of 48 hour access for investigation and treatment, but waiting lists of several weeks are common. Delayed diagnosis is a factor in onward transmission of infection.
- Ensure confidentiality of services.
- Provide “tailored” services for groups with special needs eg young persons, immigrants, gay men, lesbian women and commercial sex workers.

3. **Encourage the use of preventive measures**

- Condoms reduce the risk of transmission of many STIs and unwanted pregnancies. They are given out free in GUM and family planning services but not by GPs or other health care providers.
- Industries providing alcohol have a recognised social responsibility on issues such as drunk driving. There are direct parallels as to impaired judgement leading to unsafe sex. These industries should include sexual health issues in their advertising; provide health information via posters etc and free condoms.
— The consequences of unwanted pregnancy both in social and health terms considerably outweigh the risk of chemical contraceptive usage. Persons identified as not using contraception adequate to their needs should have immediate access to integrated sexual health services.

— Use of condoms for oral sex is negligible in both heterosexual and gay communities. Epidemiological statistics show that unprotected oral sex is of particular concern as a driver of outbreaks of syphilis in the gay community. Vigorous campaigns need to be initiated to promote the use of condoms for oral sex with casual partners.

— Screening programmes for preventable STIs would lead to important reductions in prevalence of infection. In addition to the programme being initiated for CT in females, a programme needs to be devised for males.

— Hepatitis B is a serious sexually transmissible infection preventable by vaccination. Most at risk are gay men and partners of immigrants. In the USA all children are vaccinated against this disease. A similar campaign should be instigated in the UK.

4. Minimise the impact of sexual ill health

— Implement the House of Commons Select Committee report on sexual health (Report on Sexual Health, 2003) in particular, investment in high quality sexual health services.

— Prompt access to diagnosis and treatment of STIs/HIV is essential.

— Implement a vaccine policy against hepatitis B.

— Government needs to begin planning immediately for the possibility of safe and effective vaccination against human papillomaviruses. This will almost certainly be available within five years and will potentially make a major impact on incidence of cervical cancer and other genital tract cancers.

— Asymptomatic Chlamydia infection results in serious morbidity and onward transmission. Prompt implementation of screening programmes should be instituted.

— Ensure money going to services reaches its intended goal. Anecdotal evidence exists that recent allocations, of money for hard-pressed GUM services has not been passed on to the intended recipients.

— A recent publication by MedFASH on the establishment of managed patient networks for persons with HIV/AIDS and the forthcoming recommendations for STIs would be of great value in the management of these problems. But their implementation will require considerable investment on the part of Government.

— Ensure early access to TOP services throughout the country.

— Promote use of medical induction of TOPs.

— Postcoital contraception (PCC) services should be freely available seven days a week through pharmacies, primary care and specialist sexual health services. Ideally, persons seeking PCC, should at least be given information on locally available contraceptive services and be referred through electronic booking systems.

— There should be minimum standards of investigation and treatment available to all sexual health services. For example:

  — Home therapies with podophyllotoxin/Imiquimod are under utilised. These save on clinic visits and provide private personal treatment for patients.

  — Erectile dysfunction is a major cause of mental ill health and relationship difficulties. Services across the country are erratic and medical treatments are not widely available on NHS prescription. These issues need to be addressed perhaps through a NICE assessment.

  — Access to relationship/sexual health counseling—which can prevent mental health problems and relationship breakdown—is currently inadequate. While sexual health advice is currently available through GUM clinics, access needs to widened through primary care, contraceptive services.

5. Establish effective networks of services

Government should consider taking sexual health services out of current funding arrangements through Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) where they are given low priority. The establishment of a sexual health authority to oversee the organisation and energising of services should be considered.

— The National Sexual Health and HIV Strategy outlines a vision of well-trained levels of services in primary and secondary care. This needs to be implemented.

— Integration of sexual health services would greatly enhance their efficacy and effectiveness. Models of care do exist and should be emulated.
— Budget holders (SHAs/PCTs) must ensure appropriate leads and finance are available. Currently, no PCTs have sexual health leads and the issue is low down on their list of priorities. There is evidence that money provided to GUM has not been passed on.
— Common protocols should be established for the management and investigation of STIs.
— Access to information and education through the internet, email, text and telephone communication would greatly enhance knowledge and access.
— Confidentiality remains a major issue for those accessing sexual health services. These concerns need to be addressed, particularly with the introduction of a computerised common health record.

6. Promote education on sexual health for professionals and community
— Education of health care professionals is currently inadequate to deliver a uniformly high standard of services.
— Undergraduate/postgraduate curriculums for all relevant professions need to have components on sexual health education.
— GPs with special interest (GPwSI) must have adequate training, supervision and governance.
— Instigate training of teachers as a core part of undergraduate curriculums with a postgraduate diploma.
— Every school should have at least one teacher to lead SRE.
— SRE should be made available for adults through further education authorities, night classes etc to prepare for relationships and parenting.
— Education for persons of influence ie religious leaders should be implemented.
— Establish multi religious/cultural forums to set common goals.
— Health promotion authority to promote sexual health advertising/media campaigns.

7. Promotion of research
Many disparate strands of variable quality research are currently undertaken. A sexual health authority could promote and quality ensure research in such fields as:
— Effective SRE.
— Vaccination against infections ie HIV, herpes simplex virus and C trachomatis.
— The effectiveness of health advice.
— Trends in sexual behaviour. The NATSALS survey—occurring at 10-year intervals—has provided invaluable information.
— The effectiveness of preventive measures.
— Investment in IT could enable information gathered every day at GUM clinics to become a national data resource indicating trends in sexual behaviour.
— Cohorts of young persons could be recruited for ongoing monitoring of trends in society allowing updating of goals and targets.
— Vaginal microbicides would enable women to have greater control over prevention of infection. This may be particularly important in ethnic groups.
— Drivers for and effects of sexual ill health in minority groups eg immigrants, ethnic minorities and gay men.

HEALTH INEQUALITIES
We welcome the fact that the Government now has in place a cross-government plan for reducing the socio-economic divide and tackling health inequalities: “Tackling health inequalities: a programme of action” (Department of Health, 2003); clear national targets for reducing inequality in health outcomes; as well as a number of linked initiatives and strategies such as the Teenage Pregnancy Strategy; smoking cessation, reform of the Welfare Food Scheme; and the establishment of Sure Start.

Our concern is that the actions the Government is taking on reducing health inequalities be explicitly linked to public health policy. In this context we strongly endorse the analysis of the social determinants of health as described in “The Solid Facts,” published by the WHO (1998), namely that:
— Health follows a social gradient.
— Stressful circumstances are damaging to health and may lead to premature death.
— A good start in life means supporting mothers and young children: The health impact of early development and education lasts a lifetime.
— Social exclusion: Life is short where its quality is poor. By causing hardship and resentment, poverty, social exclusion and discrimination cost lives.
— Work: Stress in the workplace increases the risk of disease. People who have more control over their work have better health.
— Unemployment: Job security increases health, well-being and job satisfaction. High rates of unemployment cause more illness and premature death.
— Social support: Friendship, good social relations and strong supportive networks improve health at home, at work and in the community.
— Addiction: Individuals turn to alcohol, drugs and tobacco and suffer from their use, but use is influenced by the wider social setting.
— Food: Because global market forces control the food supply, healthy food is a political issue.
— Transport: Healthy transport means less driving and more walking and cycling, backed up by better public transport.

While it is clear that Government has recognised the impact on health generally of these wider social determinants, there is little evidence that they have been actively considered by Ministers in respect of public health.

Obesity and Health Inequalities: An Example

Taking the link between obesity and socio-economic status as an example, people living in households without an earner consume more calories than those living in households with one or more earners. Poorer households eat less fruit and vegetables, salad, wholemeal bread, wholegrain and high-fibre cereals and oily fish, and more white bread, full-fat milk, table sugar and processed meat products. Furthermore, poorer households in poorer communities are less likely to have access to healthy, affordable food and suitable recreational facilities. The main barriers to healthy eating and adequate physical activity for those on low income are as follows:
— Low income and debt.
— Inaccessibility of affordable healthy foods.
— Lack of facilities/skills/time to cook.
— Lack of accessible information on nutrition.
— Poor literacy and numeracy skills, affecting understanding of food labeling and nutritional information.
— Lack of access to affordable sports facilities.
— Poor urban environments.
— Lack of community safety.
— Sedentary lifestyles.
— Limited encouragement of exercise at school.
— Limited play facilities.
— Lack of safe places to play or exercise.

Addressing these barriers requires action on three broad fronts—environment, empowerment and encouragement—aimed at engendering a collective behaviour change. As regards obesity this plan of action would look as follows:

1. Environment

Creating an environment (physical, social and economic) which predisposes to healthy eating and active living. The purpose is to make the healthier choices the easier choices by removing barriers such as high cost or difficult access. This includes tackling inequities caused by exclusion, disadvantage or poverty. Examples:
— Free fruit in schools.
— Healthy school policies, eg healthy catering, fruit tuckshops, plentiful drinking water, breakfast clubs, after-school activities (including dance), and an absence of vending machines dispensing sugary drinks and fatty, sugary or salty snacks.
— Conveniently placed food outlets offering healthier choices at affordable prices, including food “co-ops” in which community groups purchase foods direct from growers or wholesale suppliers and sell at cost to people on low incomes.
— Agricultural policies and food subsidies that help to provide healthier choices at affordable prices.
— Safe walking and cycling routes to school and work.
— Town planning that discourages car use.
— Safe, accessible parks.
— Buildings designed to encourage stair use and discourage lift/escalator use.
— Bike racks and shower facilities in workplaces.
— Cheaper and easier access to leisure and sports facilities.
— Culturally sensitive exercise facilities (eg women-only swimming sessions).
— Media-created ethos that a healthy active lifestyle is “cool”.

2. **Empowerment**

Giving people, particularly children and young people, knowledge and understanding of the benefits of healthy eating, active living and avoiding overweight, and the life skills to adopt healthy behaviours; boosting confidence and self-esteem, individually and collectively. This includes educating key opinion formers such as health professionals, schoolteachers and the media. Examples:

— Personal, social and health education (PSHE) work in schools.
— Teaching the principles of healthy eating and cooking skills.
— Physical education (PE), sports and other supervised physical activities in schools.
— Teaching citizenship and advocacy skills.
— Working with communities (eg minority ethnic groups or housing estate residents) to understand their needs for a healthier diet and more exercise, and to demand better access to fresh fruit and vegetables, a leisure centre etc.
— Health visitors working with new mothers and young families to support and encourage breastfeeding, healthy eating and healthy active play.
— Nutrition and physical activity and behaviour change modules built into the core basic training of health professionals.
— Clear messages about healthy eating and physical activity for all age groups.

3. **Encouragement**

Motivating and prompting people to make the necessary changes to their lifestyles here and now; and triggering action. Examples include:

— Active play for pre-school children.
— Sports and games in schools.
— Media campaigns (eg the Department of Health’s “Five-a-Day” campaign to promote the consumption of fruit and vegetables; the Health Education Authority’s “Active for Life” campaign to promote a more active everyday lifestyle)
— Trigger messages (eg low fat/sugar logos on packaged foods; low calorie options on menus; walk prompts on lifts and escalators).
— Healthy walks groups.
— Sports clubs.
— Fun-runs, aerobathons, and other mass activities.
— Life insurance health checks.
— Motivational counselling in primary care.
— Incentives/rewards for “active transport” (eg walking, cycling, etc) to school or work.

All three basic elements are essential and interdependent.

**Memorandum by Atkins Nutritionals (WP 25)**

**Atkins Nutritionals**

Atkins Nutritionals are the creators of the Atkins Nutritional Approach (ANA), a carbohydrate controlled lifestyle proven to reduce weight and maintain a healthy weight over an entire lifetime. The ANA focuses on the consumption of nutrient dense, unprocessed foods, vitamin nutrient supplementation and exercise. Atkins very much welcomes this opportunity to contribute to the ongoing dialogue over public health and is pleased to submit this written evidence to the Committee.
SUMMARY

Atkins welcomes much of what is in the Choosing Health White Paper and looks forward to working with those involved in its implementation. With particular reference to obesity it is vital that prevention is emphasised in equal measure to cure and this means finding solutions that are broad ranging in scope and varied in their target audiences. The work being conducted by the National Institute for Clinical Excellence on Obesity is targeted at the clinical setting, yet the role of prevention is just as important and warrants just as much investment. Working in conjunction with industry and harnessing its resources the Government must look at dissipating information to people from all backgrounds that is right for them and in its implementation of the White Paper the Government must build in measurable means of being judged and scrutinised.

The following looks at four specific issues and offers recommendations for the Committee to consider.

1. Food labelling

Atkins recognises that food labelling needs to be both accurate and clear to ensure that the consumer is quickly able to ascertain the nutritional quality of the products which they are purchasing. The consultation by the Food Standards Agency on this issue is to be welcomed and Atkins looks forward to being part of that process. What is vital however is ensuring that consumers are not misled and Atkins are concerned that by focusing solely on fat, salt and sugar the benefits of a controlled carbohydrate diet will be overlooked.

Recommendation

A simple traffic light system may oversimplify the food labelling process. Instead food labelling should take the form of making clear whether a product is high, medium or low in fat, salt, sugar and carbohydrate which will ensure that those following low fat and low carbohydrate programmes are able to make a clear judgement.

2. Dietary advice

Clearly for those who are not overweight or obese strategies such as the “5 A Day” campaign are sensible and laudable policies and should be seen as a key part of the solution. However for those who are already overweight or obese this will not in itself equip people with the tools to reduce and then manage their weight. One such weight management tool is the ANA, however there are other programmes which can bring weight down, and Atkins would like to see the Government do more to offer a range of advice suitable for different types of individuals. The seeds for this are evident in Choosing Health however the enactment of this process must be made to work.

Recommendation

The Weight Loss Guide, referred to on page 142, must move beyond advice that takes the form of preventing people becoming overweight or obese and instead take on a dual role that addresses prevention and also tackles weight reduction. Arming people with the tools to reduce their weight and manage it over the long term is vital if the Government is to meet its ambitious obesity targets.

3. The role of weight loss programmes

As discussed above proven dietary regimes must be seen as part of the solution to the obesity epidemic. The Health Select Committee noted in its own report on the subject in 2004 that commercial weight loss organisations have a role to play in tackling this crisis. However regulation currently going through the European legislative process in the form of the Nutrition and Health Claims Made on Foods proposal would outlaw any form of weight loss claims and make redundant any programmes and products aimed at reducing an individual’s weight. Atkins is concerned that this will disarm many of accurate advice about weight loss and instead expose consumers to misinformation and dangerous products from outside the Community that will be seen as the answer.

Recommendation

The UK government through the Food Standards Agency must work hard during Council negotiations to ensure that this disproportionate and potentially harmful ban on all weight loss claims is deleted from this legislation.
4. Research and development

Both the EU and HM Government (see page 140 of Choosing Health) have identified a lack of research to support their work in the field of obesity and this is of particular concern given the fact that a great deal of public policy work is currently being conducted in this important area. Industry has a vital role to play in filling in the gaps in knowledge suffered by those devising policies on obesity and the resources of the private sector need to be deployed in this light. As an example there currently exist 44 separate peer reviewed studies\(^63\) supporting controlled carbohydrate dietary approaches and include works on their safety, their effectiveness as a weight loss tool, as well as their beneficial effect on those suffering from diabetes.

Recommendation

The Government should put in place a mechanism for information sharing with industry where, when appropriate, research can aid policy making and ensure new and innovative products, programmes and approaches are adopted. The ANA is but one example of where this could deliver real and rapid benefits.

January 2005

Memorandum by The National Federation of Women’s Institutes (WP 26)

The National Federation of Women’s Institutes (NFWI) is the UK’s largest national voluntary organisation for women. It has some 215,000 members, in 7,000 Women’s Institutes across England, Wales and the Islands. It is an educational, social and non-party political and non-sectarian organisation that particularly represents the views of women in rural communities.

The NFWI has a long-standing history of commitment to improving the nation’s diet and health, particularly regarding food and sustainability issues. Each year the NFWI passes a number of resolutions, which form the focus of its campaigning work. At the NFWI’s AGM in 2003, WI members passed a mandate by an overwhelming majority, which states:

“This meeting views with concern the increase in obesity and diet-related health problems in children, and the associated risk of chronic disease in later life, and urges HM Government to regulate the promotion to children of foods that contribute to an unhealthy diet and to ensure increased opportunities for exercise and practical food education in schools.”

The NFWI welcomes the opportunity to submit comments to the Health Select Committee about the effectiveness of the proposals contained in the Government’s Public Health White Paper Choosing Health: making healthy choices easier (November 2004). The NFWI made a detailed response to the Public Health White Paper consultation; the response represented the views of the 202 responses received by the NFWI Public Affairs Department, which in turn represented the views of 706 NFWI members. The summary of our submission is included in Annex 1.

WI members strongly support a ban on the promotion of food to children that can contribute to an unhealthy diet. The White Paper acknowledges the problem of food promotion to children. However, it has proposed only to strengthen voluntary codes of practice rather than introduce robust legislation. The NFWI believes that this response is both weak and insufficient. WI members feel strongly that voluntary codes will not suffice in curbing industry’s advertising power over children’s diets and it would like to see the Government put firm legislation in place. The NFWI believes that regulation would be a cost effective way of protecting the nation’s public health.

The White Paper states that it will monitor the success of such voluntary measures and will assess their success in 2007 (p 36, para 58). The NFWI believes that this action is too little, too late! It believes that the continued resistance from most within the food industry to acknowledge its role in the problem suggests that industry will, again, object to and then ignore the Government’s proposed voluntary controls. The NFWI believes that an alternative approach would be that suggested by the Children’s Food Bill, which was presented to Parliament by Debra Shipley MP in May 2004 and is coordinated by Sustain. The purpose of the Bill is to improve children’s current and future health and prevent the many diseases that are linked to unhealthy diets by protecting them from commercial activities that promote unhealthy food and drink products.

In schools, the White Paper states that the Government would like to see schools provide food education and skills, promote healthy food and restrict other option. However, there is neither indication of how this will be achieved, nor of what will happen if schools do not follow this advice (p 57, para 54). It states that the Government “will strongly consider introducing nutrient-based standards” for school meals (p 58, para 57), but again there is no commitment given to do so. The NFWI would like to see concrete implementation proposals to support these statements.

\(^{63}\) Available upon request.
The Food Standards Agency’s Review of research on the effects of food promotion to children (2003) clearly establishes that food promotion has a direct effect on children’s food preferences, purchase behaviour and consumption. It is, therefore, of great concern that the Government’s Public Health White Paper relies on voluntary measures and suggested policy action for the future rather than firm commitments for policy change in the area of obesity and children’s health. The NFWI feels that the Government’s proposal will be ineffective in reducing the ever-increasing burden of obesity and that it must make firm commitments to specific action in the area of marketing unhealthy food to children and food in school environments.

January 2005

Annex

SUMMARY OF WI MEMBERS’ RESPONSES AND KEY RECOMMENDATIONS

WI members believe that children should be at the heart of any public health strategy. As the future generation they are most likely to benefit from any intervention. If the Government is sensitive to accusations of “nanny statism” then interventions aimed at children are less likely to attract this criticism. That does not mean that public health interventions should focus exclusively on children there are many initiatives throughout the life course which can have a substantive improvement in health.

WI members have again confirmed their support for a ban on the promotion of food to children that can contribute to an unhealthy diet. 87% of WI members renewed their call for regulation on food promotion to children as one of the key policy measures needed to tackle the obesity crisis in the UK. Other key policy recommendations for government from WI members were; for significantly increased opportunities for physical activity (both within and outside schools), and a strong call for the re-introduction of practical food education in schools as an integral part of “whole food policies" on food in schools to include a complete overhaul of nutritional standards in school meals.

WI members also identified the need for a clear, well-constructed health improvement campaigns to promote better diet, exercise, and healthier lifestyle choices as having the potential to impact significantly on Public Health. A range of complementary initiatives should support this; most importantly; improved food labeling; an end to the marketing of unhealthy food in schools; controls introduced on the marketing and branding of unhealthy food to children.

WI members identified parents as making the greatest difference to the choices that children make regarding diet, closely followed by the media. However it was noted that pressure from the media, and the absence of clear, unbiased labeling often made it more difficult for parents to make healthy choices on behalf of their children. WI members concern regarding media influence is clearly demonstrated with 36% of respondents citing TV and Magazines, and 29% citing advertising as having a major impact on children’s choices. WI members noted that if David Beckham and Michael Owen could be employed to promote healthy lifestyles rather than the soft drinks and crisps they currently choose to endorse, it might make parents choices easier.

WI members also called for practical action that would make it easier for people to make healthier choices such as providing subsidies on fresh fruit and vegetables, particularly those that are locally sourced. A number of members also noted that fruit and vegetables in supermarkets often attracted the highest mark up, whilst high fat, low nutrient foods, particularly at the value end of the market are sold as loss leaders to convince consumers of the competitiveness of the store. This often means that for low income consumers the most affordable options are the least healthy. If the Government helped to set up food cooperatives it would improve access to fresh fruit and vegetables for all consumers, and help the Government meet it’s a “five a day” targets for consumption of fruit and vegetables.

Key recommendations:

Introduce a school food standard: 88% of WI members endorse the Consumers Association call for a school food standard. WI members believe that a well-balanced school meal is vital to children’s health, but recognise that this would need investment to repair harm done by diminution of school meals.

Put practical cooking back on the curriculum: 91% of WI members urged the Department of Education and Skills to introduce a food curriculum where all children receive practical cookery lessons and learn about nutrition and food.

Increase physical activity in schools: 94% of WI members also noted that the current levels of physical activity are too low. There needs to be at least three hours of physical activity in the curriculum per week and the definition needs to be widened to include activities which are attractive to children and young people who are not interested in traditional sports

Regulate the advertising of food to children: 87% of WI members demanded the introduction of a children’s watershed for food advertising. Members believe that voluntary codes relating to food advertising have been proven not to work, as the food industry has patently failed to act in a responsible manner up until now.
Ensure that manufacturers act responsibly: 86% of respondents think that manufacturers should be forced to reduce levels of fat, sugar and salt in foods aimed directly at children to levels considered appropriate by the Food Standards Agency (FSA). The Government should also examine financial incentives to manufacturers to lower the levels of fat, sugar and salt in their products, and disincentives to products that are high in these. VAT should also be amended to address anomaly where VAT is charged on fruit juice but not on biscuits.

Introduce mandatory food labelling to show levels of sugar, salt and fat either high, medium or low respectively and guideline daily amounts

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Memorandum by Which? (WP 27)

INTRODUCTION

1. Which?, formerly known as Consumers’ Association, is an independent, research-based organisation that campaigns on behalf of all consumers. Funded through the sale of our range of magazines and other publications, we are the largest consumer organisation in Europe and have around 700,000 members.

2. Food and health issues have always been central to our work because they are central to consumers’ lives. As you will be aware from previous evidence that we have submitted, much of our work has focused around tackling diet-related disease and obesity from a food perspective and so our evidence should be seen in this light. This is the area where we have most experience and have therefore largely focused our comments.

WHETHER THE PROPOSALS WILL ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS

Overall approach

3. Which? strongly supports the approach that is set out in the Choosing Health White Paper and the acknowledgement that the National Health Service (NHS) needs to improve health and prevent disease, not just treat those who are ill. It also recognises that if public health is to improve a multi-sector approach is demanded across central and local government, but also involving communities, industry, the media and other non-governmental organisations.

4. Central to the White Paper is recognition that government has a role in creating an environment that facilitates healthy choices and that there is a need to focus specifically on tackling inequalities in health. We believe that the right balance has been struck between individual responsibility, the role of government and the need for other relevant stakeholders and sectors to respond. The challenge is to create an environment in which healthy choices become the easy option, or as the White Paper describes it: “to empower people, support people when they want support and to foster environments in which healthy choices are easier.”

5. With this in mind, we support the three broad principles that form the basis of the actions proposed: supporting informed choice, with a special responsibility for children who are too young to make informed choices themselves; personalisation of support to make healthy choices, with equal access to such services; and working in partnership to make health everyone’s business. We also consider that the broad themes identified in the White Paper ie health in a consumer society, specific issues for children and young people, local community action, workplace health, health in the NHS and making health “a way of life” are the key areas to focus attention.

Ensuring effective delivery

6. We have, however, heard rhetoric about public health on many previous occasions—the challenge is to make the intentions set down in the White Paper real. While it does provide a firm basis for action, we are concerned about how it will succeed in motivating and co-ordinating the necessary actors across the board in order to sustain change and really make the sentiments set down in the White Paper happen. We are also concerned that there is too much reliance on voluntary co-operation by industry and are sceptical about the ability and willingness of some sectors to deliver the changes that are necessary. Much therefore will depend on the Delivery Plan and specific action plans on food and health and physical activity that are promised for early 2005.

7. The White Paper does set out some specific mechanisms for delivery including for example, the establishment of Local Area Agreements between government, councils and local partners on local delivery of national targets to reflect local priorities and which will initially be piloted in 21 areas from April 2005. Primary Care Trusts (PCTs) are also to be required to develop targets to meet the needs of people living in their area with local partners in order to meet national targets and priorities. It is also positive that health is to be included as a specific component of regulatory impact assessment—something that is long overdue and an essential step towards ensuring a consistent approach to public health across all government policies.

The establishment of a specific target to halt the rise in obesity among children is also a useful way of monitoring progress. Given the importance of European Union (EU) action to help tackle many of the areas identified in the White Paper, we are pleased that the Government has also made “empowering people; reducing inequalities” a theme for the UK Presidency of the EU.

8. However, we believe that in addition there is a need for mechanisms to engage, co-ordinate and motivate the stakeholders across all sectors who are needed to deliver the aims set out in the White Paper. This needs to happen at national level as well as local level. Specifically, we believe that there needs to be a strategic body to over-see the delivery of the Food and Health Action Plan. As we proposed in our policy position paper “Health Warning to Government” we consider that a Nutrition Council is necessary to take a strategic over-view, to co-ordinate, and to ensure that the main stakeholders make clear commitments and deliver on them. We acknowledge that the Health Committee also suggested that the Government should consider expanding the role of an existing body or bodies or creating a new Council of Nutrition and Physical Activity to improve co-ordination and inject independent thinking into strategy in its report on Obesity.

9. The Committee’s report also recommended that a specific Cabinet public health committee be appointed, chaired by the Secretary of State for Health to ensure that the problem of obesity is recognised and tackled at the highest levels across government. While there is now a Ministerial Committee on Public Health (MISC 27) with a remit to “oversee the development and implementation of the Government’s policies on public health and reduce inequalities”, we are concerned that important agencies of government that have a key role in delivery, most notably the Food Standards Agency, are not represented on this Committee. While this is clearly a Ministerial Committee, we note that the Chief Medical Officer is invited to attend.

10. It is essential that all parts of government—both central and local—also become fully engaged and accept their responsibilities as part of the delivery process and that an impetus for action is maintained across all sectors. The White Paper is ambitious and a great deal of commitment will be necessary, backed up by government incentives including regulation where appropriate, to achieve the culture change that is needed if we are to see an improvement in public health. These issues must be addressed within the Delivery Plan and specific Food and Health and Physical Activity Action Plans.

**Marketing health**

11. The White Paper highlights the importance of marketing health, ie. promoting it on the principles that commercial markets use and therefore making it something that people aspire to, and the need for information to support healthy choices. We believe that these are important aspects, but are concerned that the proposals do not go far enough in some important areas.

12. We are pleased that the Department of Health (DH) intends to develop a strategy over-seen by an independent body that extends across all aspects of health and involves a broad range of different government departments and agencies, while also recognising the need for specific and targeted approaches. This needs to draw on the expertise of the marketing and advertising industries, while avoiding any potential conflict of interest, and use creative social marketing techniques. However, to be effective, such a strategy also needs to be closely linked to a broad range of government, community, industry and other stakeholder activities to ensure that consistent messages are promoted and that it is easy and practical for people to put them into effect.

13. As well as promoting positive health messages, it is therefore also important that misleading or potentially confusing messages which could undermine efforts to improve healthy choices are effectively tackled. This includes the way that messages are promoted through advertising and other marketing and promotional activities and information such as claims made on food labels. We welcome the sentiment set down in the White Paper that the Government now recognises that there is a strong case for action to restrict the advertising and promotion of foods high in fat, sugar and salt to children—and for this action to be comprehensive and taken in relation to all form of food advertising and promotion. Our research has shown that this is an issue of great concern to most parents and that they are supportive of greater restrictions. For example, a Which? survey in 2003 found that 70% of parents believe that there should be no advertising of junk foods during children’s viewing times. However, we are concerned that the White Paper is short on specifics about what the Government intends to do to address this—passing the issue back to Ofcom for further consultation.

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66 Response to Parliamentary Question from Baroness Howe of Idicote (HL567), 13 January 2005.
67 Face to face interviews were conducted with parents with a child between the ages of three and 12 between 11 to 17 April 2003. The data was weighted to be representative of Great Britain’s population, giving an overall weighted base of 446.
14. While it is encouraging that the Government intends to work with industry, advertisers, consumer groups and other stakeholders to encourage new measures to strengthen existing voluntary codes in non-broadcast areas, we are concerned that this is too weak. The Government states that it will monitor the success of measures in relation to the balance of food and drink advertising and promotion to children by early 2007, but we would like to see firm action to tackle the problem sooner, based on the evidence that has been provided by the FSA commissioned Hastings review and the research commissioned by Ofcom. We would like to see an explicit commitment to tackle this area, including a commitment to restrict the advertising of such foods during children’s viewing times. We would also like to see the Government pushing this message in Europe in the context of the review of the Television without Frontiers Directive.

Information to Support Healthy Choices

15. It is very encouraging that the Government has recognised the need for consumers to have simple information that they can trust. We particularly welcome the commitment to introduce a simple sign-posting or coding system for foods by 2006. This is something that we strongly supported in our written and oral evidence to the Health Committee’s Obesity Inquiry and we were therefore pleased that this was included among its recommendations.

16. It is important that industry signs up to such a scheme and that we are not presented with a proliferation of simplified labelling schemes which only serve to create further consumer confusion. It is essential that the Government over-sees and drives this forward. It is disappointing that at the moment some parts of industry do not appear to support such an approach or accept that consumers favour a simple sign-post labelling scheme. Others are developing their own schemes which is encouraging—but unless these schemes are consistent, they will merely lead to more consumer confusion. We are therefore very supportive of the research work with consumers currently being undertaken by the Food Standards Agency to decide which is the most suitable labelling format. We are also pleased that the Government will be pushing for improvements to nutrition labelling as part of the UK Presidency of the EU.

17. It is also essential that the EU develops tighter controls over health and nutrition claims and fortified foods to protect consumers from being misled. Far too many products are misleadingly promoted as healthy, including some supermarket healthy eating range products, when they are still high in fat, sugar or salt, as we highlighted in our recent report “Healthy ranges—the slim truth?” Which? briefings on the EU proposals for legislation in these areas are enclosed.

18. In terms of consumer information, we also welcome the creation of Health Direct with the aim of achieving a joined up approach with existing services, as well as new funding to enable every Primary Care Trust (PCT) to run at least one Skilled for Health programme each year, by 2007, focusing first on the most deprived areas. We also support proposals for more tailored approaches to information and support for healthy choices, including for example children’s health guides as part of the Child Health Promotion programme, but also proposals for NHS health trainers and personal health kits.

Industry Responsibility

19. As we have already emphasised, industry has a key role in tackling the barriers that make it difficult to make healthy choices. We therefore welcome the White Paper’s acknowledgement of the important role that industry must play and of the public’s expectation for industry to act in a socially responsible way. Four key areas are identified for the food industry, which we agree with: product development, labelling information, promotion and pricing and customer information and advice.

20. We agree that the food industry has a responsibility to increase the availability of healthy food and welcome the commitment to establish long-term and interim government targets for reductions in sugar and fat levels in different categories of foods, building on the work already under-way on salt, and to develop guidance on portion sizes. Research that we have carried out comparing the nutritional content of breakfast cereals and of ready meals has highlighted the huge variations in fat, sugar and salt levels depending upon which brand consumers choose and therefore the scope for making reductions. These two reports are enclosed.

21. While we hope that industry can respond constructively and act collectively to tackle the key issues, it is important that the Government carefully monitors progress and ensures that there is an adequate response. If industry does not respond, the Government must use regulation to drive responsible behaviour. As highlighted above, we remain concerned about the proposals regarding the important area of food

69 Childhood obesity—food advertising in context, Children’s food choices, parents’ understanding and influence and the role of food promotion, Ofcom, 22 July 2004.
70 Healthy ranges—the slim truth?, Which?, November 2004.
marketing and promotion. We are sceptical of the industry’s willingness to accept responsibility in this important area. Government action is therefore essential to ensure that failure to tackle any contradictory messages and promotions here, does not undermine the other commitments and proposals set down in the White Paper and the forthcoming Food and Health Action Plan.

Children and Young People

22. We welcome the acknowledgement that children need particular protection. We agree with the intention behind the Child Health Promotion programme to create a broad-based programme of support that will “address the wider determinants of health and reduce health inequalities”. This needs to address the complex interactions that come into play. For example poor nutrition may affect mental health and in-turn mental health can lead to people adopting negative health behaviours such as smoking and alcohol abuse. A co-ordinated and multi-faceted approach is therefore essential in order to tackle the different elements and address the particular problems of different groups. It will be important that local services work in a joined-up way across health, social services and education—and at local and national levels. It is essential that support is provided, and provided appropriately, at all stages of a child’s development.

23. We are, however, concerned that the proposals for schools are not ambitious enough. We do not think that it is sufficient to aim for half of all schools to be healthy schools by 2006, with the rest working towards healthy school status by 2009. We are concerned that this timetable is too long and would like to see proposals for all schools to become healthy schools as standard. We support the commitment to role out a “whole school approach to healthy eating and drinking”. However, we would again like to see this as standard and see a greater emphasis on the teaching of food skills as part of the national curriculum.

24. We are, however, pleased that the Government has more specifically committed to improving nutrition in schools, including revising both primary and secondary school meal standards and extending these standards to cover food across the school day—including vending machines and tuck shops—and supporting school meal service provision. We also welcome a similar approach to catering in other institutions and public bodies, building on this work.

Whether the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure that Proposals will be Implemented and Goals Achieved

25. We do not consider that the necessary infrastructure and mechanisms currently exist to deliver on the proposals set out in the White Paper. However, we do believe that the White Paper is a very useful starting point that now needs to be built upon through concrete steps including clear commitments at all levels and adequate resourcing.

26. Some of the measures that are set out in the White Paper will help to make delivery achievable. Primary Care Trusts (PCTs), for example, have a key role as a promoter and facilitator of good health in local areas, but must engage actively with the local community and community groups on the basis of an equal partnership. It is also important that local targets are focused on the issues that make sense and which are important to local communities, and that they focus on outcomes not just outputs or what is easily measured. Adequate resourcing by government for these initiatives will be crucial. It must be ensured that money given to PCTs for the purposes set out in the White Paper is actually spent on public health measures. It must also be ensured that PCTs have the capacity and the competence to take on this leading role.

27. The White Paper does, however, set out an ambitious vision that requires a new approach at both central and local government level as well as within the NHS. Some measures even require action at European level if they are to be put fully into effect. New challenges are also raised for communities, companies, consumer and public health organisations, the media and for individuals—actors at every level. We believe that we will only begin to see change, and change that can be sustained, if there truly is a multi-stakeholder and multi-sectoral approach to tackling public health. This requires a great deal of motivation, enthusiasm, specific commitments and perhaps most of all, effective and sustained leadership and co-ordination from central government.

Conclusion

28. We consider that the approach set out in the White Paper is the right one, but we have concerns about how the proposals will be delivered in practice. We therefore look forward to seeing how these issues will be tackled within the Delivery Plan and the specific Food and Health and Physical Activity Action Plans which must be a priority. As we have already highlighted we believe that there is a need for strategic, cross-sectoral and cross-governmental structures to be put in place if the aims of the White Paper are to be achieved and the momentum and enthusiasm that is needed to deliver better public health is to be sustained in the longer-term.

January 2005
Memorandum by Weight Watchers UK Ltd (WP 28)

1. **Introduction**

Weight Watchers welcomes the importance attached in the White Paper to the prevention and treatment of obesity, and the emphasis on encouraging healthier lifestyles.

However, the immensity of the public health task outlined in the White Paper is such that we believe many proposals will not yield results unless the Government effectively harnesses the expertise and experience of the private sector to work in partnership to deliver essential outcomes.

Weight Watchers has a strong evidence base underpinning its effectiveness, particularly in long term weight loss, and this is detailed in Annex 1. Weight Watchers is committed to supporting the Department of Health and other agencies in sharing expertise, evidence and resource, as well as access to its community based group support network.

Weight Watchers has over thirty years’ experience of helping people to lose weight, and our approach is based on coaching people to enjoy a healthy balanced range of normal food, get active and make behavioural changes. We run over 6,500 Meetings each week in the UK.

Our new SWITCH programme launched at the beginning of January is the result of detailed theory and research indicating that a behavioural approach and the availability of choice are essential to successful weight management programmes.

2. **Initiatives in the White Paper**

There are a number of initiatives in the White Paper to which Weight Watchers could contribute its expertise and experience, and work in partnership with the NHS towards successful outcomes. These are listed briefly below.

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<thead>
<tr>
<th>Initiative</th>
<th>Weight Watchers Contribution</th>
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<tr>
<td>1. Corporate Social Responsibility Values</td>
<td>Broaden our current programme of WW at Work programmes. WW would encourage a link up with the</td>
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<tr>
<td>— Local/National employers responding to people’s wish for better health.</td>
<td>Faculty of Occupational Health and/or the Occupational Health arm of the Royal Colleges.</td>
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<td>— Government to work with others to develop a network of health champions.</td>
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<td>— Seeking greater leadership in CSR from the private sector.</td>
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<td>2. Core Theme of White Paper is “Informed Choice”</td>
<td>Offer to help the NHS develop marketing skills by sharing expertise eg the Weight Watchers</td>
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<tr>
<td>— Paper proposes that health promotion learns about marketing and specifically marketing health from the private sector to learn how to create and respond to a demand for health.</td>
<td>sponsored seminar on “marketing health” targeted at Directors of Primary Care/Public Health</td>
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<td>3. Nutrition Labelling</td>
<td>Offer “test bed” of WW food products for piloting of traffic light signposting scheme.</td>
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<td>— Government intend to press the EU to simplify and make mandatory nutrition labelling.</td>
<td>Support/sponsor help line and discuss inclusion of WW services as weight loss option which</td>
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<td>— Government is working with FSA to develop criteria for fat, salt and sugar levels and indicate how food is contributing to a healthy diet. The criteria for the 5 a day logo is being used as a starting point.</td>
<td>patients could access.</td>
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<td>— Signposting system to be introduced by mid 2005 and likely to be the “traffic light” coding system.</td>
<td>Opportunity for Weight Watchers leaders (as community leaders with behavioural change skills) to link into and support delivery of this programme.</td>
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<td>4. Government to Develop “Health Direct”</td>
<td>Support or sponsor local training programmes and share WW training competencies in weight</td>
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<tr>
<td>— Consumer information service (website/telephone line) designed to facilitate access to health services.</td>
<td>management support and coaching.</td>
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<td>5. Skills for Health Programme</td>
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<tr>
<td>— To drive forward action to improve health literacy, focussing on deprived areas.</td>
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<td>— enable each PCT to run at least one Skills for Health programme.</td>
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In response, Weight Watchers could, for example:

- Broaden our current programme of WW at Work programmes.
- Offer to help the NHS develop marketing skills by sharing expertise eg the Weight Watchers sponsored seminar on “marketing health” targeted at Directors of Primary Care/Public Health specialists.
- Support/sponsor help line and discuss inclusion of WW services as weight loss option which patients could access.
- Opportunity for Weight Watchers leaders (as community leaders with behavioural change skills) to link into and support delivery of this programme.
- Support or sponsor local training programmes and share WW training competencies in weight management support and coaching.
6. Portion Sizes
   — Government will discuss with industry how to reverse trend towards bigger portion sizes.
   — Governments Specific Efforts to Tackle Obesity.

7. Care pathway
   — To develop a comprehensive “care pathway” for obesity providing a model for prevention and treatment of obesity.

8. Weight Loss Guide
   — Commission the production of a “Weight Loss Guide” to set out what is known about regimes for losing weight and help people select an approach which suits them.

9. National Partnership for Obesity
   — Government will set up this new body with a remit.
   — To promote practical action.
   — To be a source of information on obesity.

10. Test Behaviour Change Programmes
    “The independent sector may have a key role in providing effective behaviour change programmes in ways that are more acceptable than traditional NHS care to some groups of patients. We will want to test this as part of a procurement for a year in care for diabetic patients”.

3. GP Referral
   The National Obesity Forum’s protocol for the treatment of overweight patients recognises referral to a commercial slimming organisation such as Weight Watchers as a first line treatment option.

   Over the past two years, we have been working with four Primary Care Trusts to test how a partnership scheme between the NHS and Weight Watchers could work and whether it is effective. Annex 2 gives details of results to date and how we will be developing a referral scheme over the next year.

   January 2005

Annex 1

THE EVIDENCE BASE UNDERPINNING WEIGHT WATCHERS’ APPROACH

1. Published Studies on Effectiveness
   Weight Watchers has good evidence that people following the programme lose significant amounts of weight and maintain that weight loss over long periods of time (Heshka et al 2003). For example two studies have shown that over 50% of Weight Watchers members who reached their target weight five years previously, had retained a weight loss of at least 5% of their starting weight (Lowe et al, 2001, 2004). This compares very favourably with most other weight loss interventions in which virtually all weight successfully lost is regained at five years.

   The results of a recent systematic review concluded that Weight Watchers is the only commercial weight loss programme in the USA with good quality data supporting its effectiveness (Tsai and Wadden, 2005). In other words Weight Watchers is the only programme in the US with an underpinning evidence base. We believe the same to be true in the UK.

2. The Evidence Underpinning SWITCH
   In addition the SWITCH programme is based on a mass of theory and research including:
   — Weight Watchers own market research on the habits of their members who have successfully lost weight and kept it off.
   — Clear and consistent evidence indicating that a behavioural approach is a necessary ingredient in successful weight loss and weight maintenance interventions (Health Development Agency 2003).
3. References


Annex 2

WEIGHT WATCHERS’ NHS PILOTS

1. Weight Watchers has been working with four PCTs over the last two years to test how a partnership scheme between the NHS and Weight Watchers could work and whether it is effective.

These pilot partnership projects are with:

— the dietitians at Halton General Hospital (The Widnes Story below) Cheshire;
— Burntwood Lichfield and Tamworth PCT, (Midlands);
— Islington PCT (inner London); and
— the Kepier Practice (Sunderland).

2. Initial qualitative research from the pilot scheme in London indicated that all stakeholders (patients, health practitioners, Weight Watchers Leaders) were highly supportive of this type of scheme. However, the cost for the patient of attending meetings was sometimes a barrier to them taking up the Weight Watchers option and suggested that PCTs need to find creative ways of funding these types of schemes to promote access.

3. The schemes have varied in their set up, but generally have involved referral of patients for a course of Weight Watchers meetings (10–13 week course) either to established meetings or customised meetings set up for NHS patients.

4. The results are encouraging (see the Widnes story) and overall suggest that PCTs can estimate that over one third (33%) of patients will lose at least 5% and a fifth will lose 10% or more of their starting weight following a 12 week course at Weight Watchers. This compares favourably with other weight loss approaches and is beneficial in health terms. This short term success looks promising in the context of Weight Watchers evidence base on long term effectiveness shown in appendix 1.

5. Weight Watchers is now ready to release a national referral scheme this spring. The shape and format of this scheme have been informed by the four pilots. The scheme will offer a 12 week course of Weight Watchers meetings to the NHS for a specially discounted price of £35. The workings of the scheme and its materials have been pre-tested in the field with PCTs.

6. Weight Watchers acknowledge that moving the referral scheme on to a national footing will present many challenges. To enable us to respond we will approach the first year cautiously and run it as a "living pilot". Plans are in place to collect formal evaluative information on both the process (how it works) and outcomes (how effective it is in helping patients lose weight) of the national scheme. This evaluative data will be collected early in 2006 and in this way Weight Watchers will ensure that evaluative information is fed into the ongoing development of the referral scheme to maximise its long term effectiveness.
Case Study: Weight Watchers Working With the NHS—The Widnes Story

Weight Watchers has been working in partnership with Halton General Hospital to offer a 10 week course made available free of charge to overweight patients in a deprived area (Castlefields). This project was set up with Single Regeneration Budget funds. The area was such that the WW leader had to go in and run the meeting with a PCT funded “minder” to ensure everybody’s safety. The project started in January 2003 and since then two further meetings have been set up targeted at neighbouring deprived localities. The project has flourished and WW members now also have access to a Food Co-op, “Cook and Taste sessions” run by a community food worker, and exercise sessions including a Health Walks scheme. In the first year 59 patients signed up for Weight Watchers and this has increased to 93 patients over a 15 month period. Results of the initial evaluation suggested this project is successful in many different ways. Key statistics are:

- 31% of the total sample achieved a 5% or more weight loss.
- Of those who completed 10 weeks, 49% lost 5% or more.
- The average starting weight was 101 kg and the mean weight loss was 3.2 kg.
- 80% of participants said that the weight loss achieved through Weight Watchers had improved their self esteem.

Memorandum by the Local Government Association (WP 29)

INTRODUCTION

The Local Government Association (LGA) was formed on 1 April 1997 and represents the local authorities of England and Wales—a total of just under 500 authorities. These local authorities represent over 50 million people and spend around £78 billion pounds per annum. Our members include 34 county councils, 36 metropolitan district councils, 47 English unitary authorities, 32 of 33 London authorities, 238 shire district councils and 22 Welsh unitary authorities. The LGA also represents fire authorities, police authorities, national park authorities and passenger transport authorities.

The LGA exists to promote better local government. We work with and for our member authorities to realise a shared vision of local government that enables local people to shape a distinctive and better future for their locality and its communities. The LGA aims to put local councils at the heart of the drive to improve public services and to work with government to ensure that the policy, legislative and financial context in which they operate, supports that objective.

Local government has a powerful role to play in promoting public health, not only because its diverse services have a major impact on people’s lives, or that it is one of the largest employers in this country, but also because in its community leadership role enshrined in the Local Government Act 2000 it can work together with partners through LSPs to make a real difference to local communities’ health and well-being. Local Authorities have also been using the powers of the Health and Social Care Act 2001 to scrutinise the operation of health services as well as wider public health issues in their area. This relatively new role is augmented by the fact that local authorities have a democratic legitimacy that no other public organisation has at the local level.

In response to the Choosing Health? consultation, the NHS Confederation, the UKPHA and the LGA, produced a visionary public health report called Releasing the Potential for the Public’s Health, which lists 16 recommendations for the Government to act upon—a copy of the report is attached.

In addition, local government has shown its pro-active commitment to the public health agenda as demonstrated by the Shared Priority for Promoting Healthier Communities and Reducing Health Inequalities. The 12 Shared Priority pathfinders committed to the project are in the process of planning innovative solutions to local public health problems in partnership with the local NHS and key agencies at the national level. Further details on this project can be found at the IDeA Knowledge website (http://www.idea-knowledge.gov.uk/idk/core/page.do?pageId=77237).

WHETHER THE PROPOSALS WILL ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS

The LGA overall welcomes the White Paper (WP) and appreciates the extra funding, new initiatives and long-term commitments that the Government has made. However, it is clear that achieving the WP’s goals will depend on work carried out by local authorities, Primary Care Trusts and their partners at the local level. It is therefore absolutely vital that local authorities and their partners are properly reimbursed for their work (as alluded to in the New Burden’s doctrine in the WP). Local authorities will be responsible for implementing many elements of the WP including amongst many other things, tackling under age tobacco sales, extending physical activity and leisure services, expanding the number of extended schools and enforcing any legislation on smoking in public places.

The LGA is also pleased that the Government will ensure all its policies are health impact proofed. In our “Releasing the Potential” report we urged the Government to ensure that all its policies and programmes of all Departments of State are subject to a process of health impact assessments and inequality “proofing”.

whether the proposals will enable the government to achieve its public health goals
The LGA is therefore glad that the Government has taken on board this recommendation, but we would go one stage further. Along with partner organisations the NHS Confederation and UK Public Health Association, we believe that the Government should establish a new Public Health Minister of cabinet rank with cross-government responsibility for promoting public health and reducing health inequalities. We believe this would demonstrate the Government’s commitment to tackling health inequalities and ensure that there is effective national leadership and coordination of public health action. We also called for the transfer of public health responsibilities out of the Department of Health. The three organisations are of the opinion that retention of public health responsibilities by the DH obscures the cross-cutting nature of the issue and reinforces the erroneous view that the NHS alone can promote and sustain good health.

It is these radical changes at the centre that would have created the leadership and publicity to drive the agenda and help meet the WP’s goals. As it currently stands, there seems to be a myriad of different individuals and groups working on the WP and little clarity as to how they will be co-ordinated. The LGA would be happy to be involved in a co-ordination function along with other key national stakeholders.

One of the most controversial elements of the White Paper is the proposal to ban smoking in public places. But this is one of the key policy areas that, with concerted action, could significantly affect public health and reduce health inequalities in this country. Although the LGA supports the staged approach to banning smoking in public places outlined in the WP, the Association has concerns about how the proposed smoking ban in public places will be implemented and the long timescale proposed. The WP does not outline exactly how the smoking ban will be enforced, particularly with regard to the licensing of bars and pubs and how smoking will be prohibited in “bar areas”. The LGA would like the Government as soon as possible to clarify its intentions in this area, including how it will fund any extra financial burden placed on local councils. The Association is concerned about the effect the partial ban on smoking in pubs will have in terms of encouraging pubs to stop serving food, particularly in more deprived neighbourhoods. The LGA is also not aware of any research which shows that complete smoking bans would encourage more people to smoke at home. In all these areas, more evidence-based research is needed.

Finally, the LGA has reservations about the long-term effectiveness of voluntary agreements with the food industry to reduce fat, salt and sugar levels in foods or to work with the food industry and advertisers on food promotion to children and other vulnerable groups. Time will tell whether these kinds of agreements will work, but the Government must be prepared to use legislation or regulation if necessary as a last resort. The Association believes that the Government should be prepared to take urgent, precautionary action to strengthen the regulatory framework affecting the public’s health, placing the onus of proof on industry and not the public, and establish an independent, stakeholder-driven process to adjudicate the evidence.

**Whether the Proposals are Appropriate, Whether They Will Be Effective and Whether They Represent Value for Money**

The LGA endorses many of the new initiatives proposed in the White Paper:

- Extension of the Healthy Schools Programme;
- Healthy Start Programme for families;
- Pilots for promoting health in the workplace;
- Further investment in physical activity;
- The new funding for PCTs to tackle health inequalities; and
- The advent of NHS accredited health trainers and Health Direct, amongst others.

At this stage it is difficult to say whether the proposals outlined in the WP will be effective and represent value for money. Much will depend on the content and aims of the Delivery and Action Plans as well as whether the timetable for consultation, legislation and other policy developments are prioritised and delivered to schedule. It is also clear that the whole programme is regularly and independently evaluated to ensure progress is being made. Much of this will initially focus on outputs but in the medium to long-term the evaluation must focus on how outcomes from the programme is reducing health inequalities and improving the public’s health.

**Whether the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure That Proposals Will Be Implemented and Goals Achieved**

The LGA recognises that this agenda must be addressed in partnership between local government, the NHS, the voluntary and private sectors, as well as the communities themselves. Local Strategic Partnerships are an important vehicle for bringing partners together at the local level and there are some excellent examples of Health Partnerships around the country. Successful LSPs are often determined by how much different partners are prepared to invest them in terms of resources and labour. They often work best when there is a specific funding stream (such as the Neighbourhood Renewal Fund) that binds partners to a common agenda.
In this respect, the advent and pilot of Local Area Agreements is welcome. Under LAAs, local authorities, the NHS and other relevant partners will be able to negotiate with central government clear targets and outcomes for their areas, but will have the autonomy and flexibility to decide locally how best to achieve them. This new form of national/local agreement will also simplify funding streams into one pot and act as a strong inducement to joined-up working, particularly for PCTs. If proved to be successful, the LGA would like to see LAAs and other similar mechanisms mainstreamed so that they become the norm, not the exception.

The Association also applauds greater integration between the NHS and local government. Integration can be achieved through more joint appointments (esp. Directors of Public Health), joint teams and pooling together of expertise and resources (S31 agreements) as well Care Trusts, LAAs and strengthened LSPs. In this respect, it is critical that each area decides its own approach to integration. There is no standard blueprint that fits every locality. An added benefit of greater integration is that it can help overcome the different cultures, protocols and structures (linguistic, social and financial) that can sometimes divide the NHS and local government.

A further way the infrastructure for promoting public health could be improved would be by realigning the boundaries of PCTs and local authorities so that they are co-terminous. Co-terminosity is particularly an issue in two tier authorities, where one county might have to deal with four or more PCTs. Whilst we recognise that this is not an essential pre-requisite for joint working—it would nevertheless make it much easier for PCTs to set up joint teams or posts, or plan and commission services together.

The capacity of PCTs to act on public health needs to be enhanced as budgets for public health are often limited. This is often compounded by the fact that they are judged by waiting list targets and acute care—not public health or prevention. The White Paper indicates that funding for PCTs in this area will be substantially increased, especially in the more deprived areas. This needs to be mainstreamed to all PCTs as soon as possible.

An underlying concern the LGA had about the White Paper was the over emphasis it placed on the NHS. Clearly this agenda can only be effectively addressed when all the key stakeholders are prioritising public health and working together to a common agenda. This very much reflects the views of the LGA and its partners in the “Releasing the Potential” document.

CONCLUSION

Public health is as high on the agenda as it has ever been. The Government and other key stakeholders now have a great opportunity to make changes that will have an impact for generations to come. There is no doubt that there is a groundswell of interest and commitment from Local Government, the NHS and others to promote public health and to tackle health inequalities. The LGA believes that the White Paper offers strategic direction but must be seen as a first step along the path towards a healthier and less divided nation. After all, the White Paper’s success can only really be judged when health inequalities have significantly declined in this country.

January 2005

Memorandum by the British Lung Foundation (WP 30)

The following evidence is submitted to the Health Select Committee, from the British Lung Foundation (BLF), for the inquiry into the Government’s Public Health White Paper.

The BLF welcomes this inquiry by the Health Select Committee and the recognition of the serious public health issues it addresses.

Using the Committee’s terms of reference as a structure, we have concentrated our remarks to the issue of Smoking, where we feel we can most effectively contribute to the debate. We would be delighted to supply additional information, or clarification on any of the points raised in our response at a later stage.

1. BACKGROUND

1.1 The British Lung Foundation (BLF) is the only charity working to help the eight million people in the UK with all lung conditions.

1.2 The BLF runs a network of support groups across the country for people living with lung disease. There are more than 120 Breathe Easy Groups across the UK, all run by patients to support patients.

1.3 The BLF provides a wide range of information on all 43 lung conditions, in the form of leaflets and fact sheets, all of which can be accessed via our website (www.lunguk.org).

1.4 The BLF also funds medical research with the aim of finding solutions to lung diseases.
2. WILL THE PROPOSALS IN THE WHITE PAPER ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS?

2.1 The BLF welcomes the restrictions on smoking in public places announced in the public health white paper as these do represent real progress on this issue, however, we feel they do not go far enough and will therefore fall short of achieving the Government’s public health goals. We will discuss these in more detail in section three.

2.2 We support the additional focus on smoking cessation services, and helping people to quit. We feel that this is the most important element of any comprehensive package to reduce the burden of smoking related disease. Many smokers find giving up incredibly difficult—in February 2000, the Royal College of Physicians published a report on nicotine addiction which concluded that “Cigarettes are highly efficient nicotine delivery devices and are as addictive as drugs such as heroin or cocaine.”74 The BLF believes it is vital that the NHS leads the way in providing effective support to quitters in the most appropriate settings and at the most convenient times.

2.3 We welcome the renewed investment in public health advertising campaigns to encourage people to stop smoking. The Department of Health is using different messages and different mediums to reach a wide audience and we fully support this approach.

2.4 We approve of the strengthening of regulations surrounding the promotion and sale of tobacco products and fully support the use of visual warnings on pack and a clamp-down on underage sales. Evidence suggests that if you can prevent people from smoking until they reach the age of 20 it is very unlikely they will ever start. It is vital to provide support to young people to prevent them from smoking in the first place, or to support them to quit if they do start. There is a need for more smoking cessation support aimed specifically at teenagers.

2.5 We are concerned about the levels of tobacco smuggling in the UK and welcome the plans to reduce this outlined in the white paper.

3. ARE THE PROPOSALS APPROPRIATE, WILL THEY BE EFFECTIVE AND WILL THEY REPRESENT VALUE FOR MONEY?

3.1 On the issue of smoking in enclosed public places, restrictions have been announced which make provision for all NHS premises to be smoke free by 2006, all enclosed public places, excluding licensed premises, by 2007 and all licensed premises which serve food by 2008. We are concerned about the delay in implementing these proposals. We believe restrictions should be implemented much sooner to provide staff, and members of the public alike, with protection from the damaging health risks associated with Secondhand tobacco smoke.

3.2 It is our fear that the “compromise” measures of allowing smoking to continue in pubs and bars which do not serve food will only serve to increase the health inequalities gap that the Government has been trying to reduce. Initial data from research currently being conducted suggests that the majority of these so-called “wet pubs” are situated in the most deprived wards in the country, where smoking prevalence, and therefore the rate of smoking related disease, is significantly higher.

3.3 Following on from 3.2, it is not clear what definitions the Government will use to distinguish between pubs and bars preparing and serving food, where smoking will be prohibited, and those where smoking will be allowed. There is no indication in the white paper as to how the distinction will be measured, what procedures will need to be put in place to implement such a two-tier policy and what additional cost this will incur. It is fairly obvious though, that this approach will be more complicated and expensive to enforce than an all inclusive comprehensive ban.

3.4 The report from the Government’s own Scientific Committee on Tobacco and Health (SCOTH), published on the same day as the Choosing Health? white paper, identifies bar workers as the most at risk from the negative health effects of secondhand smoke. Professor Konrad Jamrozik, formerly of Imperial College London, estimated that exposure to secondhand smoke at work leads to approximately 700 deaths from lung cancer, heart disease and stroke combined, he also estimates 49 deaths—or about one a week—from exposure at work in the hospitality trades. Therefore, we are concerned that the Government is failing to protect the health of workers in those pubs and bars which do not serve food.

3.5 The white paper makes provision for smoking to be prohibited around the bar area in all licensed establishments, however, it is not possible to stop smoke spreading from one area to another and therefore this will not be an effective way of reducing the health risk faced by bar workers in pubs where smoking continues. Evidence collated in Seattle, USA, in 2003 shows that air conditioning and filtering does not provide the complete protection needed. “Using current indoor air quality standards, ventilation rates would have to be increased more than a thousand-fold to reduce cancer risk associated with secondhand tobacco smoke to a level considered acceptable to federal regulatory agencies. Such a ventilation rate is

impractical since it would result in a virtual windstorm indoors.”\(^75\) In managing workplace secondhand tobacco smoke risks, smoking policies such as separating smokers from non-smokers in the same space or on the same ventilation system expose non-smokers to unacceptable risk.\(^76\)

3.6 There would be no additional financial burden on the Government from the introduction of comprehensive smoke free legislation. Indeed evidence quoted by the CMO, in his 2003 annual report, demonstrates that a policy of creating smoke-free workplaces and public places would yield an overall net benefit to society of £2.3 billion to £2.7 billion annually, equivalent to treating 1.3–1.5 million hospital waiting list patients.\(^77\) In addition to this, evidence from around the world, where such measures are in place, suggests that till receipts within the hospitality industry have actually increased since the introduction of the legislation.

3.7 Again, taking evidence from around the world, where legislation has been introduced, it is clear that comprehensive laws banning smoking in all enclosed workplaces actually help reduce the smoking prevalence rate and the overall consumption of cigarettes among smokers. A survey by the national Quitline service in Ireland has revealed that around 10,000 smokers report that they have reduced their consumption since the ban came into force and according to the Irish Revenue Commissioners, sales of cigarettes fell almost 16% in the first six months of 2004.\(^78\) This reduction in smoking would have a positive impact on the morbidity and mortality statistics for smoking related diseases and would certainly reduce the financial burden that these diseases place on the NHS.

4. **Whether the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure that Proposals will be Implemented and Goals Achieved**

4.1 The British Lung Foundation has been concerned for some time about the long term funding for smoking cessation services. Many services are given initial funding to start up but do not have secure guaranteed funding to ensure the services can continue. We hope that the commitment in the White Paper to expand smoking cessation services will resolve this situation. We will be monitoring it closely as we feel it is vitally important that appropriate support to help people stop smoking is at the centre of any moves to reduce smoking prevalence in the country.

January 2005

Memorandum by Pesticide Action Network UK (PAN UK) (WP 31)

**About PAN UK**

Pesticide Action Network UK aims to eliminate the hazards of pesticides, to reduce dependence on pesticides and prevent unnecessary expansion of use, and to increase the sustainable and ecological alternatives to chemical pest control. PAN UK was formed (as the Pesticides Trust) in 1987 by organisations with trade union, environmental and development affiliations. These organisations were concerned about the national and global risks posed to health and the environment from pesticides, and agreed that an independent organisation was essential to provide information, advice and policy input.

There are subscribers to our journal, Pesticides News, in ninety countries, and our supporter base has been built up over 15 years. Our extensive website, [www.pan-uk.org](http://www.pan-uk.org), now receives an average of 70,000 hits a month, and our new e-library [www.pesticidelibrary.org](http://www.pesticidelibrary.org) comprises over 5,000 references on pesticides, health and the environment. Pesticide Action Network is a global network with five regional centres: PAN Europe (facilitated by PAN UK and PAN Germany), PAN Africa (based in Senegal), PAN Asia/Pacific (based in Malaysia), PAN Latin America (based in Chile), and PAN North America (based in the United States).

We provide inputs to key UK pesticide policy fora, for example, the joint working party of the Royal College of Physicians and Royal College of Psychiatrists on organophosphate sheep-dips in 1998, the Committee on Toxicity Working Group on the Risk Assessment of Mixtures of Pesticides and similar substances (WGRAMP) in 2002, and, currently, the Pesticides Forum, and the Minister’s stakeholder group on the “bystander” issue on 22 July. The PAN Europe network, in which PAN UK plays a leading role, is recognised as a key stakeholder in pesticides policy by the Environment, and Health and Consumer Protection (SANCO), Directorates of the European Commission.

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\(^78\) [www.ash.org.uk](http://www.ash.org.uk)—Impact of smoke-free legislation in Ireland.
**Choosing Health: the Public Health White Paper**

— Will the proposals enable the Government to achieve its public health goals?
— Are the proposals appropriate, will they be effective, and will they represent value for money?

We are very concerned that there are no proposals at all in the White Paper for protecting public health from the effects of environmental pollutants. This may mean there is only limited progress on the “more intractable issues and conditions” such as cancer and neurological disease.

May we draw your attention to the work by Pritchard et al on changing morbidity and mortality in respect to cancer malignancies in the UK, compared with the major Western world countries (Pritchard and Evans 1996, 1997, Public Health). The studies show rises in incidence of various cancers, especially amongst the under 34 year olds, especially young women. As there are marked differences in gender, this has to be environmental and not a diagnostic artifact. The improved cancer survival rates in the West have never been better, and this may have masked the serious increases. Nonetheless, up to the mid-1990s England and Wales had the lowest improvement in cancer survival times amongst the countries reviewed (Evans and Pritchard 2000 Public Health).

Over a 30-year period, Pritchard et al showed that from 1963, when there was very little statistical link between malignancy mortality and density of population, this grew stronger over the next 30 years. Female cancer, especially amongst young women, grew considerably faster than mens, again another indication of environmental factors (Pritchard and Evans 1997).

Perhaps even more alarming is their recent work (Pritchard et al, 2004, Changing patterns of adult (45–74 years) neurological deaths in the major Western world countries 1979–97, Public Health, 118, 268–283) showing marked changes in “neurological” morbidity and mortality in most of the major Western world countries, particularly England and Wales. Again the findings, after correcting for age, is an increase in mortality in the under 74 year olds in conditions which are recognised to have a genetic weighting. Moreover the conditions are occurring earlier and there is a significant increase in dementias in the late 40s and mid-50 year olds.

This research can not say what has specifically caused these serious changes, but a number of clinical studies point to the association of the use of multi-chemicals and pesticides and the development of some cancers and some neurological diseases. Again the time span is too short for the changes to be due to genetic factors. These results are not a diagnostic artifact, even though there may be a slight influence, but the reality of the changes is demonstrated by the differences in gender incidence and mortality over the period.

These are just a few of the studies indicating that there is a major and urgent public health issue which is ignored in the White Paper.

We believe that a national programme of biomonitoring, which would become a possibility if the UK Biobank project www.ukbiobank.ac.uk is set up to do it, is essential for research into the effects of chemicals on the body. The current lack of baseline data prevents any action on this crucial problem.

We also believe that close scrutiny of the cost-effectiveness of prevention programmes, in relation to the costs of NHS treatment, should be at the centre of public health policy. We are sceptical about the potential effectiveness of “health promotion” programmes which ignore environmental pollution as a factor in disease causation. We note, for example, the recent study by the International Agency for Research on Cancer which found that the consumption of vegetables and fruit does not protect against breast cancer.

For this reason we ask the Health Committee to consider commissioning the National Audit Office to carry out a long-term audit of prevention programmes conducted by government agencies, including the Health Development Agency, the Health Promotion Agency, the Department of Health and the Food Standards Agency. This would inform decision-making about future programmes.

*January 2005*

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**Further memorandum by Abbott Laboratories (WP 32)**

**Introduction**

1. Abbott Laboratories is an international healthcare corporation, which has been operating in the UK for over 60 years. We welcome the opportunity to respond to the Committee’s new inquiry into the Government’s Public Health White Paper.

2. Our obesity treatment Reductil (Sibutramine) was positively appraised by NICE in October 2001. We submitted a memorandum to the initial Health Select Committee Inquiry into obesity, and supported the Dr Foster survey cited in the Choosing Health White Paper (though incorrectly attributed to Roche).

3. We attach to this memorandum a soon to be published new Dr Foster survey (2004) [*not printed*]. We have supported (via an unrestricted educational grant) the research and subsequent production of this report, which contains new data for 2004 on obesity management services in primary care and comparisons with 2003 data.
Will the Committee's proposals enable the Government to achieve its public health goals?

4. In relation to tackling obesity, we are concerned that the proposals set out by the Government to date in its response to the Committee’s Report and in the Choosing Health White Paper will not enable the Government to meet its public health goals.

5. Physical activity and diet are central to improving the health of the nation, but the third pillar of a successful anti-obesity strategy (medical intervention and treatment), has not been given due consideration in the Government’s response.

6. We share the Committee’s fear (para 394) that, “the extent and seriousness of the obesity problem will be lost by including obesity only as part of a wider umbrella of general public health initiatives.”

7. While we welcome the announcement of a PSA target in obesity for under-11s, we think a corresponding target for adults should have been introduced in light of the extensive body of evidence that now exists on the costs of obesity.

8. We believe a PSA target for adults would serve to focus PCOs and medical professionals upon the importance of treating/preventing obesity and would enable service providers to adequately meet local need for obesity services through releasing funding where needed to meet the target. The Dr Foster 2004 survey reports 55% of PCOs believe the treatment/prevention of obesity is one of their top priorities for 2004–05. Given the central importance of obesity to the Government and the general public, we would like to see 100% of PCOs identify obesity as a top priority.

Are the proposals appropriate, will they be effective and do they represent value for money?

9. In order for obesity services to be effective they need adequate resources and as such we support the Committee’s call (para 63) for “funding for the large scale expansion of obesity services in secondary care, underpinned by careful management to ensure that the service provision is matched to need.”

10. We would like the Government to clarify the amount of extra funding to be made available for PCTs from 2006, cited in the Government’s response (p 24) and to state how much of this will be directly tied to the provision of obesity services. If this is general funding rather than obesity-specific, we fear the ability to determine value for money would be limited, likewise the effect on tackling obesity.

11. It is concerning that only 6% of responding PCOs in the 2004 Dr Foster survey reported that it was possible to identify the proportion of their annual budget allocated for obesity. This in in-keeping with the Committee’s finding (para 393) that, “obesity remains a low priority for the majority of service commissioners and providers in the NHS.” Those PCOs which did respond reported a woefully small percentage of their budgets as being allocated for obesity; on average just 0.33% of the budget baseline.

12. While there is no established figure for the number of obese people in the UK, this level of funding is clearly inadequate when an estimated 66% of people in England are thought to be overweight or obese.

13. Only a very small percentage of respondents (less than 3%) provided information on the percentage of budget allocated to obesity. The Committee’s assistance in gaining a response from a larger number of PCOs would be welcome.

14. The Dr Foster 2004 survey highlights a widespread failure to collect data on the provision of obesity services. Just 25% of PCOs who responded had ever audited GP practices to monitor the implementation of any obesity guidelines. As regards monitoring the effectiveness of interventions, 19% monitor the outcomes of surgery, 39% drug therapy and 45% weight management programmes.

15. If we are to determine value for money and ensure service provision is matched to need, a concerted effort to collect more data will be needed.

16. The Government proposes monitoring obesity under the umbrella of the public health domain in the new NHS performance framework described in Standards for Better Health. We welcome the new requirement to return local data on the prevalence of obesity, but would like to establish that the obesity data will be clearly distinguishable from other public health indicators so as to enable a clear obesity evaluation by the Healthcare Commission.

17. We agree with the recommendation that, “The Government’s maximum waiting time targets must apply to all of these services.” and were disappointed to see no specified commitment in the Government’s response.

Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

18. To enable the successful management of obese patients requires a multi-disciplinary team with expertise in diet, exercise and medical treatment.

19. In our previous memorandum to the Committee we criticised the lack of clear strategic direction for SHAs and PCTs on obesity, and the absence of a national framework against which local progress on obesity could be measured.
20. The Dr Foster 2004 survey also found 49% of PCOs and a worrying 69% of general practices had not established weight management clinics. Training of GPs and allied healthcare professionals in the seriousness of obesity and strategies for effective intervention and management is fundamental to this sort of initiative. Given the importance of this tool in managing obese patients, we call for efforts in this area to be recognised and rewarded in the GP contract and for the Government to commit to this position in its negotiations.

RECOMMENDATIONS FOR ACTION

21. Inclusion in the forthcoming Delivery Plan of specific measures to expand the provision of medical services for obesity with commensurate funding and targets to ensure their delivery.


23. The application of maximum waiting time targets to medical services for obesity.

24. The inclusion in the GMS contract of obesity, in its own right.

Memorandum by The Men’s Health Forum (WP 33)

1. INTRODUCTION

1.1 This short paper outlines the response of The Men’s Health Forum (the Forum) to the recent publication of the Public Health White Paper. The Forum is the leading charity working with health and other professionals to improve the health of boys and men in England and Wales. Amongst other things, the Forum is involved in:

— Research and policy development;
— Professional training;
— Providing information services;
— Stimulating professional and public debate;
— Working with MPs and Government (in particular, the Forum provides the secretariat for the All-Party Parliamentary Group for Men’s Health);
— Developing innovative and imaginative projects;
— Collaborating with the widest possible range of interested organisations and individuals;
— Organising the annual National Men’s Health Week.

1.2 The Forum exists because, to put it simply, male health is much poorer than it need be. Average male life expectancy, although rising, is just 76 years and, in some disadvantaged social groups and communities, it is as low as 71 years.

1.3 Poor male health is largely caused by the health-related behaviours of men and boys rather than biology. Many men have unhealthy diets, drink alcohol excessively and delay seeking help with health problems. But while men are currently far from “fully engaged” in their own health it is equally true that health services are far from “fully engaged” with men. There is still a limited understanding of how to develop the kind of services that will impact on male health effectively.

1.4 The Forum broadly welcomes much of the White Paper. In one respect it is fundamentally flawed, however. Despite some encouraging references to several specific aspects of male health and to the need, in general, to target health improvement at specific population groups, there is no evidence of a strategic response to gender health inequalities. This omission is despite the Department of Health’s apparent commitment, stated in several previous policies, to tackle inequalities related to gender as well as those linked to social class, ethnicity, age and geography. The Forum hopes that gender equality issues will be addressed in the forthcoming delivery plan for the white paper.

2. WILL THE PROPOSALS ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS?

2.1 The Forum believes that Choosing Health is the most comprehensive plan for improving public health ever produced for England. Whilst it is certainly far reaching in scope, and has been informed by an extended and large-scale consultation, a prime opportunity for a more “joined-up” approach to working with men has been missed.

2.2 If the Government wishes to achieve the key public health goal of reducing inequalities, far more attention must be paid to the issue of gender. For too long, “gender” has featured in Department of Health policies and plans merely as a word added to a long list of other inequalities (primarily social class and ethnicity). Rarely have specific actions to tackle gender and health inequalities been included. This clearly has implications for both male and female health but, as far as men are concerned, it means that there has been no strategic response to, for example, the marked inequalities in cancer and heart disease.
2.3 Men are much more likely to develop cancer than women and to die from it. Age-standardised data for England shows that the incidence for all cancers for men is just over 400 per 100,000 population. The figure for women is just under 340 per 100,000. That is a difference of almost 20%. The comparable figures for mortality show an even bigger difference between men and women—over 40%.

2.4 Of the 10 most common cancers that can affect both men and women, nine are more common in men—in many cases very markedly so. In total, men are almost twice as likely as women to suffer from these nine cancers. In death rates, the picture is even starker. Men are twice as likely to die from all of these 10 cancers. If the incidence of these most common “shared” cancers in men could be reduced to the level experienced by women, there would be a very significant impact on cancer rates in the population as a whole.

2.5 There is also a marked gender inequality for the other major killer, coronary heart disease (CHD). For the 35–44 age group, the age-specific death rates for CHD per 100,000 UK population are five times greater for men than women; for the 45–54, 55–64 and 65–74 age groups, the respective ratios are five, three and two.

2.6 There can be little doubt that cancer and heart disease—and many other major diseases—are “gendered”—in other words, they have a disproportionate impact on one gender. Any attempt to tackle these diseases without taking account of this inequality is likely to be less than optimally effective. Ignoring gender in these circumstances would be as ill-advised as ignoring ethnicity when tackling a condition which affects a particular ethnic group disproportionately.

2.7 The Forum also believes that, in order to achieve the Government’s broad public health goals, it is important to take gender into account even where there are no marked gender inequalities. It is clear that men and boys have gender-specific health attitudes and behaviours and respond to different health improvement interventions. For example, in the key area of obesity, men are much less well-informed than women about what constitutes a healthy diet, are more likely to drink alcohol at levels that contribute to weight problems and are generally less likely to perceive themselves as having a weight problem. They are also less likely to seek help for weight problems and, if they do, they are less likely than women to respond to diet-focused interventions. Unless men’s specific attitudes and behaviours are taken into account in tackling obesity, as well as a wide range of other public health issues, it is much less likely to be effective. To put it simply, what works for women will often not work for men, and vice versa.

2.8 It is vital that the significance of gender—and, from our point of view, the particular needs of men and boys—is highlighted in the forthcoming delivery plan. Unless the Department of Health is specific about this, the needs of men will remain largely unaddressed by primary care organisations. Given that the recent Department of Health document National Standards, Local Action requires primary care trusts to address gender equity in service planning and delivery, it would seem entirely appropriate—and be entirely consistent—for the delivery plan to include this issue too.

2.9 More positively, the emphasis in the White Paper on delivering health interventions in the workplace and using IT is likely to prove helpful for improving men’s access to health information and services. This is good news for men who are proportionately less likely to access traditional health services. There is now robust evidence that men are particularly likely to respond to health promotion in workplace settings. There is also a great deal of anecdotal evidence that suggests that men in particular will be more responsive to approaches utilising the Internet, text messaging and Health Direct. For example, the volume of visits to the Forum’s “consumer” website, www.malehealth.co.uk, is steadily rising and there are now over 780,000 “user sessions” and 42 million “hits” a year. Over 3,000 individuals have registered on the site to receive a monthly newsletter providing information about new developments and content.

3. Whether the Proposals are Appropriate, will be Effective and Whether they Represent Value for Money

3.1 The Forum broadly welcomes the range of proposals in the White Paper and believes that, as a whole, they offer a useful approach to improving public health. There are specific areas where we would have wished to have seen more robust action—notably, a complete ban on smoking in public places. (The current exemption to the ban will leave customers and staff in pubs in the most deprived, working-class neighbourhoods—which are less likely to serve food—most at risk of passive smoking.) Our principal concern, however, is that the measures will not be as effective (and cost-effective) as they could be if gender is not taken into account.
4. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved

4.1 The infrastructure and mechanisms necessary to achieve implementation in a way that takes effective account of gender are not yet in place. In this submission, the Forum wishes to highlight three key areas: the lack of an evidence-base of good practice; the weak research base; and inadequate training.

4.2 Although there are now an increasing number of examples of practice in relation to working with men and boys, there is no systematic means of evaluating and disseminating these. The Health Development Agency had, until 2004, plans to develop an evidence-base of good practice in men’s health but these were abandoned at an early stage, largely as a cost-cutting measure. It is essential that this plan is resurrected as soon as possible and the Department of Health should now take a lead on this.

4.3 The research base in gender and health is weak. In the area of cancer, for example, while the gender inequalities can be measured, the reasons for them are not yet fully understood. For example, the balance of genetic and behavioural factors requires further detailed investigation. The Department of Health should initiate a research programme in respect of cancer and other major killers to fill the current gaps in knowledge. A better understanding of the causes of gender inequalities will enable more effective health improvement interventions to tackle them.

4.4 Training for health professionals on gender issues is largely non-existent. It is difficult if not impossible for health professionals at any level and working in any field to work effectively with men without an adequate understanding of the social construct known as “masculinity”. Health professionals need to know what makes men and boys “tick”—how they think about health, how they behave and how to get them “hooked” into taking more interest in, and care of, their health. Although there are now some signs of change (eg the Royal College of General Practitioners intends to develop training on men’s health for qualifying GPs), the pace of change is too slow and too patchy. The Department of Health must ensure that the public health workforce receives adequate training in this important issue.

4.5 Choosing Health is also very enthusiastic about the role of schools. The Forum believes it is important to remember that even in a school setting, however, that the specific needs of boys can be overlooked. Teachers and other staff working in schools require additional training on how to work effectively with boys on health and health-related issues. There is a particular need to train staff to address the needs of boys in sex education; many of the staff delivering the subject lack the confidence to work with boys and also fail to engage them in the subject.

The Men’s Health Forum would welcome the opportunity to contribute further to the national debate around Choosing Health.

January 2005

Memorandum by Sport England (WP 34)

Introduction to Sport England

Sport England is responsible for providing the strategic lead for sport in England to deliver the Government’s sporting objectives. Our vision is for England to be the most active and most successful sporting nation in the world. Our mission is to work with others to create opportunities for people to get involved in sport, to stay in sport, and to excel and succeed in sport at every level.

We develop the framework for the country’s sporting infrastructure and distribute Lottery funding to where it will deliver the most value for sport. There are nine Regional Sports Boards, focused on supporting delivery, with a remit to prepare Regional Plans for Sport, develop partnerships, and secure and target investment to make the greatest impact in local communities.

Overview of the Public Health White Paper

Sport England welcomes the Government’s recognition of the unique contribution that sport and active recreation can make to deliver public health targets. The Chief Medical Officers report in 2004 outlined the conclusive evidence supporting the vital contribution that physical activity can make in both the prevention and treatment of a range of diseases. We can no longer ignore that those who are active have up to a 50% reduced risk of developing many of the chronic diseases. In his report, the CMO drew parallels with the smoking epidemic over the past 50 years and in his “Call for Action” asked government to set in place “key strategies” to bring about similar changes in physical inactivity. Many of the commitments set out in Choosing Health are a positive step towards addressing this and will help to make England a more active and healthier nation. However, without proper resourcing and continued investment beyond the White Paper there will be little change.

Sport England looks forward to working with the Department of Health and other partners to effectively deliver the physical activity commitments but to also continue to develop and extend this important and previously overlooked area of work.
Sport England submission will focus on the physical activity and sport related announcements set out within the Public Health White paper.

Will the proposals enable the Government to deliver achieve its public health goals? Are the proposals appropriate, will be effective and whether they represent value for money?

MARKETING HEALTH

Sport England welcomes the recognition of the need to better market health through a series of campaigns. It is suggested that a physical activity related campaign either developed as part of the obesity campaign or a stand-alone campaign is prioritised as an early focus within the marketing health strategy. An imaginative, consistent, sustained and well-funded multi agency physical activity marketing campaign is needed drawing on the lessons from past physical activity campaigns.

Sport England has been working with partners to better market sport and physical activity. During the summer of 2004, we ran a pilot campaign in the North East of England called, “Everyday Sport—everybody feels better for it.” Campaign messages and activities focused on promoting sport and physical activity as a fun, healthy pastime, with the intention of capturing the popular imagination and providing a persuasive and achievable call-to-action. We welcomed the Department of Health’s involvement and support, which included part funding the campaign’s evaluation.

The evaluation has shown the campaign to be a success in terms of raising awareness of the benefits of an active lifestyle and has identified Sport England as an important player in developing and delivering physical activity related campaigns. The learning from the evaluation will help to inform any future cross government national campaign which we are keen to be involved with.

Recommendations for action:
— Government to fund a physical activity campaign as a priority within the marketing health strategy.
— Government to invest in developing a PR physical activity message, similar to the Five a Day message that is easily understood by the general public.
— Physical activity campaign to build on the lessons from the Everyday sport campaign run by Sport England.
— Provide links to Active Places through Health Direct, enabling people to access information about the opportunities.

CHILDREN AND YOUNG PEOPLE

We welcome the priority given to children and young people within the paper, in particular the Healthy Schools Standard and the recognition of the importance of physical activity within this initiative. Government has done much to address the sporting needs of secondary and primary school children through the PESSCL programme. However, more needs to be done to ensure that a wide range of physical activity and sporting opportunities are provided that are relevant to young people today and reflect their choices and needs.

Recognition of the obesity epidemic through the establishment of a cross government Obesity PSA has been a very important step. However, the evidence base of what interventions, both nutrition and activity based, have an impact for the under 11s is extremely sparse. Further investment needs to be made to test out and evaluate creative approaches to inform effective delivery. It is important not to delay action because of a lack of evidence especially given the tight deadline of 2010. However, nutrition and activity colleagues are beginning to work together for the first time and we welcome the opportunity to work with new partners to find innovative solutions.

Greater attention needs to be given to preschool and primary school children particularly through supporting parents to better understand the link between active play and a healthy lifestyle. A stronger focus needs to be placed on developing young children’s physical literacy skills from a very early age. Sport England is working with the Youth Sport Trust and other partners to take forward physical literacy work and we have commissioned Liverpool John Moores University to undertake a research and mapping exercise of current physical activity initiatives for the under 11 age group to develop future physical literacy work.

Recommendations for action:
— Re: obesity PSA—commission action research in the following areas: early year’s provision, the role of play, new approaches to delivering physical education and school and community sport.
— Explore ways of supporting parents to build activity into their childrens lives through for example the development of a resource/hand book.
— Support and resource the proposals coming out of the children’s physical literacy research and mapping exercise.

**LOCAL COMMUNITIES LEADING FOR HEALTH**

Sport England supports the recognition of the vital role that Local Authorities play in promoting health within their communities and the need for Local Authorities and Primary Care Trusts to work more closely together especially through local strategic partnerships and local area agreements. More however needs to be done to forge closer partnerships between health and sport/leisure through shared budgets and developing appropriate structures at the local level possibly through physical activity and health partnerships.

The White paper acknowledges that people face many barriers to leading active lives such as poor quality environments and access to sporting facilities. The paper however sets out few proposals for addressing these problems, which will exacerbate health inequalities for many communities.

Sport England welcomes the creation of the Physical Activity Promotion Fund (PAPF) to support the roll out of targeted evidence based community physical activity interventions. The fund will build on the emerging learning from the Local Exercise Action Pilot programme which is jointly funded with Sport England and the Countryside Agency. It is clear that a creative route for the delivery of the fund is required and that an outcome-focused approach is adopted which responds to local needs and priorities.

Primary Care Trusts are not best placed to bring together partners and lever in additional resources to make a real difference on the ground. Building on our commitment and role within the LEAP programme, Sport England would welcome the opportunity to play a key role in the management and delivery of the fund through our existing Regional Sports Boards. The membership of the RSBs reflect a broad range of stakeholders including the Regional Directors of Public Health, local authority, the voluntary and private sector players, who understand regional and local needs for the effective delivery of community based work. The Boards have a track record of leveraging additional regional and local funding and we would welcome the opportunity to discuss how together we might boost the current allocation with potential matched regional funding.

The RSBs membership, role, capacity, expertise and track record in investing in sport and physical activity interventions provides an excellent delivery model for government to consider adopting for the roll out of the Physical Activity Promotion Fund.

The development of the free swimming and PCT and sport clubs guidance is welcomed although more resources need to be earmarked to help implement the learning more widely.

**Recommendations for action:**

— Building on the Local Strategic Partnership model to develop structures to address physical activity through the creation of and strengthening of physical activity and health partnerships.

— Sport England to play a key role within the management and delivery of the Physical Activity Promotion Fund.

— More specific proposals to be developed to create safer and more activity friendly environments.

— Sport and physical activity to be a core element of the community health initiatives outline in the paper.

**HEALTH AS A WAY OF LIFE AND A HEALTH PROMOTING NHS**

Sport England welcomes the proposals to support individuals in making the right decisions for their own health through the creation of NHS health trainers. Physical activity advise and support needs to be a core element of the role. Sport England would welcome involvement in the development of core competencies framework for developing the necessary skills for health trainers. It is important for health trainers to link with existing services being provided by the sport, leisure and exercise sector who are promoting healthy lifestyles through physical activity.

**Recommendations for action:**

— SkillsActive and Skills for Health to work together to develop the skills and knowledge required by professionals promoting physical activity.
WORK AND HEALTH

The workplace offers a significant potential setting to promote healthy lifestyles as over half of the UK population are currently in employment and it is estimated that individuals may spend up to 60% of their waking hours in their place of work. Sport England supports the commitments outlined to promote the work environment as a setting for better health. We are seeking to be an exemplar employer in terms of supporting staff to be more active through for example the introduction of a healthy lifestyle benefit, workplace challenges, free pedometers being given to all staff and flexible working. We support the call for the NHS to take the lead as examples of healthy employers.

We welcome the opportunity to work with other government departments to provide advise on encouraging activity within the workplace. The intention is to test out this service in two or three key departments this year, potentially starting and leading with the Department of Health The resource implications of providing a free consultancy service needs further consideration and we call on DH to provide some financial support towards the delivery of this service.

We are working with the British Heart Foundation, Department of Health and Business in the Community to create the evidence base on promoting health and well being through the workplace. An applied research programme called “Workplace Health” is being developed. Nine regional pilots will be established during 2005 to test the effectiveness of health promoting interventions in the workplace relating to physical activity and other lifestyle behaviours such as diet and smoking.

We support the development of healthy business assessments to be incorporated into the IIP standard to highlight to employers and employees the benefits of investing health and well being of staff. We encourage the Department to learn from the experience of the Yorkshire region who are looking to test out the development of a new work life balanced module to be incorporated into IIP.

Recommendations for action:

— Department of Health to lead by example as a healthy employer by taking advantage of Sport England’s consultancy service.
— DH to support the testing out of a new physical activity/work life balance module to be included into the IIP standard across the Yorkshire region.

DO THE NECESSARY PUBLIC HEALTH INFRASTRUCTURE AND MECHANISMS EXIST TO ENSURE THAT PROPOSALS WILL BE IMPLEMENTED AND GOALS ACHIEVED?

Sport England believes that key to the realisation of many of the commitments in the White paper is to radically review the way that public health is planned and delivered and to consider how best to capitalise on sport’s contribution to improving public health. It is crucial that an outcome-focused approach is adopted, allowing local determination of priorities, which reflect regional and local needs, capacity and resources.

A key requirement for the delivery of the national framework is the need for the Department of Health to demonstrate commitment and leadership, working more effectively across government with a strong focus on prevention. DH needs to clarify the role of the Activity Coordination Team (ACT) and take the lead in coordinating the departments who share responsibility for physical activity. We recommend that the core membership of ACT should be rationalised to key delivery departments and agencies, with other bodies brought in at appropriate times for specific areas of work.

It is vital that regional delivery is supported and the commitment to create a regional physical activity post in each region is welcomed. We would recommend from our own experience in establishing a strong and vibrant regional structure that the approach adopted is not overly prescriptive.

Much greater coordination and support for physical activity initiatives is required at the local level. PCTs should be given sufficient capacity to enable them to effectively adopt a lead role in driving the local physical activity agenda, potentially linked to Local Strategic Partnerships, as they need to work in conjunction with delivery agents such as local authorities, sport and leisure providers, social services, transport, environment and education etc. The introduction of Local Area Agreements offers significant opportunities for PCTs councils and other partners to address improvements in the health of their communities.

Developing a local infrastructure that engages all relevant partners and works in a joined-up way to support the delivery of physical activity is likely to lead to the establishment of local physical activity and health partnerships. There is a strong case for linking these partnerships to Local Strategic Partnerships and strengthening the role of LSPs. LSPs should be seeking pooled budgets and joint commissioning for public health issues such as physical activity. Delivery could then be co-ordinated through LSPs having structures that address individual areas such as physical activity.

More needs to be done to incentivise joined up working at a local level by including physical activity in appropriate performance assessment mechanisms. Sport England has been working closely with the Audit Commission to build physical activity targets into the Local Public Service Agreements and Comprehensive
Performance Assessments for local government. We also hope to co-operate with the Department of Health and the Healthcare Commission to develop physical activity criteria on which PCTs could be performance managed.

Recommendations for action:

— Reduce the membership of ACT to the key delivery departments and agencies.
— LSPs to develop structures to address physical activity possibly through physical activity and health partnerships.
— Additional resources to be deployed to ensure that physical activity levels can be measured at a PCT and local authority level to enable impact assessment.
— Develop physical activity criteria against which PCTs can be performance managed.

January 2005

Memorandum by the Health Development Agency (HDA) (WP 35)

1. Summary of the Evidence

1.1 This memorandum presents the views of the Health Development Agency (HDA) on the issues raised by the terms of reference of the Health Committee's inquiry. We look at the Government’s public health goals in light of the new white paper, Choosing Health—Making healthy choices easier, and discuss the difficulty of assessing the likely impact of the complex and ambitious programme it proposes. We then consider appropriateness, effectiveness and value for money in relation first to proposals on specific interventions and second to proposals on the public health infrastructure. We use the recommendations of the Wanless review and the HDA's recommendations to the consultation on the white paper as assessment criteria. The key points from our memorandum are as follows

1.2 The white paper proposals should be seen in the context of targets for other government departments that contribute to public health goals, particularly the sub-set of public service agreements (PSAs) defined as “floor targets” for neighbourhood renewal and social inclusion. It is welcome that PSAs for the Department of Health and the rest of government increasingly contain an inequalities dimension.

1.3 There are around 170 commitments in the white paper, including a large number of initiatives which pre-date it. This makes it difficult to assess the plausibility of this complex and ambitious programme, particularly in the absence of important evidence—the white paper delivery plan.

1.4 With certain caveats, we regard the white paper proposals as an appropriate response to the Wanless review. They represent an evidence-informed approach, which is likely to be effective if vigorously and efficiently implemented, and so should help reduce certain demands on the NHS.

1.5 The proposals on smoking, obesity, diet and nutrition, exercise, sensible drinking, sexual health, mental health—the white paper’s overarching priorities—are informed by evidence. Crosscutting proposals on, for example, action in settings such as schools, enhancing services for children and families, an integrated approach to social marketing of health, and re-orientating the NHS towards prevention should help in implementing these priorities.

1.6 The creation of the National Institute for Health and Clinical Evidence (NICE) will speed up the flow of evidence on the cost-effectiveness of specific public health interventions.

1.7 The white paper delivery plan should include the development of a macro-level framework, building on the Wanless model, for assessing progress towards full engagement and testing assumptions about the impact of the white paper as a whole on health spending, using as it does so the evidence of NICE and others.

1.8 Broadly, the white paper responds in some degree to all of Wanless’s concerns about the public health infrastructure, particularly those to do with evidence gaps, promoting local partnerships, workforce capacity and capability, and the theme of individual engagement in health. It also gives a high priority to tackling obesity, a particular Wanless concern.

1.9 The white paper demonstrates a continuing commitment to tackling health inequalities, particularly in its concern that disadvantaged groups should be supported in making healthy lifestyle choices. However, it is essential that the social distribution of the impact of both national campaigns and local programmes—such as personal health trainers—is carefully monitored so that they can be modified if they are not reaching disadvantaged groups.

1.10 The proposal to include health in regulatory impact assessment would be strengthened if the distribution of health costs and benefits across the socio-economic spectrum were included in the analysis.
1.11 Neither the new NHS standards and planning framework nor PSAs of other government departments contain targets that adequately reflect the white paper priorities on diet and nutrition, physical activity, alcohol, and sexual health. It is essential that the promised six-monthly progress reports include timely data on indicators concerned with these priorities.

1.12 The annual Chief Executive’s report to the NHS should report on progress on the NHS as a good corporate citizen and as a healthy workplace, subjects it has not so far covered.

2. ABOUT THE HDA

2.1 The Health Development Agency (HDA) is the national authority on what works to improve people’s health and to reduce health inequalities. We work in partnership across sectors to support informed decision making at all levels and the development of effective practice.

2.2 The HDA came into being in 2000 to support the aim of the white paper, *Saving Lives. Our Healthier Nation*, of improving the health of everyone, particularly the worst off, taking into account the social, economic and environmental factors affecting health (Department of Health 1999). The HDA’s role is to:

- gather evidence of what works;
- advise on good practice;
- support all those working to improve the public’s health.

2.3 The recent public health white paper, *Choosing Health—Making healthy choices easier*, announced that the functions of the HDA would be transferred to the National Institute for Clinical Excellence (NICE) to form a new body with a wider focus on both care and health—the National Institute for Health and Clinical Excellence—within which there would be a Centre for Public Health Excellence.

3. WILL THE WHITE PAPER PROPOSALS ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS?

3.1 Broadly, the Government’s public health goals are to improve the health of the population and reduce health inequalities. The white paper *Saving Lives—Our Healthier Nation* (Department of Health 1999) set national targets for cancer, coronary heart disease, accidents and mental health. The *NHS Plan* (Department of Health 2000) announced that there would be national health inequalities targets. These were specified in *Tackling Health Inequalities—A programme for action* (Department of Health 2003). The current expression of these priorities and targets for the Department of Health and the NHS is the standards and planning framework for the period 2005–06—2007–08, *National Standards, Local Action* (Department of Health 2004a), which exactly reflects the Department of Health’s public service agreement (PSA) from the 2004 round of the spending review (HM Treasury 2004).

3.2 The white paper proposals should be seen in the context of targets for other government departments that contribute to public health goals, particularly the sub-set of PSAs defined as “floor targets” for neighbourhood renewal and social inclusion, which deal with broader determinants of health. It’s noteworthy, and welcome, that PSAs for the Department of Health and the rest of government increasingly contain an inequalities dimension. For example, the targets for reducing mortality rates from heart disease and stroke and from cancer in the Department of Health’s PSA require not just progress for the population as a whole but also a reduction in the inequalities gap between the most deprived areas and the population as a whole (Department of Health 2004a). Similarly, “floor targets” on education, housing, worklessness, crime, and liveability now more explicitly require a narrowing of the gap in outcomes between the most deprived neighbourhoods and the rest of the country (Office of the Deputy Prime Minister 2004).

3.3 The white paper proposals are underpinned by the following principles:

- **Informed choice:** people should be supported in making healthier choices for themselves, though their health should be protected from the actions of others, and the particular needs of the young should be recognised.

- **Personalisation:** support has to be tailored to the “realities of individual lives” in order to be effective in tackling health inequalities.

- **Working together:** partnerships in communities must complement the actions of government and individuals.

3.4 More specifically, the proposals focus on certain overarching priorities. These are expressed as follows in the executive summary of the white paper (though not so explicitly in the white paper itself):

- Reducing the number of people who smoke.
- Reducing obesity and improving diet and nutrition.
- Increasing exercise.
- Encouraging and supporting sensible drinking.
- Improving sexual health.
- Improving mental health. (HM Government and Department of Health 2004).
3.5 There are around 170 commitments in the white paper, many of which are multi-faceted. Furthermore, they include a large number of initiatives, particularly from other government departments, which pre-date the white paper—for example, the chapter on "Children and Young People—starting on the right path" draws heavily on the recently announced children’s NSF, and NHS performance management arrangements were published in July 2004. It is proper that the white paper should bring together, give coherence, and, in many instances, propose enhancements to existing initiatives. However, the problem of deciding what is in the white paper box and what in some other policy box adds further to the difficulty of assessing the plausibility of a complex and ambitious programme, particularly in the absence of important evidence—namely the white paper delivery plan, due in February. The quality of this plan will be an important success factor.

3.6 The white paper was in large part a response to the Wanless report’s analysis of what would be required to attain the “fully engaged scenario” of high NHS productivity and high levels of individual involvement in health (Wanless et al 2004). In the following section we therefore treat the Wanless recommendations as criteria for considering the plausibility of the white paper’s proposals. We also relate the proposals to the recommendations in the HDA’s submission to the consultation on the white paper (HDA 2004), which themselves built on recommendations to the Wanless review (HDA 2003).

3.7 The HDA’s overall view is that, with certain caveats, the white paper proposals are an appropriate response to Wanless, and that they represent an evidence-informed approach, which is likely to be effective if vigorously and efficiently implemented, and so should help reduce certain demands on the NHS.

4. ARE THE WHITE PAPER PROPOSALS APPROPRIATE, WILL THEY BE EFFECTIVE AND DO THEY REPRESENT VALUE FOR MONEY?

4.1 Appropriateness, effectiveness and value for money are inter-related. In this section we discuss whether the specific health interventions proposed in the white paper are appropriate and likely to achieve their intended aims and be value for money. In the next section we consider whether proposals are relevant to acknowledged deficiencies in the public health infrastructure or delivery system.

4.2 We have assumed that the more a proposed intervention is informed by evidence, the more likely it is to be effective. As noted above, the white paper proposes a complex array of often inter-connected interventions, which makes assessment of the extent of support provided by evidence more difficult. In addition, Wanless rightly supported innovative approaches so long as they were properly evaluated. Almost by definition, such approaches will be less evidence-based, or less likely to be based on the most scientifically rigorous evidence.

4.3 Below, we comment on whether proposals relating to the white paper’s overarching priorities are evidence-based by reference to the interventions recommended in the HDA’s consultation response (HDA 2004)—see Annex 2. We assume effective implementation through the delivery plan.

4.4 Smoking: We consider that the various proposals on reducing smoking are informed by evidence and add up to a comprehensive approach, though attention should be paid to the issue of effective targeting of the more disadvantaged sections of the community. The issue of the rate of progress in banning smoking in workplaces has been much debated; the white paper is pointing the right direction.

4.5 Obesity, diet and nutrition: We consider that the proposals on obesity, diet and nutrition, which include those on physical activity, are generally informed by evidence and are comprehensive. We welcome the proposal to develop a “care pathway” for obesity and the acknowledgement of work by NICE and the HDA. However, we are concerned that there may be some duplication of effort, as clarification of the obesity care pathway is one of the expected outcomes of the NICE/HDA work.

4.6 Exercise/physical activity: The HDA recommendations put a more specific emphasis than the white paper on the importance of walking: interventions that encourage walking and do not require attendance at a facility are the most likely to lead to sustainable increases in overall physical activity. However, we welcome proposals to improve green and public spaces, thereby creating safe walking environments, and to achieve shifts in transport mode, including to walking. The evidence, including that from HDA-supported work with older people by the Healthy Communities Collaborative, suggests that roles such as health trainers could be important in promoting physical activity. It also suggests that self-monitoring is an attribute of effective interventions, something which the distribution of pedometers could support.

4.7 Sensible drinking: The evidence supports the proposals on brief interventions, although the HDA recommended that brief interventions in primary care should recur as part of routine clinical management of patients—particularly women—who are reducing their alcohol intake. The HDA also recommended that, intensive, high quality training for people serving alcohol should be developed, in partnership with the alcohol industry and local authorities. This was not picked up in the white paper, though it is relevant to the problem of binge drinking and thus to the very recent proposals on responsible drinking (Home Office 2005). We hope it becomes part of government discussions with the industry.
4.8 Sexual health: We welcome the proposals on funding and service modernisation to tackle the high rate of STIs as an important step towards the provision of effective services. The aims should be to create an integrated approach to the prevention of STIs in which interventions are tailored and targeted to specific groups, delivered by specialist services, and emphasise training in personal skills. The evidence supports the proposals to make sexual health services, including information, more accessible to young people.

4.9 Mental health: Many of the proposals could be expected to contribute to improved mental health, whether support services for parents and families, action in schools through the Healthy Schools programme, local community programmes aimed at creating a less stressful physical and social environment, and programmes to improve the physical health of people with poor mental health.

4.10 There are crosscutting proposals in the white paper which should be important in implementing work on these priorities—for example, those that:

— emphasise the importance of action in settings, particularly schools and the workplace, including NHS workplaces. Such action is well supported by the evidence.
— enhance services for children and families reflect evidence findings about the importance of interventions at this early stage of the life course.
— create an integrated approach to the social marketing of health in relation to all the overarching priorities, including the provision of accessible, personalised information and other services to those newly motivated to choose a healthier lifestyle.
— reorientate the NHS towards prevention, including a comprehensive and integrated prevention framework across all the NSFs.

4.11 The Wanless review presented a strong economic case for the fully engaged scenario. The white paper recognises and proposes solutions to the problem of lack of evidence about cost-effectiveness. Highly significant among these solutions is the creation of the National Institute for Health and Clinical Excellence. NICE will speed up the flow of evidence on the cost-effectiveness of specific public health interventions. However, there also needs to be a macro-level framework, building on the Wanless model, for assessing progress towards full engagement and testing assumptions about the impact of the white paper as a whole on health spending, using as it does so the evidence of NICE and others. The development of such a framework should be part of the white paper delivery plan.

5. Do the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure that Proposals will be Implemented and Goals Achieved?

5.1 The Wanless review highlighted many deficiencies in the public health infrastructure and made numerous recommendations under the following headings: delivery of public health; case studies of the most important public health issues; public health evidence; investing in public health; roles and responsibilities; and government levers.

5.2 The white paper itself identifies the main areas of this infrastructure or delivery system as:

— evidence and information;
— workforce capacity and capability;
— systems for local delivery;
— the accountabilities of the Department of Health and the rest of central government.

5.3 The table in Annex 1 lists examples of proposals that relate to key Wanless recommendations. Broadly, we consider that the white paper responds in some degree to all of Wanless’s concerns, particularly those to do with evidence gaps, promoting local partnerships, workforce capacity and capability, and the theme of individual engagement in health. It also gives a high priority to tackling obesity, a particular Wanless concern.

5.4 On the central Wanless theme of engagement, the consultation on the white paper was itself noteworthy in stimulating a high level of public interest. The Department of Health is to be commended for its efforts to encourage comment. The proposals on “Health in the consumer society” (chapter 2) seem to be a more than adequate response to the Wanless recommendations, setting out as they do a social marketing strategy for health that seeks to integrate efforts to:

— Stimulate demand—for example, through national campaigns on sexual health, obesity, smoking and alcohol that provide clear messages and are sensitive to the way people live their lives.
— Provide trustworthy, accessible information, whether on products, such as food and tobacco and alcohol products, or through new national and local information services—for example, Health Direct.
— Put in place local supply of the healthy option—supportive and personalised local services (such as NHS health trainers) or easily accessible healthier products.
— Ensure a local environment that makes healthy choices easier—for example, healthy schools and well-ordered and stable communities where there is good access to services, clear leadership, social cohesion, and partnerships among local government, the NHS, the voluntary sector, community organisations and business.

5.5 In its response to the white paper consultation (see Annex 2) the HDA was particularly concerned that the white paper should:

— maintain the momentum created by the programme for action on health inequalities (Department of Health 2003);
— take a “social gradient” approach to tackling health inequalities—by ensuring that interventions were directed at people below the middle of the socio-economic spectrum as well as the most socially disadvantaged;
— recognise that interventions—including those aimed at enhancing public engagement—needed to be targeted and tailored if they were to be effective in meeting the needs of the most disadvantaged segments of the population;
— recognise that policies aimed at influencing the underlying determinants—including existing policies—should be screened for their impact on health inequalities.

5.6 We consider that the white paper demonstrates a continuing commitment to tackling health inequalities, particularly in its concern that disadvantaged groups should be supported in making healthy lifestyle choices. We welcome the fact that local information and personal support services are to be tailored to meet varying needs and that new or enhanced services, such as Skilled for Health programmes, NHS health trainers, personal health guides, and “choose and book” Stop Smoking Services, are to be rolled out in the most disadvantaged areas first—specifically, the “spearhead group” of local authorities and PCTs (Department of Health 2004b). We welcome also the recognition that the national social marketing strategy should use a variety of routes to reach its target audiences and frame its messages to speak to its audiences’ health concerns.

5.7 These provide safeguards against the risk that the social marketing strategy could widen health inequalities by stimulating a stronger demand for healthy choices among the better off than among those at the lower end of the socio-economic spectrum. Nonetheless, it is essential that the social distribution of the impact of national campaigns is carefully monitored so that they can be modified if they are missing their targets. Similarly, evaluations of new interventions—such as NHS health trainers—should focus on effective practice in reaching the most disadvantaged groups, something that is not automatically guaranteed by rolling them out first in the most deprived areas. At the same time, PCTs will want to use health equity audit techniques to check that disadvantaged groups are benefiting from all programmes, including the services of a “health-promoting NHS” (chapter 6).

5.8 The white paper commitment to build health into all future legislation by including health in regulatory impact assessment appears to relate to the HDA’s recommendation on the need to screen policies for their impact on health inequalities (and the similar recommendation in the Wanless report). We assume that the intention is to factor health costs and benefits into options appraisals in the development of new policies. We suggest that this proposal would be strengthened if the distribution of health costs and benefits across the socio-economic spectrum were included in the analysis.

5.9 The HDA was also concerned about the lack of a coherent approach to performance managing action on public health, so we welcome the proposals on strengthening and co-ordinating the components of the performance management system—ie incentives (including targets), standards, developmental support, performance monitoring, and regulation—and on aligning the performance management systems of the NHS and local government so as to enable closer partnership working locally. For example, it will be important that the public health guidance issued by NICE is given the same status, by ministers, as its current clinical practice guidance, and that the same effort is put into monitoring its implementation, by the Healthcare Commission, in the NHS and by the Audit Commission in local authorities.

5.10 With regard to incentives, we particularly welcome the introduction of an inequalities dimension into most of the Department of Health’s PSA targets, and thus into the standards and planning framework for the next three years, and the greater emphasis than before on narrowing the gap in outcomes in floor targets for other government departments (Office of the Deputy Prime Minister 2004).
5.11 Targets are an effective way of getting services to take priorities seriously (see, for example, Audit Commission 2003). Yet neither the new NHS standards and planning framework nor PSAs of other government departments contain targets that adequately reflect the white paper priorities on diet and nutrition, physical activity, alcohol, and sexual health:

— There are shared PSA targets on sport in schools and in the community, but sport can only make a relatively small contribution to levels of physical activity in the population.

— Physical activity and diet are such important risk factors for a range of health outcomes that they need to be monitored independently of the shared PSA target on obesity.

— There is a target for teenage conceptions but not sexually transmitted infections (STIs).

5.12 This is why it is important that the six-monthly progress reports promised in the white paper on key indicators for targets that relate directly to improving health include timely data on indicators concerned with diet and nutrition, physical activity, alcohol, and STIs. There are a number of relevant sources of data, such as the Health Survey for England, the Transport Trends survey, the National Diet and Nutrition Survey, and the routine statistics on STIs collected by the Health Protection Agency. We would expect the use and, where necessary, enhancement of surveys such as these to be considered as part of the white paper delivery plan.

5.13 We welcome the new Health Poverty Index visualisation tool, which, among other things, gives PCTs and their local authority partners baseline data on diet, physical activity and alcohol for their area (see www.hpi.org.uk). It should support them in setting targets for action on these topics and may counteract tendencies, which the new standards and planning framework does not discourage, to concentrate on what they imagine to be the quicker wins of the treatment and secondary prevention options rather than primary prevention approaches.

5.14 The remaining HDA recommendations called for a national workforce development strategy, national leadership on making the NHS a “good corporate citizen”, the NHS to become an exemplary “healthy workplace”; and action to make the NHS smoke-free. The white paper meets all these recommendations. The inclusion of good corporate citizenship and the NHS as a healthy workplace among the themes that the Healthcare Commission proposes to cover in assessing healthcare organisations’ compliance with standards is a very welcome prompt to action by the NHS (Healthcare Commission 2004). The Healthcare Commission can maintain a national overview of these themes by periodically examining them in its annual State of Healthcare Report. The HDA also recommended that the annual Chief Executive’s report to the NHS should report on progress on these themes—they have not so far been covered.

January 2005

REFERENCES


Office of the Deputy Prime Minister (2004). Briefing note on changes to PSA1 and floor targets as a result of the Spending Review 2004 (SR04).

## Annex 1

### White Paper proposals and the recommendations in the Wanless Report

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## Annex 2

### HDA recommendations to the consultation on the White Paper

1. The HDA recommends almost 70 interventions in the areas of alcohol misuse, tobacco, accidental injury, mental health, obesity and nutrition, physical activity, drug misuse, sexual health, children and young people, housing, and working with communities.

2. There should be a “social gradient approach” to tackling health inequalities, which means focusing interventions on those below the middle of the socio-economic spectrum, as well as on the most socially disadvantaged.

3. The recommended interventions need to be targeted and tailored if they are to be effective with different segments of the population and to avoid the risk of making the gradient in inequalities steeper.
4. To tackle the social gradient in inequalities, policymakers must consider the social distribution of health determinants. The impact of new policies can be blunted by the effects of existing policies. The HDA recommends that existing policies should be screened to establish whether they are impeding progress on tackling health inequalities.

5. Initiatives aimed at enhancing public engagement will have to be highly differentiated and tailored to the sensitivities of particular population groups. The HDA recommends a strategic approach, which includes supporting public demand through measure to raise levels of “health literacy”.

6. National priorities and targets, standards, support mechanisms for practice and organisational development, monitoring arrangements, and inspection and regulation have to be coordinated so that they strengthen the public health delivery chain.

7. There must be a national public health workforce strategy to deal with the lack of public health capacity and capability, both within the NHS and in the wider public health workforce.

8. There must be stronger national leadership on making the NHS a good corporate citizen—good corporate citizenship should be a priority in the new NHS priorities and planning framework, and there should be inspection by the Healthcare Commission, performance monitoring by strategic health authorities, and annual reporting by the NHS Chief Executive.

9. NHS organisations must set an example to other sectors as healthy workplaces. As with good corporate citizenship, performance management mechanisms must be applied.

10. NHS organisations should be required to set targets for becoming smoke free.

Memorandum by Smoking Control Network (WP 36)

The Smoking Control Network

The Smoking Control Network is a collaboration of leading British health charities and commercial and professional organisations, which work together to reduce the deaths and disability caused by smoking related diseases.

The Smoking Control Network’s voluntary and professional members comprise: Asthma UK, British Heart Foundation, British Lung Foundation, British Vascular Foundation, Cancer Research UK, Diabetes UK, QUIT, the Roy Castle Lung Cancer Foundation, The Stroke Association, Royal College of Midwives, Royal College of Nursing and No Smoking Day. ASH is an observer. The administration of the Network is supported by an educational grant from GlaxoSmithKline Consumer Healthcare.

Will the Proposals enable the Government to achieve its Public Health Goals?

1. The Smoking Control Network warmly welcomes the Public Health White Paper’s proposals for tobacco control. In particular, we welcome the Government’s intentions contained in paragraph 76 that “All enclosed public places and workplaces . . . will be smoke free”.

2. We regret, however, that the Government then undermines this principle with exemptions for licensed premises which do not prepare or serve food and private members’ clubs.

Are the proposals appropriate, will they be effective and do they represent value for money?

3. The report from the Government’s own Scientific Committee on Tobacco & Health (SCOTH), published with the White Paper, concluded that:

   “knowledge of the hazardous nature of secondhand smoke (SHS) has consolidated over the last five years, and this evidence strengthens earlier estimates of the size of the health risks. This is a controllable and preventable form of indoor air pollution. It is evident that no infant, child or adult should be exposed to SHS. This update confirms that SHS represent a substantial public health hazard.”

4. In the light of the above conclusion, we ask the Committee to press the Health Secretary to explain:

5. Why is it acceptable to expose any worker anywhere—including in a bar or club—whether or not it serves food—to the health risks from secondhand smoke?

6. What definitions will the Government propose to distinguish between “pubs and bars preparing and serving food”—which will be smoke-free—and those which do not?

7. How will this distinction be measured and what procedures will be needed to implement this exemption and at what cost?

8. What will be the impact of such a discrepancy of provision on health inequalities—when it is likely that the majority of non-food pubs will be located in some of the most disadvantaged wards in the country?
9. How can the Government claim that “smoking in the bar area is prohibited everywhere”, when it is an established fact that smoke drifts between smoking and non-smoking areas and even the best ventilation systems do not protect non-smokers from the health risks of other people’s smoke?

Public Health Infrastructure for the Proposals to be implemented and goals achieved

10. Why are the Government’s proposals for England so modest, compared to the more comprehensive protection from secondhand smoke for workers being offered in Scotland and which the Government appears to be allowing for Wales and Northern Ireland?

11. The Smoking Control Network congratulates the Scottish Executive on the proposals for smokefree workplaces contained in its Smoking, Health and Social Care (Scotland) Bill and looks forward to its enactment and implementation by 2006.

12. The Network is backing Julie Morgan MP’s Smoking in Public Places (Wales) Bill to enable the National Assembly for Wales to prohibit or restrict the smoking of tobacco products by any person in a public place in Wales.

13. Network Members also support the Private Bills being brought by Liverpool and London. We look forward to a constructive debate at Second Reading in the House of Lords of the Liverpool City Council (Prohibition of Smoking in Places of Work) Bill and the London Local Authorities (Prohibition of Smoking in Places of Work) Bill. We urge the Government not to hinder the progression of these Bills through to full scrutiny at Committee stage.

14. The Smoking Control Network regrets that the Government has not had the confidence to propose a comprehensive ban on all smoking in the workplace, as has been introduced with such success in Ireland.

Recommendations for Action:

15. The Smoking Control Network urges the Government to reconsider its plans and to make a commitment in the first Queen’s Speech after the anticipated General Election to legislate to prohibit smoking in all enclosed workplaces.

January 2005

Memorandum from the Soil Association (WP 37)

SUMMARY AND RECOMMENDATIONS

1. The Soil Association’s Food for Life report and action pack, published in 2003, launched the recent public debate on the need to improve school meals. Through our Food for Life programme the Soil Association has worked on changing national policy so that the Government provides a more supportive framework for school meal providers. The Food for Life programme also delivers: practical work with schools to get unprocessed, local and organic meals served in schools; education work to reconnect pupils to food and where it comes from; and work on menus to meet the Caroline Walker Trust guidelines for nutrition. To date, the Soil Association is working directly with five local authorities and 150 schools in England and Wales to implement these changes. We are also working closely with the “Hungry for Success” programme in Scotland.

2. School meals are the one area where Government has the opportunity and responsibility to determine children’s diets. We know that eating patterns formed in childhood have a long-term impact on adult diets and ultimately public health. Our work and the work of others such as the Food Standards Agency has shown that school meals are all too often too high in fat, sugar and salt and low in essential nutrients. We welcome the Government’s announcements in the White Paper on school meals. However, we are concerned about the contradictory statements made in the White Paper on the introduction on nutrient-based standards (in different places the Government say they “will” or will “strongly consider” introducing nutrient-based standards). It is essential that nutrient-based standards are introduced in order to guarantee that children get the essential nutrients they need and don’t consume a diet too high in fat, sugar and salt.

3. We recommend that the Health Committee calls on the Government:
   — to introduce nutrient-based standards for primary and secondary schools as a matter of priority; and
   — to make available sufficient funds to fund an improvement in the quality of ingredients, adequate staffing and staff training, and in some cases, the re-equipment of school kitchens.
The Soil Association and organic food and farming

4. The Soil Association is the main organisation of the organic movement in the UK, and also the main Government-approved certifier for the UK organic sector, certifying 70% of the organic food sold in the UK. Our responsibility for organic farming and food is evident throughout the entire food chain, from consumers, retailers, processors and wholesalers, to producers, researchers and policy makers. Membership of the Soil Association charity (over 25,000) includes members from every link in the chain and we represent them all in working to develop the organic sector.

5. The objectives of organic farming are the sustainable management of soil and the natural production of healthy crops with high nutrient levels, to produce healthy livestock, and healthy food for humans. This is achieved through good soil management focussing on the maintenance of soil organic matter levels and soil biological activity.

6. We hope that over time all farming and food will switch to modern organic methods. This is currently the only system that could in future allow us to feed ourselves sustainably, without depleting non-renewable resources like soil, fresh water and carbon. Certified organic farming accounts for about 4% of UK farmland. The market for organic food is worth over £1 billion, and is growing at 10% per annum. UK organic farmland is supplying about 45% of this and the rest supplied by imports. The Government’s target is for 70% of the organic market to be sourced from UK farmers by 2010. Local and direct organic sales (through farm shops, box schemes and farmers’ markets, and to local schools, pubs and restaurants) are growing at 16% per annum. An increase in the area of organic farming is one of the Government’s “quality of life” indicators. The DEFRA action plan for organic farming, adopted in 2002, and updated in 2004, supports the development of the sector.

7. In the EU, 13% of Austria’s farmland is organic, with market growth running at 11%, and Germany’s annual market for organic food is twice the UK’s, at £2.1 billion. The world-wide market for organic food is worth £15 billion; the US market (the largest in the world) has grown at between 17 and 22% in recent years, compared to just 2 to 3% growth in non-organic food, and is expected to be worth $32.3 billion by 2009.

8. DEFRA, English Nature, the Royal Society for the Protection of Birds and others have published peer-reviewed papers setting out in detail the sustainability and biodiversity benefits of organic farming. The Food Standards Agency have said that consumers wishing to avoid pesticide residues in food or to buy sustainable food can buy organic, and English Nature wants to see more organic farming because there is more wildlife on organic farms. There is good evidence that organic farming conserves rather than depletes soils (as is the case with some non-organic farming). The Government accepts the sustainability, biodiversity and animal welfare benefits of organic farming, and the Government’s policy on sustainable public procurement includes encouraging the purchase of organic food for those reasons.

Whether the proposals will enable the Government to achieve its public health goals

9. School meals is the one area where the Government is responsible for what the most vulnerable group, young children, eat. It is an area where the state has to, and does, act as “nanny”, as children in school, and especially in primary schools, are effectively in the care of the Department of Education and Skills, and the standards determining what they get to eat are set by DfES. Eating habits formed in primary schools will either reinforce healthy eating, or set a pattern which children will take with them to secondary schools, and maybe for the rest of their lives. Of all the areas where the Government can take action to improve the nation’s diet and health, reforming school meals is the key. This is the only time that Government action will definitely change the diets of children in an effective way.

10. The Department of Health’s (DH) Consultative Document, “Choosing Health? Choosing a Better Diet”, states that: “Action in schools can impact on key health outcomes”, and notes that effective “school-based interventions to reduce obesity and overweight in schoolchildren, particularly girls” include “the modification of school meals and tuckshops”.

11. With the move for schools to open between 8 am and 6 pm food provision in schools will becomes even more relevant to child health as increasing number of children will eat breakfast, lunch and an early evening snack in the Government’s care.

12. The Soil Association therefore warmly welcomes the Government decisions set out in the White Paper to invest over the next three years to improve nutrition in schools by:

— revising both primary and secondary school meals standards to reduce the consumption of fat, salt and sugar and to increase the consumption of fruit and vegetables and other essential nutrients;
— strongly considering the introduction of nutrient-based standards that will be taken into account in Ofsted inspections;
— subject to legislation, extending the new standards to cover food across the school day, including vending machines and tuck shops;
— providing new guidance on food procurement for heads and governors, and improving training and support for school meal providers and catering staff; and
— developing the Healthy Schools Programme to include policies on healthy and nutritious food.

13. In the 1980s nutritional standards for school meals were abolished, and the current Government eventually replaced them with guidelines which do not specify, for example, vitamin or nutrient content, or place limits on fat, sugar or salt. There are excellent nutritional standards, developed by the Caroline Walker Trust, for primary school lunches, but DfES only attaches these as guidelines to their current nutritional advice. The difference in the two sets of standards is shown in the attached illustrative menus, one that meets the Government’s current standards, the other that meets the Caroline Walker Trust standards.

January 2005

Memorandum by the Royal College of Nursing (RCN) (WP 38)

SUMMARY

— The RCN considers the measures outlined in the White Paper as insufficient to address current health inequalities. A greater focus on specifically targeted services is required as well as greater recognition of the role of the health service itself in reducing inequalities. The RCN also urges caution over the presumption that choice is a matter purely for the individual.

— For the White Paper to be successful the public need to be fully engaged in their own health. However the proposals are relatively weak on the need for public and community engagement in public health issues.

— The RCN welcomes many of the specific interventions outlined in the White Paper, but feels that there are still some areas for improvement, in particular around smoking, obesity, sexual health and school nursing.

— The White Paper has significant implications for workforce planning and underlines the need for greater investment in recruitment and retention of the nursing workforce, as well as the need for a significant change in the culture of the NHS as a whole.

1. INTRODUCTION

The nursing workforce is a key resource in the improvement of public health with nurses providing 80% of all patient care. Nurses work in a variety of settings such as schools, communities, general practice, the workplace, hospitals and care homes. Each role encompasses a health promotion aspect and for this reason maximising the contribution of nursing staff in public health will be key to ensuring the successful implementation of the public health White Paper.

With a membership of over 370,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN welcomes much of what is proposed in the public health White Paper, as it marks a turning point for health service delivery by emphasising the responsibility of local populations in health improvement. However we retain some specific concerns, which are outlined below.

2. WILL THE PROPOSALS ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS

2.1 The RCN considers the measures outlined in the public health White Paper insufficient to address the health inequalities which currently present the greatest challenge to the nation’s public health. The link between health inequalities and social inequalities is well known and accepted, with a marked difference in life expectancy and morbidity between socio-economic groups 1 and 5.79 We recognise that whilst the health service alone cannot completely ameliorate health inequalities, it can make a significant contribution to health improvement by tailoring services to those in greatest need. However the principles behind the public health White Paper need to be strengthened if the health inequality gap is to be significantly reduced. The RCN believes there are a number of ways in which this could be achieved.

2.2 Targeting the health of disadvantaged groups is key to reducing health inequalities. Doing so can both assist in equalising access to services and equalising outcomes from health care interventions. The RCN strongly believes in redesigning health services so that they focus on those most in need in order to compensate for poorer health status. However the public health White Paper places insufficient focus on the need for specifically targeted health services.

2.3 If a reduction in health inequality is to be achieved, the role of children and families will be crucial. There is evidence to suggest that early years experiences can be a protective factor against social disadvantage in later life. For example, research has demonstrated significant improvement to the birth weight of babies born to low income mothers who received tailored support from midwives during pregnancy. Clearly pregnancy and the early years are a crucial period in which attention must be paid to supporting parents to nurture the physical and emotional wellbeing of their children. Educating and investing in families is the most effective way of empowering people to take control of their own health, and both midwives and health visitors are the professionals best placed to provide such support. However there is a shortfall of midwives and health visitors across the UK and those who are practicing face workload and time pressures which means that in practice they have little time to devote to children and families for this purpose.

2.4 Whilst the RCN acknowledges that a key principle underpinning the White Paper is the enablement of individuals to take personal responsibility for their own health, we urge caution over the presumption that choice in public health is a matter simply for the individual. Adult behaviours are shaped by social and environmental circumstances as well as the individual’s will. Therefore changing health behaviour is much more than merely providing information on healthy and unhealthy lifestyles. Similarly, there needs to be a balance struck between individual choice, and action taken in the interest of the public good. The ability to express a choice may be hampered if it is to be determined that the public interest will be served by a particular course of action — eg water fluoridation.

2.5 The health service itself can make a significant contribution to reducing health inequalities as it is the largest single employer in the UK, a fact which merits greater attention. The potential impact the health service can have on improving local employment and therefore the local economy is considerable, with the subsequent knock on effect of improving health inequalities within the local population. There are serious shortages of staff in the NHS workforce, yet the local population is often not considered as a source of candidates for health service jobs. The RCN believes that the public health White Paper should emphasise investment of NHS funds in pre-employment training, “access” courses to professional education and local recruitment as a means of developing the local workforce and, in the long term, reducing health inequalities.

3. **WHETHER THE PROPOSALS ARE APPROPRIATE, WILL BE EFFECTIVE AND WHETHER THEY REPRESENT VALUE FOR MONEY**

3.1 The RCN believes that if the public are to be “fully engaged” in health matters as envisaged in the Wanless review, and if true value for money is to be achieved, the overriding aim of the White Paper should be to create a demand for health, rather than merely a demand for health care. The extent to which the public are engaged in their own health will be a measure of the effectiveness of the proposals in the White Paper. Yet it is relatively weak on the need for public and community engagement in public health issues, even though evidence suggests that community participation which focuses on building social cohesion can impact on health outcomes.

3.2 Whilst the RCN welcomes many of the proposals set out in the White Paper there are a number of specific areas of intervention outlined which need to be strengthened:

3.3 **Smoking**

Whilst the RCN warmly welcomes the measures on smoking cessation, we feel the proposal to exempt some licensed hosteries from a ban on smoking does not go far enough. The RCN believes that a ban on smoking in all enclosed places should be introduced. Nurses see the devastating effects of smoking on patients every day. At RCN Congress in May 2004, RCN members voted in favour of a resolution to campaign for a ban on smoking in public places. We believe that only a complete ban will help to protect people from second-hand smoke, encourage people to give up and ultimately act as a deterrent.

Towards this objective, the RCN is working with the Department of Health on a campaign targeting nurses who want to give up smoking. The RCN firmly believes the health of the nursing workforce is of paramount importance, and staff will be provided with support and guidance in smoking cessation as part of the Government objective of a smoke free NHS.

3.4 **Obesity and Diet**

Whilst the RCN welcomes the “Healthy Start” proposal to provide vouchers to be exchanged for fresh fruit and vegetables, the RCN believes that there is a need for stronger measures to ensure school meals are nutritious and healthy. This is a particular concern given the dependence of a substantial number of children on these as their main meal of the day. The White Paper outlines that the Government will consider introducing nutrient based standards for school meals and vending machines. However the RCN recommends that this should be a concrete commitment to ensure food provided in schools is as healthy as possible.

3.5 Sexual Health

The RCN welcomes the proposed national roll out of clamydia screening by 2007, however we feel strongly that new and imaginative ways of working need to be found in order to ensure this can be achieved. Similarly, the proposal to reduce waiting times for both clinic appointments for sexually transmitted infections to 48 hours, and termination of pregnancy before 10 weeks gestation is a positive development. However measures need to be put in place to ensure this can be implemented. Current specialized sexual health services are stretched to the limit, but primary care services are ideally placed to work in partnership with them to reach these targets.

However education in sexual health at pre-registration level in both medicine and nursing is insufficient and needs to be increased. Improving skills in sexual health for current and future practitioners is a priority so that primary care services and general practices within them are fully equipped to offer a full range of sexual health services. The RCN therefore recommends that funding for sexual health treatment and promotion services should be ring fenced rather than, as is often the case, diverted to other services within a Primary Care Trust.

3.6 School Nursing

The RCN warmly welcomes the target set in the White Paper for one full time school nurse within one secondary school and the associated cluster of primary schools by 2010. The role of the school nurse is integral to the health and well being of children, fulfilling functions such as immunisation, providing health education, tackling bullying and promoting children's emotional wellbeing. However there is currently a shortfall in the number of school nurses and wider problems about recruitment and retention of the nursing workforce generally. The RCN's most recent labour market review, Fragile Future revealed that more than a quarter of the profession are now over 50 and there is an increasing reliance on bank and agency nurses. The RCN believe the proposal outlined in the White Paper should be accompanied by a recruitment campaign to highlight school nursing as a career option.

In addition we are also aware of significant problems in access to specialist school nurse post registration education courses, as some higher education institutions no longer run these. In light of this we feel it would be appropriate for the Department to undertake specific workforce planning around the school nursing workforce to identify future projections of staff numbers and the level of need for training.

4. WHETHER THE NECESSARY PUBLIC HEALTH INFRASTRUCTURE AND MECHANISMS EXIST TO ENSURE THAT PROPOSALS WILL BE IMPLEMENTED AND GOALS ACHIEVED

4.1 Given the prevalence of the role of nursing in public health at all levels, the White Paper has significant implications for workforce planning. Community nurses, health visitors and midwives already undertake a substantial proportion of face to face contact with patients and communities, and have the potential to contribute further to make a real impact on public health. However workload pressures and time constraints prevent this. If the White Paper is to be implemented successfully investment in recruitment and retention of the nursing workforce is crucial.

4.2 The proposals outlined in the White Paper also have significant implications for the working culture of the NHS as a whole. As outlined in the RCN’s response to the Health Select Committee's inquiry into public health in 2000, a notable cultural shift is required if improvements in public health are to be achieved. The culture of the NHS does not lend itself well to broader public health. This is largely because the core business of the NHS is seen by both the professionals who work within it, and by the public, to be about delivering services to care for or cure individuals who are ill. The RCN believes that in order to achieve such a cultural shift, public health should be part of a whole systems approach to healthcare rather than treated in isolation. Organisational performance management is needed which integrates both planning and delivery of public health. The RCN believes that public health performance management and assessment is required in all health trusts so that public health becomes a mainstream activity alongside healthcare and treatment.

4.3 There is a pressing need to foster multi-disciplinary, multi-agency teamwork in public health. At present different agencies and disciplines meet at strategic level to consider public health issues. However there is no national mechanism to bring together those who practice in the front line of public health, and the RCN recommends that teamwork should be developed in public health practice in every locality. Doing so will ensure that public health is everyone’s business by creating an infrastructure that supports practitioners and local people working together to identify issues and seek local solutions.

January 2005

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84 RCN response to the Health Select Committee inquiry into public health, 2000.
Memorandum by SSL International plc (WP 39)

INTRODUCTION TO SSL INTERNATIONAL PLC

SSL International plc is a multinational healthcare business, manufacturing well-known brands including the world’s leading condom brand—Durex.

SSL’S RESPONSE TO POINT TWO IN THE TERMS OF REFERENCE: WHETHER THE PROPOSALS ARE APPROPRIATE, WILL BE EFFECTIVE AND WHETHER THEY REPRESENT VALUE FOR MONEY

The activity proposed in the White Paper can only be positive, though its success will depend on targeting those most “at risk” with a very direct and relevant message.

Generic media campaigns have not had the desired impact recently, therefore it is important to look at needs on a local level, and tailor messages accordingly.

A number of best practice case studies are available on www.durexchange.co.uk and Durex continues to support new and more effective ways of improving sexual health through its Innovation in Sexual Health Award.

In addition to this, the contents of the Government’s White Paper, together with the recent research carried out by the Office for National Statistics, combines to support Durex independent research on sexual health in the UK.

According to the 2004 Durex Global Sex Survey risky sexual behaviour is now endemic among the younger generation—39% of 16–20 year olds in the UK admit to having had unprotected sex without knowing their partner’s sexual history.

The survey also showed under 16s to be the biggest gamblers with a third (33%) stating they would play the sex lottery with their sexual health and risk unsafe sex with a partner who refused to wear a condom.

The need to improve sexual health is underlined by the continued rise in teenage pregnancies, HIV and other sexually transmitted infections.

According to the ONS after a three year decline there has been a 0.2% rise in the number of teenage conceptions to girls under 18 in the space of a year—meaning our rates remain the highest in Western Europe.

In addition, the number of new HIV diagnoses rose by 20% last year, which means an estimated 50,000 people are currently living with HIV in the UK.

The Health Select Committee has also called for sex and relationships education (SRE) to become a statutory part of the National Curriculum.

Everything points to that fact that much more needs to be done to educate people about protecting their sexual health.

Results from the 2004 Durex Report confirm that young people currently do not feel their school sex education is beneficial and just 9% chose a teacher as the most useful source of information.

The Durex sex education CD Rom, comprising 10 modules aimed primarily at 14–16 year olds, with lesson plans, role playing exercises and debates continues to be requested. With over 5,000 copies having been distributed free of charge to teachers, school nurses and healthcare professionals, the demand for this type of resource remains high.

In addition to this, the Durex National Condom Week is a high profile, educational campaign now in its eighth year. Durex also works closely with healthcare providers, educators and pharmacists to communicate the importance of sexual health to young adults. Thousands of resource packs are distributed nationwide to support teachers and healthcare professionals in raising awareness of good sexual health among young adults.

January 2005

Memorandum by the British Retail Consortium (WP 40)

The British Retail Consortium (BRC) represents the whole range of retailers including large multiples, department stores and independent shops, selling a wide selection of products through centre of town, out of town, rural and virtual stores. In March 2004, the retail sector employed some 2.8 million people (11% of the workforce) and retail sales were £235.8 billion in 2003. The retail sector consists of 291,000 enterprises, contributing an estimated 6% to national Gross Value Added (GVA). Grocery retailing is significant in macro economic terms and was valued at end 2003 at £113 billion.

As this is a short enquiry, the following response is in summary form. The BRC would be happy to respond to any questions the Committee may wish to put if and when oral sessions are held.
Q.1 Will the proposals enable the Government to achieve its public health goal?

1.1 The overall aim of the White Paper is, in John Reid’s words: “...for everyone to achieve greater health and mental well being by making healthier choices.” This focuses attention on:

- the extent to which consumers generally are aware of why they should make healthier choices for themselves and their motivation to do so.
- in the case of diet, the extent to which those choices are made easier by the actions of food retailers (and the food industry in general) through their product development, merchandising, promotions, pricing and communication strategies and tactics.
- the balance between prescriptive regulation and self-help incentives in the overall development of policy in this area.

1.2 Consumer awareness and motivation are major issues. According to recent research by IGD:

- the majority of consumers have a reasonable understanding of what constitutes a healthy diet but 61% believe their own diet is currently healthy and only 11% believe that it is consistently unhealthy.
- in deciding whether or not they are overweight, most adopt a limited frame of reference, eg comparing themselves with the average size of the population or their own circle of friends.
- most see healthy eating as a means of losing weight, not preventing weight gain.
- a large minority (45%) do not look for any nutritional information on pack when choosing food.

1.3 Will the White Paper’s proposals on “signposting” help tackle these issues? If we believe that the main reason why nearly half of all consumers never look for nutritional information relates to its complexity and their own lack of time and understanding, then a simple visual “signposting” system should help them. But while this may well apply to some consumers, it is very doubtful whether signposting is a panacea for the lack of motivation noted above. Consumers seek dietary guidance only if they believe they personally need it.

1.4 A serious objection to a simple, composite signposting system, ie a colour coding applied on pack combining the varying levels of fat, sugar and salt contained in the product, is that it could mislead consumers and discourage them from following a balanced diet. Many common foods (eg cheese) contain both positive and negative components which are fine if consumed as part of a balanced diet. The danger is that someone (presumably the FSA and/or the manufacturers) will be obliged to make a one-size-fits-all judgement about the colour coding a particular product should carry. To the extent that consumers are influenced by the colour code on the pack, this could (as in Sweden) seriously skew their diet away from the idea of everything in balance.

1.5 The food industry generally prefers to continue developing and if possible simplifying the system of Guideline Daily Amounts, which UK retailers pioneered in the 1990s. The results of the FSA’s current programme of testing alternative signposting models with consumers are therefore awaited with interest.

1.6 In the meantime—and for the foreseeable future—food retailers will continue to extend their range of healthy options, particularly in convenience foods, and communicate the “five a day” message to their customers. The industry will also pursue its current strategy of gradual changes in the composition of its standard products. Early last year, the BRC committed its members to achieving the FSA’s target of 6gm of salt per person per day by gradually reducing the salt content of thousands of products in nine categories. This programme, which in some cases began two or three years ago, is based on gradual reductions over the next few years, as distinct from a shorter timescale. Gradualism is essential in order that consumers should not notice a change in the flavour of their usual foods and be tempted to add salt back when consuming them.

1.7 The next task is to look at how we can reduce the fat and sugar content of standard and premium products (ie those not already branded as a healthy option). These two ingredients are even more fundamental than salt to the recognised taste and character of many foods and the FSA recognises that reducing their presence will be a more complex and longer-term process. Preliminary discussions with the FSA will begin over the next few weeks.

Q.2 Whether the proposals are appropriate, will be effective and whether they represent value for money

2.1 The appropriateness of the proposals depends on how you define the problem they are meant to resolve. The emphasis in the White Paper on continuing consultation with the food industry is welcomed and contrasts with some earlier ministerial statements which implied a more adversarial approach. At the risk of stating the obvious, food retailers want their customers to eat sensibly, take exercise and live long and healthy lives—if only so they can go on shopping. Contrary to the views of certain conspiracy theorists, healthier options are not inherently less profitable than other products. The food industry as a whole has a critically important part to play in any strategy designed to halt and reverse the current imbalance between energy input and energy output. But, as the White Paper recognises, many other actors have to be involved as well.
2.2 One disappointing aspect of the White Paper is its failure to grasp the need for a major and sustained national media campaign aimed at the 61% of the population who apparently believe their diet is healthy enough as it is. Last year the major parties in the food supply chain (NFU, FDF, BRC, BHA) made a proposal to the DoH and separately to the Prime Minister for such a campaign in which the food industry would play its part. Drawing on our experience with “five a day” and other campaigns, we believe that the frequent repetition of one or two simple messages, communicated with dramatic visual aids, is the only way to get through to a resistant or indifferent audience. Recent anti-smoking media campaigns provide useful examples. Instead, however, the White Paper seems to envisage a plethora of smaller scale, more fragmented campaigns which the DoH believes the food industry should help fund. This is unlikely to evoke a positive response.

2.3 The White Paper also lacks clarity on measures of success and timescales. In his introduction, John Reid says that success will be measured “first, in the increased number of healthy choices that individuals make, and then in the lives saved, lengthened and improved in quality”. The difficulty here is that many of the social and lifestyle changes which are driving the growth of obesity and related health problems have been gradually gaining momentum over the past 30 years or more and are not going to be halted, let alone reversed, in a hurry. While there is clearly a strong temptation, especially in an election year, for ministers to focus on quick wins and headline-grabbing “initiatives”, these will have little or no effect on the problem.

Governments have been campaigning against smoking for over 40 years, aided by heavy excise duties, a large and growing number of smoke-free places to eat, drink, travel and be entertained, and dramatic “smoking kills” warnings on labels. Yet smoking remains fashionable among many teenagers and is still common in lower income groups.

2.4 Experience with decades of anti-smoking campaigns underlines yet again that most consumers are more responsive to communication which encourages them to do something positive than they are to messages which try to prevent them doing something they would otherwise like to do. IGD research suggests that:

— Many consumers equate healthy eating with dieting (ie weight loss), which they in turn associate with self deprivation.

— The diet industry now offers so many alternatives, some contradictory, that consumers are understandably confused about which one is suitable for their own needs.

— Many consumers start weight-loss regimes only to drop them after two or three weeks because they fail to deliver rapid reductions in weight and they are often bland, rather boring substitutes for “real” food.

2.5 The conclusion is that food is for most people a source of pleasure. This is why we believe the basis of future strategy must lie squarely in the concept of a balanced diet, backed by sensible exercise designed to get energy input and output back into balance.

Q.3 Will the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

3.1 The food industry now has a well-established but vigorous relationship with the Food Standards Agency. We also have parallel discussions with DG Sanco. It would be helpful if a clearer demarcation line could be drawn between the roles of the FSA and the DoH respectively in this area of nutrition and health. On several occasions over the past year, it has seemed to the industry that these two agencies were in conflict over the same nutritional territory.

3.2 Beyond the existing arrangements, it might be useful if a national forum on health and nutrition could be put in place to review progress towards achieving whatever targets emerge from the Action Plan and discuss best practice. The DTI has already introduced several bodies of this kind, eg for retailing, the motor industry and chemicals, and Defra is considering a similar initiative. The advantage is that they bring all the major interested parties round the table to discuss upcoming regulatory issues and help to develop shared understandings and commitments. This model is worth further consideration.

January 2005

Memorandum by the Association of Directors of Public Health (WP 41)

GENERAL COMMENTS

The ADsPH broadly welcomes the White Paper on Choosing Health. We note however that the focus is very much on lifestyles and individual choices which, while important, also misses much of public health. There are three domains of public health practice which incorporate health improvement, health protection and heath services. Health Improvement does include promoting healthy lifestyle but also needs to address the importance of the underlying determinants of health (including poverty, educational attainment, housing and social networks). The White Paper also omits mention of health protection and preventive
programmes such as immunisation and screening and much of the public health contribution of health services. The implication of this partial view of public health will affect the ability of the Government to achieve its public health goals. We understand the Governments wish to focus on choice as part of its system reform agenda but we would seek recognition that this does not encapsulate a rounded public health analysis of contemporary public health challenges.

To ensure effective implementation you need public health programmes, which address all three domains of public health practice. Public health programmes need to address the problems (eg heart disease) in terms of promoting and protecting health, preventing disease, diagnosis, treatment and care. Each programme will need a strategy which identifies the role of national, regional and local partnerships. It is this conceptual framework that will assist the Select Committees appraisal of whether the infrastructure and mechanisms proposed in the delivery plan are fit for purpose.

**Specific Issues**

— We welcome the emphasis in the White Paper on Directors of Public Health Annual Reports being submitted to the LSPs and Local Authority partners who will be expected to issue a formal response to the recommendations. The annual report needs to be a statutory responsibility and DsPH be given the resources to produce effective reports and follow through via local partnerships on a year on year basis.

— Sufficient resources must mean increasing public health capacity so PCTs are all able to recruit a DPH and those in post don’t find themselves exposed as single handed specialists. Since Shifting the Balance this has been a common experience of our members in England.

— We also support the development of joint appointments between the PCT DPH and the partner Local Authority. Often these arrangements are notional with little resource being made available to the DPH in the local government sector and no clear corporate position. There are however a number of successful examples of effective joint appointments and these are usually where there is a unitary authority and the boundaries of both organisations are coterminous.

— The ADsPH recognise that for many PCTs the lack of coterminosity makes the development of effective LSPs problematic. It also makes joint appointments impossible. If there is to be more organisational changes in the NHS or Local Government then moving toward shared populations should be a priority.

— Since 1974 the issue of the location of public health leadership within either the NHS or local government has been debated in a sometimes divisive way. There is clearly a need for the local NHS and local government to demonstrate the duty of partnership as the lead statutory bodies for public health. Joint appointments and the development of effective LSPs will be critical.

— We welcome the development of Local Area Agreements and the explicit linking of national PSA targets with local PSA target delivery. Clearly getting greater clarity, consistency and synergy from the centre to the locality via central/local government and the NHS will make the delivery of the White Paper goals more likely.

— The question of political and civil service leadership for public health needs review. We recognise that the Health Select Committee has looked at the Minister for Public Health post and its seniority and position in the DH before. In view of the fact that so much of the White Paper and Public Health requires cross government working that consideration be given again to create a Cabinet level post who could provide the leadership across government. The current junior level Ministerial post in the DH is not a good signal of the priority given to Public Health challenges.

**Conclusion**

The ADsPH have a long history of representing Public Health Directors in statutory organisations since the middle of the 19th century. We recognise the need to influence government policies at national, regional and local levels. We hope that the Health Select Committee will urge the Government to ensure that at each level of the public health system there is sufficient public health capacity and that the leadership is positioned corporately to have optimal impact on government at each level and through the NHS.

January 2005

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**Memorandum by Diabetes UK (WP 42)**

Diabetes UK is delighted to contribute to this inquiry into the Government’s Public Health White Paper. Diabetes UK is the charity for people with diabetes. One of Europe’s largest patient organisations, it aims to improve the lives of people with diabetes and work towards a future without the condition. 1.8 million people in the UK have diabetes. A further 1 million have the condition but don’t yet know it. Diabetes is a leading cause of blindness, heart disease and amputations.
Obesity, poor diet and leading a sedentary lifestyle are major contributing factors to the development of Type 2 diabetes. This type of diabetes usually appears in people over the age of 40, though in South Asian and African-Caribbean people often appears after the age of 25. However, over recent years Type 2 diabetes has been diagnosed in British children, precipitating research, such as the “Early Bird” study, into why this worrying development is occurring and the true nature and extent of the problem.

Diabetes UK is committed to promoting good public health through physical activity, eating a healthy balanced diet and public awareness of the risks of developing diabetes—poor weight management being a significant risk factor. We awaited the publication of the Government’s Public Health White Paper with anticipation and hoped that it would provide us with a major step forward in tackling this increasing problem.

1. **Will the Proposals Enable the Government to Achieve its Public Health Goals?**

As the delivery strategy for the white paper has not yet been published, it is difficult to fully assess whether the proposals will help the Government achieve its public health goals. However, our initial thoughts on the White Paper were positive, being the first of its kind and trailed as a framework for real action. Much of the media attention focussed on the issues of banning smoking in public places and banning advertising of junk food to children. However, these issues, while important, are only part of a much wider picture. The white paper starts to look at this wider picture but at this stage may raise more questions than answers.

2. **Are the Proposals Appropriate, Will They be Effective and do They Represent Value for Money?**

Increasing the amount of physical activity people take has been outlined as a priority within the white paper. We welcome the fact that action is being taken on this issue. Increasing physical activity will reduce obesity, lowering the number of people developing diabetes and improving the health of those who already have the condition. The vast majority of England’s 1.5 million people with Type 2 diabetes are overweight at the time of diagnosis. Support and facilities are required to help people become more active. The white paper has started to address this with initiatives such as NHS health trainers in the community and more physical activity in schools. These proposals are certainly an appropriate response but their efficacy and value for money will only be clear once there is more detail on these and the other fitness initiatives outlined.

Reducing obesity through improving diet and nutrition is another essential target within the white paper. Eating a healthy, balanced diet is important for everyone and is a key part of managing diabetes. Balancing medication and physical activity with the food eaten is an everyday task for people with diabetes. Along with physical activity, providing people with easy to read nutritional information about the food they are buying can make a real difference. Diabetes UK will be watching closely to see how food manufacturers respond to the Government on issues such as labelling and promoting unhealthy food. We are concerned the Government did not take this opportunity for immediate regulatory action as the voluntary code may be ineffective and valuable time could be wasted. Any failure to make real progress is unacceptable. Again, it is impossible to assess efficacy and value for money of the proposals before we have the detail on exactly how the initiatives will be implemented.

We welcome action to reduce the numbers of people who smoke. People with diabetes are already at an increased risk of heart attacks, strokes, erectile dysfunction and other circulatory problems. Smoking doubles that risk again. Action is required to both help people give up smoking and to protect them from the harmful effects of passive smoke. The white paper’s proposals to restrict smoking in public places and to provide more information and support to quit will go a long way to reducing the threats for people with diabetes. However, only making the ban applicable in certain circumstances is questionable and will leave unjustifiable gaps.

3. **Whether the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure That Proposals Will be Implemented and Goals Achieved**

Much still needs to be done to ensure the infrastructure is in place to implement the proposals within the white paper. For example improved and accessible sports facilities need to be put in place in many areas, funding is needed for new posts like NHS trainers and full time school nurses and the building blocks to support community health programmes need to be established. The delivery strategy needs to outline exactly how the Government intends to put in place the infrastructure to support their proposals.

The challenge is now for the Government to deliver real improvements. The first step is to inform people about healthy choices and why they are important, mechanisms then need to be in place to ensure people are supported as they make lifestyle improvements. Diabetes UK looks forward to seeing the detail of the white paper implementation in the delivery strategy, the “Food and Health Action Plan” and the “Physical Activity Plan”.

*January 2005*
Memorandum by J Sainsbury plc (WP 43)

Sainsbury’s welcomes this opportunity to share their views on some of the key measures in the Public Health White Paper relating to their business. Sainsbury’s is Britain’s longest-standing food retailer serving over 11 million customers a week through its 583 stores throughout the country.55

The White Paper, the consultations preceding it, as well as the work of the Committee have helped to stimulate an informed discussion around food and health in the UK and the policies which should be implemented in response to the challenges of we face. The White Paper covers a wide range of issues and we have chosen to respond to those areas where our customer interests and understanding are strongest.

OVERVIEW

1. The White Paper outlined several areas for action within the food industry including in healthier own brand product development86 and working with the Food Standards Agency (FSA) and food industry to develop nutritional criteria and signposting for food to help consumers make healthy choices.87 We are aware that the British Retail Consortium will be providing the Committee with an industry wide response on a number of issues and support their positioning.

2. Sainsbury’s own initiatives have focused on helping consumer understanding and reducing salt in our key products as well as a range of other initiatives, especially on children’s food and education, which we have outlined below.

3. Sainsbury’s will continue to work closely with the Department of Health on their national Food and Health Action Plan, the Department for Education and Skills, Scottish Executive and the Food Standards Authority as well as health professionals and education organisations to ensure, where possible, we can help all consumers improve their diet and live more healthily.

LABELLING

4. Our customers tell us that they are increasingly concerned about the nutritional make-up of their food. The White Paper pledges that the Department of Health and FSA will work together to introduce a system that could be used as a standard basis for signposting food.88 Whilst we would support the introduction of basic standards we believe that attempts to oversimplify could be confusing.

WHEEL OF HEALTH

5. We feel it is important industry takes the lead in providing their customers with honest, accurate, easy to read labelling including full nutrition information and healthy hints on all our products wherever possible. Following extensive customer research and engagement about what information they need, Sainsbury’s has developed a new, innovative labelling system to help customers make healthier food choices called the Wheel of Health.

6. Our research shows that providing information in this format helps customers to identify specific nutrient concerns they have, eg. saturated fat or salt, to identify foods to suit their individual needs. In addition as individual foods vary in their calorific and nutrient value we believe this system encourages customers to choose a wide variety of different foods and as far as possible does not demonise individual foods as good or bad.

7. The Wheel of Health appears on the front of pack labelling and features five key nutrients which are colour coded as red—think, orange—ok or green—go. The contribution of five nutrients to the Guideline Daily Amounts (GDAs) is shown—salt, fat, saturated fat, added sugars and the number of calories per serving. These are key nutrients which we believe must be included to enable customers to make an informed choice and reduce the threat of an obesity epidemic. We launched this new labelling initially on 30 products from January 2005. An example of which can be seen below.

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55 Figures correct at March 2004.
86 Page 31, Choosing Health.
87 Page 25, Choosing Health.
88 Page 25, Choosing Health.
8. On the back of the product we state how these amounts compare with the GDAs for healthy eating.

9. The colours demonstrate the contribution of these nutrients towards the “Guideline Daily Amount” which will help highlight to customers how individual foods contribute to their daily food intake.

10. Sainsbury’s have worked closely with the FSA during our development of the Wheel of Health and continue to share information with them.

**Five A Day**

11. Sainsbury’s also supports the Government’s 5 a day campaign. In May 2003 we introduced a 5 a day logo that clearly highlights the number of portions of fruit and vegetables contained within a portion of our own label products.

**Product Development**

**Salt Reduction Campaign**

12. Sainsbury’s places a great deal of importance on reducing the salt in our own brand products and we have been active in this area for many years. We took the lead back in 1994 by introducing the Healthy Balance symbol on food with limited amounts of fat and saturates and limited amounts of added sugar and sodium. In October 1999 we launched our salt reduction initiative, which aims to reduce the salt content of own brand foods by 10–15% without compromising on safety or eating quality.

13. Since March 2001, in response to consumer research, we started to introduce information about salt into the Nutrition Panel, along with salt Guideline Daily Amounts, where space permits. Whilst legally, sodium has to be declared on the nutrition panel on a label, we found that the term was only understood by the minority, with “salt” being the preferred term.
14. In 2004 Sainsbury’s launched a three year strategy for reducing salt in five key product categories; sandwiches, pizzas, ready meals, soups and breakfast cereals which has been welcomed by the Food Standards Agency and Department of Health. Targets have been set in consultation with the FSA, setting upper salt limits for our own label products in these categories. We have fully achieved our year 1 targets and are now focusing on achieving this year challenging targets while maintaining the quality, taste and safety of our products. We are aware that the FSA have revised their salt reduction model and are currently reviewing our own targets against this.

**ACTIVE KIDS CAMPAIGN**

15. With the continued national debate surrounding physical activity amongst children Sainsbury’s has developed a major new campaign that aims to inspire pupils and teachers alike to get more active. The Sainsbury’s Active Kids campaign delivers real benefits in the form of equipment, kit and experiences that go beyond the traditional curriculum based sports and PE lessons, for all types of schools and for all ages and abilities.

16. From 2 March 2005 until 30 June 2005, every time a customer spends £10 at Sainsbury’s or Sainsbury’s To You (our internet shopping website) they will receive one Active Kids voucher.

17. As a major food retailer we believe it is important that we offer our customers choice but we are also committed to encouraging them to make healthier choices. As an added bonus therefore one extra Active Kids voucher will be issued for every £5 spent on fresh fruit and vegetables to help encourage healthy eating.

18. Schools can use vouchers to redeem against a wide range of active equipment and kit—from footballs to space hoppers and trampolines. There is also the chance to use the vouchers to take groups of children to experience a range of activities such as ice-skating, scuba diving and ten-pin bowling. In addition we will also be heavily investing in coaching for primary school teachers.

19. Sainsbury’s Active Kids is open to all primary and secondary schools in the UK—this is approximately 35,000 schools and a potential 10 million pupils.

20. We have been in liaison with Government officials about these plans and see them as complementary to the Government’s drive to extending the range and scope of physical exercise in schools.

**CONCLUSION**

21. Sainsbury’s would be happy to provide further information to the Committee on any of these initiatives. In addition, you will find a number of other initiatives outlined in the Annex.

_January 2006_

**ANNEX**

**TASTE OF SUCCESS**

22. The Sainsbury’s “Taste of Success” Award Scheme in partnership with the British Nutrition Foundation and the Design Technology Association supports food studies in the curriculum and recognise pupil’s achievements in good practical food and nutrition skills. This scheme is run across the UK and over 170,000 pupils have gained these skills to date and received a Sainsbury’s Taste of Success Gold, Silver or Bronze award. The Scheme is supported by the Department for Education and Skills.

**MOVE4HEALTH**

23. As part of the Taste of Success scheme Sainsbury’s have sponsored a joint initiative with Move4health and Urbanwalks to promote healthy living. 35 MPs were challenged to wear a pedometer during the Party Conferences to encourage them to increase the number of steps they take daily. The nine MPs who improved most have won a Food Inspiration School Visit where Sainsbury’s Michelin star executive chef, John Wood, will hold an interactive healthy eating presentation for a local school of their choice. The winning MPs have also had a map produced by Urbanwalks for their constituency. These guides encourage people to explore their local area on foot as a positive step towards a healthier lifestyle.

**MEND**

24. Specifically to help address the issue of obesity in children, Sainsbury’s is supporting a project run by Great Ormond Street Hospital called Mind, Exercise, Nutrition and Diet or “MEND”. This project looks at solutions to tackle childhood obesity based on a multi-disciplined approach combining nutrition and a balanced diet, a safe exercise programme and also considers the psychosocial issues faced by children and families who are obese.
Sainsbury’s Product Ranges

25. Following research in May 1999, Sainsbury’s developed the “Be Good To Yourself” range with the objective of creating a range of lower fat and calorie options across a wide variety of products. Be Good To Yourself products are either less than 3% fat or have at least 50% less fat than standard products, contain sugar levels that are no higher than those found in standard products and are also part of our overall salt reduction plan. Additives are also restricted in the range and only colours permitted by the Hyperactive Children’s Support Group (HASC) are used.

26. Sainsbury’s developed its “Blue Parrot Café” range in 2001. This is a healthier food range for children and addresses the issue of children’s diets being high in saturated fat, salt and sugar and lacking in fruit and vegetables. There are 80 products in the range from various fruits and fruit pieces to ready meals such as shepherd’s pie.

27. In 2002 Sainsbury’s launched its “Free From” range is a specially produced range of gluten, wheat or dairy free products targeted to meet the needs of an increasing number of people in the UK suffering from food allergies or intolerances—indeed between 5–7% of children suffer from some form of allergy. The range is endorsed by Allergy UK, the UK’s leading charity for allergy sufferers.

Memorandum by Cancer Research UK (WP 44)

This memorandum represents the view of Cancer Research UK. All correspondence regarding this submission should be directed to Mr Richard Davidson, Director of Policy and Public Affairs at Cancer Research UK, at the address above.

Cancer Research UK is the world’s largest independent cancer research organisation, with an annual research spend of over £213 million. Cancer risk is greatly affected by our lifestyle choices, particularly smoking habits, diet and physical activity, alcohol consumption, and home and working environment. Public health policy is therefore of great interest to Cancer Research UK, and we welcome the opportunity to submit evidence to this important inquiry.

Our Chief Executive, Professor Alex Markham, is available to provide oral evidence to the Committee.

General Comments and Summary

Cancer Research UK supports many of the public health measures outlined in the Government’s Public Health White Paper (hereafter referred to as “the White Paper”). With regard to the prevention of cancer, tobacco control policies are of paramount importance. We have therefore chosen to focus our submission to the Committee on this public health area.

The tobacco control policies outlined in the White Paper show progress but do not go far enough. In particular, we urge the Committee to recommend that the Government remove the proposed exemptions from the legislation to restrict smoking in workplaces and enclosed public places, and instead introduce comprehensive legislation to make all workplaces and enclosed public places smoke-free.

Tobacco Control Policies

The Health Committee has asked whether the White Paper proposals will enable Government to achieve its public health goals: Specifically, the Government has a target to reduce smoking rates from 27% to 21% or less by 2010. Cancer Research UK believes that stronger tobacco control policies than those outlined in the White Paper will be needed to achieve this goal.

We endorse the submission made to the Committee by Action for Smoking and Health. Further to that submission, we wish to highlight certain areas as outlined below, and urge the Committee to consider making recommendations along these lines to the Government.

Tobacco Control Strategy development and co-ordination

We welcome the proposal for a new public health cabinet sub-committee. However, a smaller tobacco coordinating group of political and civil society membership also needs to be established to develop and oversee the implementation of the Department of Health’s tobacco control strategy and conform with the guiding principles of the Framework Convention on Tobacco Control.

We welcome the establishment of a health information and intelligence task force. Key information would include a longitudinal panel survey to monitor smokers’ behaviour in response to national policy initiatives, with publicly available results.

There should be greater funding commitment for longer-term social marketing mass media and public education campaigns.
Smoking in workplaces and enclosed public places

The SCOTH report’s unequivocal conclusions about the harmful effects of second-hand smoke should be reported to the UK Committee on Carcinogens and the Committee should be asked to assess whether second-hand smoke is a workplace carcinogen.

The present proposal to make all enclosed public places smoke-free by 2008, excluding pubs that do not serve food and private membership clubs (chapter 4, para 76) should be re-worded to recognise that legislation is vital and that the proposed exemptions should be removed. This is because:

(a) the present announcement will leave many thousands of workers still exposed to second-hand smoke;
(b) it will miss a timely opportunity to reduce smoking prevalence rates as much as possible;
(c) it will contribute to increased inequalities in health; and
(d) regulation without legislation will not achieve even the White Paper’s present proposals.

We therefore urge the Committee to recommend that the Government include a comprehensive bill in the first Queen’s Speech after the General Election to make all workplaces and enclosed public places smoke-free.

Tobacco and Nicotine Regulation

The White Paper provides conflicting information about the need to set up a UK agency to regulate tobacco. Smoked tobacco is by far the most harmful form of nicotine consumption, but other forms of nicotine, such as medicinal nicotine which is at least 100 times less risky, are currently only available as an aid to giving up smoking. Some form of regulatory body is needed as a matter of priority to ensure uniform regulation on all products containing nicotine. The remit of such a regulatory framework should be to minimise the proportion of regular nicotine users in society, and, amongst them, the proportion regularly obtaining nicotine from smoked tobacco products.

Stop smoking services

The White Paper correctly recognises that the Government’s Stop Smoking Services have been very important. However, the White Paper does not pick up some of the criticisms set out in the latest Wanless report. In particular, the four-week quit targets give a misleading impression of success. We recommend therefore that targets for cessation services should be re-framed to cover both referrals and success rates, and standard measures for quit rates are needed. Performance indicators must also reflect the extent to which smokers from deprived groups are being targeted. Finally, smoking cessation also needs to be fully integrated into clinical guidelines for all smoking-related chronic diseases.

Health Warnings

Increasing evidence shows that graphic warnings can be powerful in reducing the number of smokers. We welcome the Government’s move to consult on how to use them after the development of the EC’s final proposals.

Tax and Smuggling

We believe that the price of tobacco should continue to be an important element of government tobacco control policy. An FCTC protocol on smuggling should therefore be a priority.

Other Policy Areas

Beyond tobacco control, there are a number of other initiatives identified in the White Paper which could have an impact on the prevalence of cancer in this country.

In general terms, we support the initiatives outlined to combat the growing prevalence of obesity. Among non-smokers, who now comprise the majority of the population, obesity is the most important preventable cause of cancer. Although we have chosen to focus this submission of evidence on tobacco control policy, we nevertheless urge the Committee to give careful consideration to the proposals regarding obesity. If required by the Committee, Cancer Research UK experts in the field could provide further, detailed advice and information as to the likely efficacy of the White Paper’s proposals.

We are also encouraged by the plans to strengthen public health research as outlined in Annex B of the White Paper. Cancer Research UK is actively involved in some of the initiatives outlined in the White Paper, through the National Cancer Research Institute. We urge the Committee to call on Government to give high priority to ensuring the effective implementation of its proposals for public health research.

January 2005
Memorandum by The Maranatha Community (WP 45)

1. INTRODUCTION

1.1 This Document

This document has been prepared in response to the Consultation by the Health Committee on the Government’s Public Health White Paper “Choosing Health” launched by The Secretary of State for Health.

The submission has been prepared by the Maranatha Community together with the Council for Health and Wholeness. Representatives from both bodies would be happy to give oral evidence to the Committee.

1.2 The Maranatha Community

The Maranatha Community is a Christian movement with many thousands of members throughout the country active in all the main churches. Its membership includes a substantial number of people involved in the health and caring professions and in a wide range of voluntary work. Since its formation 23 years ago, it has been deeply involved in work amongst children and young people, people with drug and alcohol problems, the disabled and disadvantaged. It has taken the initiative in a broad range of projects directly contributing to the health of the nation and it also has extensive international experience. The Trust is a registered charity number 327627.

1.3 The Council for Health and Wholeness

The Council is a multi-disciplinary body embracing doctors drawn from a variety of specialisms, nurses and various medical auxiliaries, counsellors, chaplains and others. It has close links with the healing ministry of the Christian church and is involved in a broad range of research projects.

The Council for Health and Wholeness is based in the offices of the Maranatha Community.

2. SUMMARY WITH RECOMMENDATIONS

2.1 The Maranatha Community and the Council for Health and Wholeness welcome this consultation. We believe that this is a timely opportunity to re-evaluate the current approach to public health. We recognise many excellent proposals in the White Paper, however are concerned at a large number of areas that have not been addressed which are major determinants of public health. We are therefore concerned that the beneficial impact of this White Paper will be much smaller than the Department of Health would have hoped for.

2.2 We are convinced that the UK faces the greatest challenge to public health since the inception of the NHS. If current trends continue, we will not be able to fund the cost of treating the explosion of chronic diseases.

2.3 The dramatic increase in family breakdown has led to a trail of casualties, especially among children. There has been a dramatic increase in family breakdown over the past 40 years: In 1961, 350,000 British people got married for the first time, 50,000 remarried, and 30,000 divorced. Forty years later, 180,000 married for the first time, 120,000 remarried, and 150,000 divorced. The proportion of children raised in single-parent households is higher in the UK than elsewhere in Europe. Could it be, that at the root of many of the concerns we have for children, such as the high rates of drinking, drug taking, teenage pregnancy and childhood poverty (all the highest or among the highest in Europe) is the high rate of family breakdown in the UK?

2.4 There is a wealth of evidence linking family breakdown with many adverse health outcomes for children, such as higher mortality, emotional problems, poor school performance and poverty. Children from broken families are also more likely to become drug addicts, teenage parents and contract sexually transmitted diseases. They are more likely to engage in criminal activity and are over-represented in the prison population. Conversely, marriage confers many health benefits including lower mortality, less depression and less alcohol abuse and increased life expectancy. This is similar in men to the increased life expectancy of non-smokers. Cohabitation does not confer the same protective benefit that marriage does. While the White Paper obviously is concerned about the above mentioned problems such as childhood poverty, emotional problems in children, teenage pregnancy etc. the White Paper fails to recommend the most basic and in our view most effective strategy to address these issues, the strengthening of the marriage-based family.

2.5 With the direct cost of family breakdown being estimated in the region of £15 billion per year—if one takes into account the indirect costs, then the total cost of family breakdown is likely to be in the region of £30 billion and rising—there is an urgent public health need to strengthen the family and marriage, supporting dysfunctional families and thoroughly reviewing legislation and policies that undermine marriage. We are concerned that the White Paper does not even mention marriage or family breakdown—
even though a majority of the population consider the marriage-based family as the ideal for children to be brought up—but rather than lack of parents. The White Paper is concerned about childhood poverty but fails to recognize that one of the major contributing factor to childhood poverty is family breakdown, which leads to a significant reduction in the income available to families. Unfortunately, strengthening marriage and families do not appear to be a political priority nor does it feature in the White Paper. Therefore, a major determinant for public health is not even addressed in the White Paper.

2.6 The “safe(r) sex” experiment has failed. We face a public health crisis regarding sexual health. Sexually transmitted infections now are out of control. Most STIs have doubled over the past six years and chlamydia infection rates among young women have trebled over the past decade. Syphilis has increased by over 500% over the past six years. Teenage pregnancy rates are the highest in Western Europe. Some Genitourinary clinics turn hundreds of patients away a week and are unable to cope with the huge demand. GU-clinic attendances have doubled over the past decade.

2.7 Official strategies such as the National Strategy for Sexual Health and HIV as well as the Teenage Pregnancy Strategy have singularly failed to address the underlying cause for the explosion in STIs and will continue to do so. Underlying this dramatic increase in STIs is a dramatic increase in casual sex, promiscuity including an increase in concurrent and sequential sexual relationships, earlier sexual activity and increasingly risky sexual behaviour. Casual sex may be casual in intent, but certainly not in outcome.

2.8 The only evidence-based definition of “safe sex” is—apart from abstinence—mutual monogamy with an uninfected partner. This is in essence the meaning of marriage. However it is a sad truth that sexual abstinence until marriage is not even mentioned as a possibility in the UK sexual health strategy. The most important risk factor for contracting a STI is the number of sexual partners a person has. Condoms are not as “safe” as they have been promoted to be and many, especially young people, are stunned to find that they have contracted an STI, often incurable, despite using condoms. Condoms may be effective in reducing the risk of contracting HIV (“always condom use” reduces the risk of HIV transmission by 85%), however the risk reduction is far less for essentially all non-HIV STIs, such as chlamydia, gonorrhoea, syphilis, genital warts etc, where the risk reduction, even with “always condom use” is more in the region of 50% or less. The “faith in the condom” is misplaced.

2.9 The widespread adoption of the ABC approach in Uganda has led to a 70% decrease in HIV over the past decade. This contrasts with a more than 100% increase of most STIs in the UK over the same period. Abstinence until marriage needs to be actively promoted from a public health point of view. Opponents of this approach frequently state that this equals to “moralising” or “preaching”. However, to promote sexual abstinence is as much “moralising” or “preaching” as it is to encourage a smoker to quit smoking. Both are public health interventions aimed at reducing a lifestyle, sexual promiscuity or smoking, that have very adverse effects on the health of the nation. As the White Paper fails to address the real reasons for the explosion of STIs, we are not convinced that the chosen strategy will be effective and predict further increase in the number of STIs diagnosed.

2.10 Illicit drug misuse in the UK is out of control. The UK has probably the worst drug problem in Europe. British young people have higher rates of drug misuse, including cannabis, cocaine, ecstasy and amphetamines than most other young Europeans. Over 4 million of the population use an illicit drug and 1 million use class A drugs such as heroin, cocaine, crack or ecstasy. The economic, social and health costs of Class A drugs alone is conservatively estimated to be up to £17 billion per year. The Home office estimates the total cost of the UK drug problem to be in the region of £20 billion per annum. This translates to just under £800 per household per year. The number of drug-related deaths exceeds 3,500 per year.

2.11 Across Europe, countries with a high level of cannabis misuse, for example the UK, also have high levels of “hard drug” misuse such as cocaine and ecstasy. Countries with low levels of cannabis misuse such as Sweden have low levels of other “hard drug” use. Indeed, Sweden has among the lowest, possibly the lowest, rates of drug misuse of any European country.

2.12 Sweden appears to be the only European country with the goal to create a drug-free society. Drug misuse, especially cannabis misuse is strongly discouraged. There is a very strong consensus in society against drugs and parents, teachers, police and politicians are all strongly supportive of a restrictive drug policy. The basis of the Swedish drug policy is the recognition that the only indispensable part of the drug problem is the drug user and therefore primary prevention of drug misuse—demand reduction—is given the highest priority.

2.13 The Swedish approach contrasts greatly with the UK approach where increasingly drug policy appears to be based on the very dubious concept of “harm reduction”. “Harm-reduction” essentially portrays drug misuse as inevitable, based on the wrong assumption that “young people are going to use drugs anyway so we might as well teach them how to do it safely”.

2.14 It is interesting that a “harm-reduction” approach is used regarding illegal drugs but not regarding any other illegal activity. No one would teach young people how to speed or to steal safely, the clear message instead is “speeding is dangerous and illegal”. Harm-reduction accommodates and normalises, rather than prevents, drug misuse. There are examples of harm-reduction drug education material being used in UK schools which aim to teach pupils the skills of “safe drug use”. This is a contradiction in itself, since there are no safe ways of taking drugs. This type of educational material encourages rather than discourages drug misuse. It should not be used in schools or in any health education context.
2.15 Significantly, the Swedish Drug policy was liberal in the 1960s, essentially using a “harm-reduction” approach. Following this, drug misuse escalated to very high levels in Sweden and in the 1970s, the goal to create a drug-free society was adopted with all the above mentioned policies based on demand reduction and primary prevention. Subsequently, there was a very significant drop in drug misuse in Sweden. There is no good reason why this could not happen in the UK. We deploy the downgrading of cannabis as misguided and are concerned that there is no coherent political message focussing on drug prevention and demand reduction. Furthermore, the high rate of family breakdown in the UK contributes to the drug problem. However, this issue is not addressed by the White Paper. For these reasons, we are not convinced that the currently adopted drug strategy will be successful.

2.16 There is an urgent public need to identify and, wherever possible, to avoid toxic substances. We are at risk of being poisoned in a variety of different ways, through contaminated water, contaminated nutrition, through outdoor and indoor pollution, possibly also low-level radiation and electromagnetic fields. Perhaps the most worrying issue is our obvious ignorance of the long-term effects of many of the toxic substances to which we are exposed. There is legitimate and growing concern that a large proportion of our entire population are being placed at risk.

2.17 It is impossible to even give an accurate overview of the effects of toxic substances on human health and public health. We therefore want to limit our submission to a few examples of the devastating effect toxicity has on public health, especially on children.

2.18 Children are exposed to potentially carcinogenic pesticides from many sources of contamination. Childhood malignancies linked to pesticides include leukemia, neuroblastoma, Wilm’s tumor, soft-tissue sarcoma, Ewing’s sarcoma, non-Hodgkin’s lymphoma, and cancers of the brain, colorectum, and testes. There has been a significant increase in childhood cancer over past decades, including non-Hodgkin Lymphoma. Could it be that toxicity from pesticides and other sources plays a significant role in this increase?

2.19 It is estimated that every year there are 8,100 deaths from particulate matter and 3,500 deaths because of sulphur dioxide in urban areas of Great Britain. The numbers of deaths by ozone in both urban and rural areas of Great Britain during summer ranges between 700 and 12,500. Particulate pollution therefore costs many lives, far more than the number of deaths from road accidents.

2.20 There has been a dramatic increase in childhood conditions such as learning difficulties, ADHD and autism. There are many, sometimes controversial, theories on the causation of these conditions. However we are concerned that there appears to be little awareness—even in professional circles—of the contribution of neurotoxins such as lead, mercury, cadmium, dioxins, organophosphates and other toxins to those conditions.

2.21 While there has been some research—not all of it independent of industry—into the health effects of toxic substances such as pesticides entering the food chain we are concerned that much of the safety data relates to adults. It is therefore very likely that official “safe” thresholds are by no means safe for developing bodies, especially the developing brains, of children. Furthermore, there seems to be only very little research looking at the adverse health effects of toxic substances in combination.

2.22 We call for the establishment of a Royal Commission—totally independent of the chemical industries—to assess the full impact of toxic substances on public health, especially on children. We furthermore are convinced that there should be a national screening programme for the most common toxins that adversely affect children such as lead, mercury, cadmium, dioxins, organophosphates and others. Again, we are concerned that the issue of toxicity is not given prominence in the White Paper which we believe to be a major omission.

2.23 Alcohol misuse has a huge toll on the population. Over 5,500 people die a year due to direct effect of alcohol, however the total number of deaths where alcohol plays a part may be in excess of 30,000 a year. The number of alcohol-related deaths has increased dramatically over the past five years. One person in 13 is dependent on alcohol in Britain. British adolescents are among the worst in international comparisons regarding alcohol consumption, drunkenness and binge drinking. Alcohol misuse costs the UK in excess of £10 billion a year in health and social costs. We therefore call for the urgent development of a coherent Alcohol strategy in the UK.

2.24 It is likely that many of the diseases that place the main burden on the NHS are due to changes in our diet and lifestyle. The dominating illnesses in modernised societies are new, or have become newly prominent, in the past 100–150 years. Some of these are increasing dramatically. These conditions include cardiovascular diseases such as ischaemic heart disease, hypertension and stroke, respiratory diseases such as asthma, metabolic diseases such as obesity and diabetes, malignancies such as major types of cancer including cancers of the breast, prostate and colon, allergies, gastrointestinal conditions such as appendicitis, inflammatory bowel diseases, irritable bowel syndrome and coeliac disease and behavioural disorders especially in children such as childhood hyperactivity and “autism”.

2.25 While it is possible that some of the above conditions are due to a “westernised lifestyle”, part of the “westernised lifestyle” comprises a “western diet” which in itself consists of increased intake of processed foods, including increased intake of fats, sugars, salt and an increased intake of total calories. The WHO finds that worldwide 60% of all deaths are “clearly related to changes in dietary patterns and increased
consumption of processed fatty, salty and sugar foods”. Obviously, other factors also contribute to a “western lifestyle” such as reduced physical activity and increased exposure to toxic substances through for example pollution.

2.26 The medical treatment of many chronic diseases such as ischaemic heart disease, hypertension, stroke, diabetes, asthma and cancer uses up most of the resources of the health service including drug budgets. The cost of diabetes to the NHS is estimated at £5 billion per year. The economic cost of being obese or overweight is estimated in the region of £7 billion a year. The social, economic and health costs of heart disease is estimated to be another £7 billion per year. In addition to those costs, the social and economic cost due to incapacity, disability and death caused by these diseases can hardly be overestimated. The anticipated increase in these conditions, especially obesity, diabetes and cancer is likely to financially crush the NHS. Currently, among the highest prescribing drug costs in UK General Practice are cholesterol-lowering statins. However, antihypertensives and inhalers for asthma/COPD also contribute very significantly to drug costs. Statins are currently prescribed to about 1.8 million people in the UK, at a cost of £700 million a year. This is expected to rise to more than £2 billion a year by the year 2010.

2.27 The nutritional treatment of many chronic diseases is relatively cheap compared to drug costs. For example, one strategy for the secondary prevention of ischaemic heart disease (IHD) used a Mediterranean-style diet. This intervention led within three years to a 70% reduction in overall mortality rate, compared with the far more expensive statin treatment, which, over a five-year period led to at most 30% reduction in overall mortality. Another study examined the impact of eating two or three portions of fatty fish per week on the survival of men with a previous heart attack. Within two years of the commencement of this simple diet change, a significant reduction in all-cause mortality was observed. This mortality reduction was similar to the reduction achieved in trials using statins for a period of over five years.

2.28 Statin treatment is expensive. It costs in the range of £4,000–9,000 per year to save one life with statins in patients who already have established IHD. This contrasts with Mediterranean diet, which, at a cost of around £300 per life-year saved, is only a fraction as expensive as statin treatment. Some dietary changes in the secondary prevention of IHD appear to reduce mortality twice as much as statin treatment. We are convinced that the currently adopted strategy of combating IHD with statins while neglecting more beneficial dietary interventions both for prevention and treatment is a grave misallocation of scarce public funds.

2.29 There is strong evidence that several dietary strategies are effective in preventing the development of IHD. A recent review from Harvard University concluded: “Substantial evidence indicates that diets using non-hydrogenated unsaturated fats as the predominant form of dietary fat, whole grains as the main form of carbohydrates, an abundance of fruits and vegetables, and adequate omega-3 fatty acids can offer significant protection against coronary heart disease. Such diets, together with regular physical activity, avoidance of smoking, and maintenance of a healthy body weight, may prevent the majority of cardiovascular disease in Western populations.”

2.30 Unfortunately, while commonsense teaches that nutrition is essential for health and well-being, nutritional medicine as a medical and public health specialty is, in our view, a neglected area. There appears to be comparatively little research done in this field, compared, for example, with the research into drug treatment of chronic diseases funded by drug companies. There is however a case for a UK-wide integrated nutritional medicine strategy, especially for the prevention and treatment of chronic diseases such as heart disease, stroke, asthma, high blood pressure, diabetes, obesity, cancer and other chronic conditions. We welcome the suggestions in the White Paper, however believe that these suggestions do not go far enough.

2.31 A highly controversial area is the health impact of processed and refined foods and of food additives including colourings, preservatives, trans-fats and others. We therefore call for the establishment of a Royal Commission, independent of the food industry, to examine the short and long-term public health effects of processed foods and food additives. We are concerned that political pressure from the food industry prevents the Government to independently examine the effect of processed foods. We are convinced that the health impact of processed foods is very significant. Unfortunately, this issue is not addressed in the White Paper.

2.32 Exposure to media, including watching TV, playing video games, listening to radio and reading magazines has a very powerful formative impact on children and young people, including their physical, emotional and spiritual health. Time spent watching TV and playing computer games exceeds the time spent on physical activity for most children and for many children exceeds the time spent with parents. Time spent watching television or playing computer games takes away from important activities such as social interaction and development, especially time spent with the family, physical activity, including playing, but also reading and school work. British children spend on average five hours per day using media—far more than in any other European country.

2.33 Because children have high levels of media exposure, more so than in previous generations, the media have greater access and time now to shape young people’s attitudes, values and behaviour than do parents or teachers. The media therefore replaces parents and teachers as educators, role models, and the primary sources of information about the world. In this context we disagree with the statement by OFCOM quoted in the White Paper, that a ban on childhood food advertising on TV would not be effective. If TV food advertising had no effect, why would food manufacturers spend millions on food advertising? We
consider advertising of food products to children on TV essentially unethical and call upon the Government to follow the lead of other countries such as Sweden and Norway and ban TV advertising of food products to children completely. We urge the Government to without delay implement regulation of advertising of unhealthy products, especially those with high levels of sugar, salt and fat, just as the advertising of cigarettes has been regulated.

2.34 There is significant evidence linking time spent watching TV with the prevalence rates of obesity. Obesity measurably increases for every hour spent watching TV. Reducing the time watching TV reduces childhood obesity rates. While the White Paper makes a link between time spent watching TV and childhood obesity we consider that more action could be taken to reduce the time that children watch TV.

2.35 There has been a steady increase in the amount of sex in the media, especially TV but also glossy magazines and an increase in the explicitness of these portrayals. There appears to be a fairly consistent sexual message: most portrayals of sex depict or imply heterosexual intercourse between unmarried adults portraying promiscuity as the norm, with little reference to sexually transmitted infections, pregnancy, or use of contraception. There is evidence that young people aged 12–17 who watch far more TV are up to twice as likely to engage in sexual activity as those who watch far less. References in TV regarding possible adverse consequences of precocious sexual activity can delay early sexual activity.

2.36 The sexually explicit messages daily portrayed by the media have a formative influence on children’s and adolescent’s sexual behaviour, possibly more so than the influence of parents and the educational system. We are therefore particularly concerned about misleading, inaccurate and unrealistic information about sex which may be taken as “fact” by young people. For example, how many people in soap operas—in contrast to “real life”—contract an STI or become pregnant following casual sex? We therefore are concerned that the White Paper does not call for a significant reduction in the sexual explicit content on TV. We would not be surprised if a significant reduction in sexually explicit content on TV coupled with portrayals and information on potential adverse effects of precocious sexual activity will have more impact in reducing early sexual activity in adolescents than “traditional” approaches such as school sex education.

2.37 Viewing media/TV violence can lead to increased antisocial or aggressive behaviour, desensitisation to violence or increased fear of becoming a victim of violence. Exposure to media violence results in many physical and mental health problems for children and adolescents, including aggressive behaviour, desensitisation to violence, fear, depression, nightmares, and sleep disturbances. Furthermore, prolonged exposure to violent media portrayals results in increased acceptance of violence as an appropriate means of solving problems and achieving one’s goals. All this has a direct bearing on society and the NHS.

2.38 Many studies show that young children under eight years of age are developmentally unable to understand the intent of advertisements and, in fact, accept advertising claims as inherently true. The youngest viewers, up to age eight, cannot distinguish advertising from regular television programming.

2.39 We believe that there needs to be an urgent Public Health Summit involving representation from the Government, OFCOM, representation from professional organisations, the media including TV, magazines and advertising companies. This should assess the impact of the media on young people’s health including the possibility of legislative control. The areas that need to be examined include: advertising to children, impact of violence and sex depicted on TV and the impact of electronic media on eating patterns as well as their impact on health and physical activity of young people.

2.40 The spiritual dimension of life is a fundamental part of the healing process. Modern western medicine acknowledges the contribution of body, mind and emotions in disease and healing but fails to recognise, and totally lacks understanding of, the spiritual dimension of health and sickness. We deplore the complete absence of an understanding of the spiritual roots of sickness. We consider these very significant contributors to ill health, perhaps comparable to the contribution of nutrition both to ill health and to healing.

2.41 Spirituality refers to the relationship between man and God. Spirituality is the means, both for the individual and society, to bring a sense of meaning to “being human”. The spiritual component of the healing process enables patients to have a sense of identity and self-worth, belonging and purpose, even in sickness. In comparatively recent times there has been a quite irrational trend towards the dismissal of the central role of spirituality both in causing disease and in the healing process.

2.42 Faith significantly reduces the risk of depression and suicide, and reduces the risk of alcohol, nicotine and drug misuse. Adolescents who report that religion is important to them are much less likely to engage in binge drinking, smoking, or using cannabis. They are more likely to eat in a healthy fashion and to exercise regularly. Among adults, spirituality is associated with increased physical exercise, lower rates of smoking and alcohol abuse, improved mental health including reduced depression, and maintaining marital stability. Furthermore, spirituality can positively help patients dealing with recovery from surgery, or with severe or chronic medical or emotional illness including cancer. Faith can play a central role in the lives of those who are terminally ill and allows them to “die well”.

2.43 It is therefore not surprising that faith is linked with significantly increased life expectancy. The beneficial effect of spirituality on life expectancy is comparable to the effect of not smoking or taking regular exercise.
2.44 There is very substantial evidence that Christian experience and belief has a powerful and some times
 dominant influence on the healing process. We are today seeing the emergence of a large number of Christian
 healing centres in which there is a partnership between ordained priests and ministers and health
 professionals.

2.45 As a Christian community, the Maranatha community has extensive experience in all aspects of the
 Christian Healing ministry and over many years we have experienced many healings—sometimes quite
 dramatic healings—through prayers. Perhaps one of the most relevant aspects of spirituality in terms of the
 healing process is the message of forgiveness, especially in the Christian faith, whether we call it
 reconciliation, restoration, offering new hope, affirming acceptance etc. Experience has shown that the
 giving and receiving of forgiveness, personal, individual and corporate, is pivotal to many aspects of healing.

2.46 Whereas the Department of Health must clearly meet the needs of the minority religions, sight
 should not be lost of the fact that in the last national census, 72% of the population of the United Kingdom
 claimed to have a Christian faith. It is important that the majority of the population should not in any way
 be deprived of the benefits of Christian prayer within hospitals and clinics, especially as there is very clear
 evidence supporting the benefits of spirituality in recovery from illness. It needs to be recognised that a very
 substantial proportion of all patients are in a real emotional and spiritual need and this should not be
 disregarded.

2.47 As a Christian community, we would like to introduce the biblical term “righteousness” into the
 discussion on public health. Righteousness means “right relationships” between man and God. Furthermore, it
 means a right relationship to myself (Jesus’ command is to love your neighbour as your self—there is the command to have a right relationship with others and with oneself) right relationships with others and
 right relationships with nature and the environment. The right relationship of the individual with
 God leads to a meaningful life and to healing through experiencing God’s love. The right relationship with
 oneself leads to a healthy lifestyle, including healthy nutrition, a healthy self-image which is neither
 corrupted by self-aggrandizement nor self-denigration and no need for drug or alcohol dependencies. The
 right relationship with others leads to peace and healthy communities. The right relationship with the
 environment leads to a respect for nature and the environment, reducing pollution and preserving species.
 We believe that if this concept of righteousness were followed, it would lead to a healing of the individual,
 of society and of the environment.

2.48 There is a need for greater consideration to be given within the NHS to the spiritual dimension of
 healing and it is suggested that the church’s experience of the healing process should be shared more widely
 with the National Health Service. It is, therefore, proposed that there should be a consultation between the
 Department of Health and representatives of churches and experienced specialist Christian bodies.
 Consideration should be given to the carrying out joint studies with doctors and those experienced in the
 Christian Healing ministry, to explore ways and means of achieving a deeper understanding of the spiritual
 aspects of the healing process in the interest of public health. Put simply, God cannot be dismissed from the
 healing process.

2.49 We are convinced that the healing process must be seen as far more than attending to physical
 ailments. It must embrace the broader moral, spiritual, emotional and societal factors, which govern health
 and wholeness, both personal and social.

2.50 In this Submission, we focus on some of those areas where our nation can choose health rather than
 disease. We are concerned that, as a society, we are increasingly choosing disease rather than health. We are
 concerned that the individual choices based on “rights” rather than “responsibilities” have a deleterious
 impact on public health and the NHS. We deplore the widespread assumption that “what I do with my body
 is my choice and only affects me”. This is inherently selfish and ignores the fact that individual choices have
 a profound impact on society as a whole.

2.51 We conclude that far higher priority should be given to public policies, clinical practices and
 educational procedures which focus on the prevention of disease in comparison with treatment. We
 recognise that the White Paper is attempting to do this. However, we are concerned that many areas that
 have a major impact on public health are not being addressed, perhaps out of concern to appear “politically
 incorrect” (as in the area of family breakdown and marriage support), perhaps because of influences of the
 food industry (food advertising, impact of processed foods, food colourings etc.) or influence of the
 pharmaceutical industry (in the area of nutritional prevention of chronic diseases). There is an immediate
 need for political and social leaders, both nationally and locally, to face up to what is, in effect, a public
 health crisis in the nation. In our opinion the National Health Service will soon be overwhelmed, unable to
 provide adequate treatment and be crushed by the huge burdens placed upon it by the increases in “lifestyle
diseases” such as diabetes, obesity, sexually transmitted infections, to name but a few. Furthermore, society
 as a whole will be unable to fund the dramatic costs of lifestyle choices such as widespread drug misuse,
 unstable relationships and family breakdown with all the adverse effects on children. Catastrophic trends
 need to be admitted and the need for radical change honestly accepted. We are not convinced that the “White
 Paper” is going far enough in analysis and recommendations. For this reason, we are not convinced that it
 will have only a fairly limited positive impact on the health of the nation.
3. **Marriage**

*Its positive contribution to public health*

3.1 Discussions about public health usually fail to mention the positive contribution that marriage has for public health. For example, the health benefit of being married for men is similar to the health benefit gained from not smoking. While we see a very strong campaign to try to get smokers to quit, we do not see any campaign aimed at supporting marriage.

3.2 Recent legislation has sought to undermine marriage. Furthermore, the UK tax system is less favourable to marriage than the tax systems of France and Germany. Significantly, both France and Germany have a lower rate of family breakdown.

3.3 Much of the guidance for teachers of sex and relationship education (SRE) in schools emphasises the importance of a “value-free” approach to relationships. As part of SRE, different family constellations should be discussed as being equally valid and acceptable. In a sex education pack intended for primary schools, beginning with key stage one, the teacher is encouraged to discuss different family arrangements, for example children living with married or unmarried parents, single parents, lesbian, gay and bisexual parents, grandparents etc. Teachers are instructed that “it is important not to try to ‘promote’ a particular type of home life as the norm or superior” (Julian Cohen. Primary School Sex and Relationships Education Pack, Healthwise 2001; p 22) Thus, children are not being taught that marriage is the most beneficial family structure, to be discarded at our peril.

3.4 It is clear that marriage has significant health benefits according to published evidence. Why, therefore, are pupils not told this?

3.5 It is clear that marriage reduces mortality. Married people, as opposed to divorced and separated individuals, have a lower mortality rate and are healthier. Marriage is associated with greater happiness, less depression and less alcohol abuse. It is interesting to note that cohabitation does not appear to confer the same protective benefit than marriage does.

3.6 As a Christian Community, we are convinced that marriage is the basic building block of society and contributes massively to the wellbeing of the nation. If marriage is being abandoned to other forms of living together such as cohabitation and same-sex partnerships, our entire society and especially our children will suffer. Marriage is ordained as a covenant relationship by God and it therefore has a major positive contribution to physical, emotional and spiritual health of married couples, their children and society as a whole. Conversely, the adverse effects of marriage breakdown are devastating for the individuals concerned, especially children and society as a whole as we see in the next section on family breakdown. (See evidence in Annex A.) [Not printed.]

**Recommendations**

— The promotion of marriage should, as a matter of urgency, be firmly placed on the curriculum of every school and at the centre of all sex and relationship education programmes.

— There needs to be a thorough and co-ordinated review of legislation introduced during decades which have had a direct or indirect deleterious effect on the institution of marriage. This should include aspects of the taxation system which should be more favourable to marriage.

4. **Family Breakdown**

*Its negative contribution to public health*

4.1 There is a wealth of evidence linking family breakdown with many adverse health outcomes for children, such as ill health including higher mortality, emotional problems, poor school performance and poverty. Children from broken families are also more likely to have problems with substance misuse and poor sexual health including teenage pregnancy. Furthermore, they are more likely to be engaging in criminal activity and are disproportionately over-represented in the prison population. Finally, family breakdown is associated with an increased risk of being physically or sexually abused.89

4.2 There has been a dramatic increase in family breakdown over the past 40 years: In 1961, 350,000 British people got married for the first time, 50,000 remarried, and 30,000 divorced. Forty years later, 180,000 married for the first time, 120,000 remarried, and 150,000 divorced. (Andrew Oswald, The economics of Love, May 2003).

89 All studies of child-abuse victims which look at family type identify the step-family as representing the highest risk to children. However, the term step-father needs to be defined, since it used to refer to men who were married to women with children by other men. It is now used to describe any man in the household, whether married to the mother or not. An NSPCC study of 1988 which separated married step-fathers from unmarried cohabiting men found that married step-fathers were less likely to abuse: “for nonnatatal fathers marriage appears to be associated with a greater commitment to the father role”. (Gordon, M and Creighton, S(1988), “Natal and nonnatal fathers as sexual abusers in the United Kingdom: A Comparative Analysis”, Journal of Marriage and the Family 50, pp 99-105.)
4.3 With the direct cost of family breakdown being estimated in the region of £15 billion per year—if one takes into account the indirect costs of family breakdown, then the total cost of family breakdown is likely to be in the region of £30 billion and rising—there is an urgent public health need to strengthen the family and marriage, supporting dysfunctional families and reviewing legislation and policies that undermine marriage.

4.4 At the root of many of the problems we see in children and young adults—such as emotional and behavioural difficulties, poor school performance, substance misuse, precocious teenage sexuality including teenage pregnancy and juvenile delinquency—is the dramatic increase in family breakup and “relationship turnover” of parents, adversely affecting their children?

4.5 Unfortunately, we do not detect any strong political leadership encouraging marriage, despite its many public health benefits, both to married couples, their children and society as a whole. We are convinced that reducing family breakdown will have a more significant and positive impact on many health problems seen in young people—such as substance misuse, poor sexual health including teenage pregnancy and others—that some of the official strategies currently adopted. These strategies, including drug and sex education, access to family planning clinics and others, usually fail to take into account the significant benefits gained for young people through a stable marriage of their parents. (See evidence in Annex B.) [Not printed.]

RECOMMENDATIONS

— More resources should be devoted to helping dysfunctional families in order to avoid marriage breakup with all the adverse effects on public health.
— Research needs to be carried out into the financial and social incentives and disincentives to marriage-based family life.

5. SEXUALLY TRANSMITTED INFECTIONS: PREVENTION RATHER THAN JUST TREATMENT

5.1 The UK faces an epidemic of sexual ill health. Sexually transmitted infections (STIs) are out of control, having doubled over the past six years, with some infections such as syphilis increasing by more than 500%. Over the past decade, the rate of chlamydia diagnoses in 16–19 year old girls nearly trebled. Britain’s teenage pregnancy rate, the highest in Western Europe, has not substantially changed over the past 25 years, despite several government initiatives.

5.2 The underlying cause for this is the high increase in promiscuity, risky sexual behaviour and earlier sexual activity. However, the UK sexual health strategy does not even address the underlying cause for the epidemic in sexual ill health. It is surprising to note that the National Strategy for Sexual Health and HIV fails to mention reduction in promiscuity, it also fails to mention marriage or sexual abstinence until marriage even as a remote possibility. Instead, the current approach to sexual health is based on the promotion of condoms and other contraception, access to family planning clinics and genitourinary clinics in a “value-free” and “non-judgmental” environment. However, record attendances at both GU clinics and family planning clinics together with an increase in condom use have failed to make a positive impact on the nation’s sexual health. Indeed, the nation’s sexual health continues to deteriorate at an alarming rate. Is it not time to re-evaluate the current approach to sexual health? Is it not time to assess the significance of powerful formative influences shaping sexual behaviour?

5.3 The more than doubling of STIs in the UK over the past decade contrasts with a more than 70% reduction of HIV in Uganda over the same period of time. Uganda has adopted the ABC programme: Abstain from sex, Be faithful—Partner reduction, “zero grazing”, monogamy—or if that fails use Condoms. The reduction in HIV was mainly due to behavioural change—essentially a reduction in casual sex. The promotion of condoms in Uganda had only a minor contribution to this fall in HIV. Other African countries that rely on condom promotion rather than behavioural changes, did not see significant HIV declines.

5.4 While we are aware of cultural differences, we urge the Government to learn from the success of Uganda’s balanced “ABC” approach to sexual health and urge this approach to be adopted throughout the UK. A public health campaign aimed at modifying behaviour, with a predominant emphasis on reduction of casual sex, is the only measure that will stop the epidemic of STIs in the UK. To combat STIs with the currently adopted strategy will inevitably mean continued failure.

5.5 As a Christian community, we recognise that the guidance given to us by God, for example emphasising that marriage is a lifelong covenant relationship and discouraging sex outside of marriage, is very relevant to promote good physical, emotional and spiritual health for the individual but also for society as a whole. We are concerned, that the current approach to sexual health appears to discount the physical, emotional and spiritual consequences of promiscuity. (See evidence in Annex C.) [Not printed.]

RECOMMENDATIONS

— There should be a complete overhaul of current sexual health strategies, questioning the fundamentally flawed assumptions of policies pursued in the past decades.
— There needs to be a review of the allocation of public funds to the various clinics, sexual health “educators” and others who appear to be a fundamental part of the problem rather than its solution.

— There needs to be a public health campaign warning both young people and adults of the risks involved in contracting especially non-HIV STIs, realistic information about the level of protection conferred by condoms, and a warning of the extremely dangerous consequences of abnormal sexual practices such as anal intercourse, which is both unnatural and disease prone.

6. Drug Misuse

Prevention rather than just damage limitation

6.1 The UK has one of the worst drug problems in Europe. Figures for the prevalence rates of illicit drugs, including cannabis, cocaine, ecstasy and amphetamines are among the highest, if not the highest in Europe. Over four million of the population use an illicit drug and one million use class A drugs such as heroin, cocaine, crack or ecstasy. The economic, social and health costs of Class A drugs alone is conservatively estimated to be up to £17 billion per year.

6.2 Comparing data on the prevalence of drug misuse across Europe one trend is quite obvious: countries with a high level of cannabis misuse, for example the UK, also have high levels of “hard drug” misuse such as cocaine and ecstasy. Countries with low levels of cannabis misuse such as Sweden, have low levels of other “hard drug” use. Indeed, Sweden has among the lowest, possibly the lowest, rates of drug misuse of any European country.

6.3 What are the lessons that the UK can learn from Sweden? Sweden appears to be the only European country with the goal to create a drug-free society. Drug misuse, especially cannabis misuse is strongly discouraged. There is a very strong consensus in society against drugs. Parents, teachers, police and politicians are all strongly supportive of a restrictive drug policy. The basis of the Swedish drug policy is the recognition that the only indispensable part of the drug problem is the drug user and therefore primary prevention of drug misuse ie demand-reduction, is given the highest priority. Furthermore, the Swedish drug policy is formulated around the gateway hypothesis, ie use of cannabis is associated with the use of harder drugs.

6.4 While we are aware that the gateway hypothesis is controversial we would like to point out that it cannot be denied that essentially all heroin and other “hard drug” users started on cannabis as their first illicit drug. Furthermore, there have been several powerful studies recently supporting the “gateway” hypothesis. Cannabis is therefore considered to be a very serious problem in Sweden and Swedish drug education is very clear about its many dangers. Interestingly, the Swedish Criminal justice system is given the right to enforce drug testing and compulsory drug treatment. Significantly, the Swedish Drug policy was liberal in the 1960s, essentially using a “harm-reduction” approach. Following this, drug misuse escalated to very high levels and in the 1970s, the goal to create a drug-free society was adopted. Subsequently, there was a very significant drop in drug misuse in Sweden. There is no good reason why this could not happen in this country.

6.5 The Swedish approach contrasts greatly with the UK approach where increasingly, drug policy appears to be based on the very problematic concept of “harm reduction”. “Harm-reduction” essentially portrays drug misuse as inevitable, based on the wrong assumption that “young people are going to use drugs anyway so we might as well teach them how to do it safely”. There are examples of drug education material used in the UK which aims to teach pupils the skills of “safe drug use”, a contradiction in itself, since there are no safe ways of taking drugs. It is interesting that a “harm-reduction” approach is used regarding illegal drugs but not regarding any other illegal activity. No-one would teach young people how to speed or to steal safely, the clear message instead is “speeding is dangerous and illegal”. Harm-reduction accommodates and normalises, rather than prevents, drug misuse. While “harm-reduction” may have its place once a person is addicted, for example some heroin addicts may benefit from methadone maintenance, it has no place as part of drug education in schools, where still the majority of pupils are not taking drugs regularly. Instead, the focus of drug education should be the prevention of drug misuse.

6.6 The recent reclassification of cannabis has caused major confusion. Surveys show that many pupils now think that cannabis is legal, harmless and even some form of medicine. However, cannabis is not the innocuous drug it is made out to be. There has been a very significant increase in the numbers of young people attending drug treatment centres with cannabis addiction as their main problem. There is a wealth of evidence linking cannabis with serious mental health problems including schizophrenia, psychosis and depression. It is estimated that in London, about 80% of all new cases of schizophrenia are due to cannabis misuse, therefore causing major problems to an already overstretched psychiatric service. Cannabis is addictive and impairs learning, concentration and educational performance. Cannabis is also associated with significant lung damage including severe emphysema and head and neck cancers in young people. Cannabis on its own but especially in combination with alcohol increases the risks of road traffic accidents.

We agree with the International Narcotics Control Board when it stated last year: “Advocates of drug legalisation, particularly of cannabis, are vocal and have access to considerable funds that are used to misinform the public.”
6.7 We believe that widespread cannabis abuse has become a major public health hazard and we note with grave concern that, while there is a focussed public health campaign against smoking tobacco, there is no such campaign against smoking cannabis.

6.8 From a Christian standpoint we are concerned that the issue of drug misuse is frequently focussed only on the physical and perhaps also the emotional aspects of drug misuse, ignoring the spiritual dimension. For a drug user, drugs offer "salvation" from pain or a painful reality or from trauma, from depression, or from poor self-esteem and boredom. This, obviously, does not just apply to illicit drugs but also to legal drugs such as alcohol and tobacco. However this "salvation" is a myth and creates further serious problems including addiction and potentially early death. (See evidence in Annex D.) [Not printed.]

RECOMMENDATIONS

— There should be an urgent overhaul of the current national drugs strategy. There must be a major shift away from harm reduction to primary prevention and demand reduction as the basis for all drug policies.

— The Government should pay far more attention to leading medical scientists, clinicians and researchers, rather than just selected advisors and NGOs in pursuing drug policies.

— A fundamental element of future policy should be the reversal of the recent reclassification of cannabis.

— There needs to be a major public health campaign warning especially young people of the dangers of cannabis abuse and discouraging cannabis abuse.

— Consideration, encouragement and support should be given to the established track records of many Christian help groups and drug treatment centres. (There is widespread concern that some of them are being penalised for no other reason than their religious affiliation).

— Schemes for compulsory treatment for drug offenders should be expanded and far more rigorously enforced.

7. Toxicity and Allergies

The hidden risks

7.1 There is an urgent public need to identify and, wherever possible, to avoid toxins.

7.2 It is widely recognised that we are living in a dangerous environment in which we are in danger of being poisoned in a variety of different ways, through contaminated water, contaminated nutrition, through outdoor and indoor pollution, possibly also low-level radiation and electromagnetic fields. Perhaps the most worrying issue is the obvious ignorance of the long-term effects of many of the substances that we are ingesting.

7.3 While there has been some research—not all of it independent from industry—into the health effects of toxic substances such as pesticides entering the food chain, we are concerned that much of the safety data relates to adults. It is therefore very likely that official "safe" thresholds are by no means safe for the developing bodies, especially the developing brains, of children.

7.4 Furthermore, we are seriously concerned that the data examining toxic substances appears to focus on isolated substances. Not much research has been done examining the additive toxic effects of substances in a "cocktail". There is evidence, however that there can be a significantly increased toxic "cocktail effect" by the combination of several toxic substances even though all of them are well below their "safe" limits.

7.5 It is impossible to even give an overview of the effects of toxins on human health and public health. We therefore want to limit our submission (including the evidence in the appendix) to a few substances and examples of toxicity, focusing on the adverse impacts of pesticides, air pollution and the role of toxicity in childhood conditions such as learning difficulties, autism and ADHD.

7.6 Children are exposed to potentially carcinogenic pesticides from use in homes, schools, other buildings, lawns and gardens, through food and contaminated drinking water, from agricultural application drift, and from carry-home exposure of parents occupationally exposed to pesticides. Parental exposure during the child’s gestation or even preconception may probably have great significance. Childhood malignancies linked to pesticides in case reports or case-control studies include leukemia, neuroblastoma, Wilms’ tumor, soft-tissue sarcoma, Ewing’s sarcoma, non-Hodgkin’s lymphoma, and cancers of the brain, colorectum, and testes. There has been a significant increase in childhood cancer over past decades, including non-Hodgkin’s Lymphoma. Could it be that toxicity from pesticides plays a role in this increase?

7.7 In this context we want to remind the Department of Health of the devastating effect of excessive alcohol consumption in the UK and deplore, that there appears to be no current Alcohol strategy in the UK. We are particularly concerned about the consequences of the proposed liberalisation of licensing laws. This can only add to the already crippling problem faced by the emergency services.
7.8 Alcohol misuse has a huge toll on the population. Over 5,500 people die each year due to direct effect of alcohol. However the total number of deaths where alcohol plays a part may be in excess of 30,000 a year. The number of alcohol-related deaths has increased dramatically over the past five years. One person in 13 is dependent on alcohol in Britain. British adolescents are among the worst in international comparison regarding alcohol consumption, being drunk and binge drinking. Alcohol misuse costs the UK in excess of £10 billion a year in health and social costs.

7.9 It is estimated that every year, there are 8,100 deaths from particulate matter and 3,500 deaths because of sulphur dioxide in urban areas of Great Britain. The numbers of deaths by ozone in both urban and rural areas of Great Britain during summer ranges between 700 and 12,500 depending on which threshold for ozone is used. Particulate pollution therefore costs many lives, far more than the number of deaths from road accidents.

7.10 There has been a dramatic increase in childhood conditions such as learning difficulties, ADHD and autism. There are many—sometimes controversial—theories on the causation of these conditions. However we are concerned that there appears to be little awareness—even in professional circles—of the contribution of neurotoxins such as lead, mercury, cadmium, dioxins, organophosphates and other toxins in those conditions.

7.11 Socially, mental and moral toxicity may be spread through the media which condition viewers, listeners and readers to sex, violence and degradation. The desensitizing and indoctrinating of the public has a knock-on effect on national health. (See evidence in Annex E.) [Not printed.]

Recommendations

— We believe that there needs to be a Royal Commission—indepen dent of the chemical and food industries—to assess the full impact of toxicity and of processed foods on our lives.
— In view of the widespread lack of awareness regarding the adverse effects of toxins, especially neurotoxins, on children, we believe that there should be a national screening programme for the most common toxins that adversely affect children such as lead, mercury, cadmium, dioxins, organophosphates and others.
— In view of the devastating effect of alcohol on society we urge the Department of Health to develop an integrated alcohol strategy for the prevention and treatment of alcohol addiction, including ensuring the education system warns children of the dangers.
— Resource allocation should be directly related to epidemiological evidence, and to the operation of “early-warning” public health systems. This should not be restricted just to infectious diseases, but should focus on a wider remit.

8. DIET AND NUTRITION

A neglected area

8.1 Healthy nutrition demands that we have a balanced diet, but millions of people suffer because of a serious imbalance of diet. We are constantly encouraged by commercial interests to consume excessive amounts of fat, salt and sugar. Children are encouraged to eat junk food and adults to have an excess alcohol intake. All this is leading to enormous social and health problems with substantial strain on the health service, which no government can ignore.

8.2 It is likely that many of the diseases we see currently in western societies are due to changes in our diet: The dominating illnesses in modernised societies are new, or have become newly prominent, in the past 100–150 years. When traditional societies modernise, they, too, seem to develop these same “modernisation diseases” within a few decades. These illnesses include cardiovascular diseases such as ischaemic heart disease, hypertension and stroke; respiratory diseases such as asthma, metabolic diseases such as obesity and diabetes, malignancies such as major types of cancer including cancers of the breast, prostate and colon, allergies, gastrointestinal conditions such as appendicitis, inflammatory bowel diseases, irritable bowel syndrome and coeliac disease and behavioural disorders especially in children such as childhood hyperactivity and “autism”.

8.3 While it is possible that some of the above conditions are due to a “westernised lifestyle, part of the “westernised lifestyle” comprises a “western diet” which in itself consists of increased intake of processed foods, including increased intake of fats, sugars, salt and an increased intake of total calories. Obviously, other factors also contribute to a “western lifestyle” such as reduced physical activity, increased exposure to toxins through for example pesticides, air pollution, etc. exposure to electromagnetic fields, reduced amount of sleep and other influences.

8.4 The medical treatment of many chronic lifestyle diseases such as ischaemic heart disease, hypertension, stroke, diabetes, asthma and cancer uses up most of the resources of the health service including drug budgets. The anticipated increase in these conditions, especially obesity, diabetes and cancer is likely to financially crush the NHS. Currently, among the highest prescribing drug costs in UK General
Practice are cholesterol-lowering statins. However, antihypertensives and inhalers for asthma/COPD also contribute very significantly to drug costs. In addition to those costs, the social and economic cost due to incapacity, disability and death caused by these diseases can hardly be overestimated.

8.5 The nutritional treatment of many chronic diseases is relatively cheap compared to drug costs. For example, one strategy for the secondary prevention of ischaemic heart disease (IHD) used a Mediterranean-style diet. This intervention led within three years to a 70% reduction in overall mortality rate, compared with the far more expensive statin treatment, which, over a five-year period led to at most a 30% reduction in overall mortality. Statin treatment is expensive. For secondary prevention, statins costs in the range of £4,000-9,000 per life-year saved. Primary prevention is even more expensive. Mediterranean diet is with a cost of around £300 per life-year saved only a fraction as expensive. Another study examined the impact of eating two or three portions of fatty fish per week on the survival of men with a previous heart attack. Within two years of the commencement of this simple diet change, a significant reduction in all-cause mortality was observed. This mortality reduction was similar to the reduction achieved in trials using statins for a period of over five years. We are convinced that the currently adopted strategy of combating IHD with statins and neglecting more beneficial dietary interventions both for prevention and treatment is a grave misallocation of scarce public funds.

8.6 There is strong evidence from many studies that at least three dietary strategies are effective in preventing IHD: replace saturated and trans-fats with non-hydrogenated unsaturated fats, increase consumption of omega-3 fatty acids from fish or fish oils, and consume a diet high in fruits, vegetables, nuts, and whole grains and low in refined grain products. However the usual recommendation to simply reducing total fat in the diet is unlikely to reduce IHD. A recent review from Harvard University concluded: “Substantial evidence indicates that diets using non-hydrogenated unsaturated fats as the predominant form of dietary fat, whole grains as the main form of carbohydrates, an abundance of fruits and vegetables, and adequate omega-3 fatty acids can offer significant protection against coronary heart disease. Such diets, together with regular physical activity, avoidance of smoking, and maintenance of a healthy body weight, may prevent the majority of cardiovascular disease in Western populations.”

8.7 There are examples of community-based intervention programmes, such as the Finnish North Karelia Project, which influence diet and other lifestyles that are crucial in the prevention of cardiovascular disease. Broad community organisation and the strong participation of people were the key elements. Following this, the diet of the population has changed and these changes have led to a major reduction in average serum cholesterol and blood pressure levels. Following this, ischaemic heart disease mortality has declined by 73% in North Karelia. The project was based on low-cost intervention activities, where people’s participation and community organisations played a key role.

8.8 Unfortunately, while common sense teaches that nutrition is essential for health and well-being, nutritional medicine as a medical and public health specialty is, in our view, a neglected area. It is a fairly new science, not routinely taught at medical school and appears to attract less attention than drug prescribing.

8.9 It appears that far more research is done into drug treatment of chronic diseases funded by drug companies. Drug companies are obviously more interested in selling their drugs—ideally, from a company point of view, to patients with often life-long “incurable” illnesses such as IHD, hypertension, diabetes and asthma, than into the prevention and possibly even cure through nutrition. How many times have doctors been approached by drug representatives trying to promote for example a statin as opposed to someone wanting to promote olive oil or nutritional supplements?

8.10 One relatively recent development over the past decades is the increase in consumption of processed foods. Processed foods include those that have been heat-ed or fried, refined, artificially coloured, blended, or enriched to provide different flavours, textures and colour. Almost all processed foods contain many different chemicals and additives to help stabilise and preserve the texture, colour, flavour and freshness of the food. Additives including animal and vegetable fats, trans fats, salt colour dyes and chemical flavours are added to food to make them more appealing. In addition, preservatives like nitrates, sulphates and salt, are added to prolong the shelf-life of processed foods. This processing of food must be balanced against the fact that foods naturally degrade over time.

8.11 The significant increase in ready-made meals which are based on processed foods show the following statistic: In 2002, the average household spent just 20 minutes preparing each main meal—down from one hour in 1980. British consumers now spend £7,000 a minute on ready meals. This is three times more than any other European country. (The Guardian, 29 May 2004)
8.13 There is now no doubt that many food additives are actually or potentially dangerous, but often little seems to be done to take this matter seriously, presumably because of huge commercial pressures. Manufacturers deliberately manipulate the taste process of foods, increasing the appetite for “more” of the same food. The government needs to be far more aware of the significant danger of allowing commercial interests to endanger public health, particularly with the use of very dangerous chemicals which enter the food chain.

8.14 Frying foods, especially starchy foods (potato and cereal products) at high temperature produces acrylamide, classified as probable carcinogen in animals. Furthermore, acrylamide is toxic to the nervous system of animals and humans. Swedish research found that while their raw ingredients contained no detectable levels of acrylamide, crisps contained levels 500 times more than the WHO maximum recommended level for drinking water. French fries contained levels 100 times more.

8.15 Despite the widespread increase of allergies there appears to be very little knowledge on how to prevent the development of allergies in the first place. Treatment of allergies should not be limited to the reducing or eliminating of allergens but with altering the “wrong” immunological response of the allergic individual. Far more attention, therefore, needs to be given in the healing process to methods of building up the immune system so that it can deal effectively with disorders. A substantial contribution in this respect can be made by diet and with mineral and vitamin supplements. Sadly, under obvious pressure from international pharmaceutical companies, the European Union have seen fit to pass legislation which will dramatically hinder the use of these supplements. (See Annex F.) [Not printed.]

Recommendations

— There is a case for a UK-wide integrated nutritional medicine strategy. There is a need for a nutritional prevention strategy of chronic diseases such as heart disease, stroke, asthma high blood pressure, diabetes, obesity, cancer and other chronic conditions.
— A highly controversial area is the health impact of processed and refined foods and of food additives including colourings, preservatives, trans-fats and others. We therefore call for the establishment of a Royal Commission independent of the food industry to examine the public health effects of processed foods and food additives.
— We strongly recommend there should be a national programme of research and development to guide the food industry in developing alternative technologies to decrease the content of food additives but also sodium, sugars and fat in prepared and processed foods, while maintaining quality, acceptability, and cost.

9. Health, Children and the Media

Power without responsibility?

Lifestyle and the Media

9.1 Exposure to media, including watching TV, playing video games, listening to radio and reading magazines has a powerful formative impact on children and young people, including their physical, emotional and spiritual health. Time spent watching TV and playing computer games exceeds the time spent on physical activity for most children and for many children exceeds the time spent with parents. British children spend on average five hours per day using media—more than in any other European country. In the US a young person graduating from high school has spent more time in front of a TV than at school.

9.2 Television and the media therefore have a major influence on the values and behaviours of young people in addition to the impact on health and educational achievement. We are convinced that it has not yet been fully realised that the media has a formative influence on the values and behaviour of children and adolescents.

9.3 Because children have high levels of media exposure, more so than in previous generations, the media have now greater access and time to shape young people’s attitudes, values and behaviour than do parents or teachers. The media therefore replaces parents and teachers as educators, role models, and the primary sources of information about the world and how to behave.

9.4 Time spent watching television or playing computer games takes away from important activities such as social interaction and development, especially time spent with the family, physical activity including playing but also reading and school work.

9.5 Children’s behaviour is influenced by information from television totally inappropriate for their age, and even incorrect. While there is the “watershed” this is rendered essentially irrelevant through video recorders that can be pre-programmed and the fact that nearly two-thirds of all children under six have a television in their room, and one-third of those up to the age of three have their own screen in their room.

9.6 Younger children under the age of 8 often cannot tell the difference between the fantasy presented on television versus reality. Children are also adversely influenced by the thousands of advertisements they see each year, many of which are for alcohol, junk food, fast foods, and toys.
9.7 Advertising often works by making the viewer feel unhappy with our lives, anxious and dissatisfied, lacking something. The messages are that you are not OK unless you buy this, wear that brand, wash your hair with, and look like that very slim model. It attacks our self-esteem. Girls in early adolescence are particularly vulnerable to messages about being OK as they are sensitive about their body image and whether they measure up to the peer group. Recent research indicates that there is a marked link between TV watching, and negative body and eating disorders in adolescents.

9.8 Violence, sexuality, certain stereotypes, but also drug and alcohol abuse are common themes of television programmes and some computer games. Young children are impressionable and may assume that what they see on television or experience in a computer game is typical, safe, and acceptable. As a result, television and computer games expose children to damaging behaviour.

9.9 Children who watch a lot of television are likely to have lower grades in school, read fewer books, exercise less, be overweight and are more likely to be verbally and physically violent.

9.10 Public health initiatives therefore need to address the negative impact of the media on public health. We should not, however, overlook the fact that the media can sometimes have a positive impact on behaviour.

9.11 We are particularly concerned about the negative effect of the media including TV advertising on public health in the following areas: nutrition and health including obesity and diabetes, behavioural changes including increased violence, sexual behaviour and self-image, educational achievement including literacy.

Food, Healthy Eating and the Media

9.12 There are many adverse effects of watching TV on children’s health. The time spent watching TV is not spent on physical activities and the foods depicted on TV—both in programmes and in advertisements—are frequently unhealthy. Also, while watching TV children are more likely to snack. Watching TV lowers children’s metabolic rate to below what it would be even if they were sleeping, therefore by watching TV children “burn off” fewer calories than while sleeping.

9.13 It is interesting to note that—at the same time where there is an explosion in childhood obesity—there has been a steady increase in time children spend watching TV, playing computer games or spending time on the internet. While the media alone cannot explain the explosion in childhood obesity, they play a major role in causing the epidemic of childhood obesity.

9.14 There is significant evidence linking time spent watching TV with obesity. In one of the first studies examining this link it was found that among 12 to 17-year-olds the prevalence of obesity increases by 2% for every hour spent watching TV. Conversely nearly one-third of childhood obesity could be prevented by reducing TV watching to 0-1 hour per week.

9.15 In addition to obesity caused by reduced physical activity while watching TV, the advertisements seen while watching TV are a powerful force to influence children’s behaviour. They influence children to eat certain foods, drink certain drinks or buy certain toys. Advertisements have a powerful force to influence values (for example to impart the values of a consumerist society) and to shape behaviour.

9.16 In the US, it is estimated that children have viewed an average of 360,000 advertisements on TV before graduating from high school. In addition to this children are exposed to advertisements in radio, newspapers, magazines and billboards.

9.17 Many studies show that young children under 8 years of age are developmentally unable to understand the intent of advertisements and, in fact, accept advertising claims as true. The youngest viewers, up to age 8, cannot distinguish advertising from regular television programming.

9.18 The media regularly carries advertising campaigns advocating the taste or the value of various foods, or promoting the image of the food supplier. What these campaigns often ignore is the absolute health factor of the food being promoted. In particular, sugar, salt and fat levels are often way above the levels that dietary experts say should be the maximum daily intake. Even foods promoted with campaigns that expound a healthy aspect of a particular food often ignore worryingly high levels of other ingredients such as sugar, salt or fat.

Alcohol Consumption and the Media

9.19 The media have consistently depicted the drinking of alcohol as socially acceptable. Most television “soap operas” are built around the “local”—the Queen Vic for Eastenders, the Rovers Return for Coronation Street and the Woolpack for Emmerdale. In these programmes, all transmitted before the watershed, excessive consumption of alcohol is regularly depicted.

9.20 Even in “docu-soaps” excessive alcohol consumption is regularly seen. Programmes about holiday reps and those programmes built around images from public monitoring cameras, tend to present images of peers who are drinking heavily, promoting the excessive intake of alcohol as a norm. Reality TV shows such as “Big Brother” often use alcohol as a reward measure. Many adolescents admire the fact that drunken behaviour has “bought” a member of their peer group their “15 minutes of fame”.

9.11 We are particularly concerned about the negative effect of the media including TV advertising on public health in the following areas: nutrition and health including obesity and diabetes, behavioural changes including increased violence, sexual behaviour and self-image, educational achievement including literacy.
Sexual Health and the Media

9.21 There has been a steady increase in the amount of sex in the media, especially TV but also magazines and an increase in the explicitness of these portrayals. There appears to be a fairly consistent sexual message: most portrayals of sex depict or imply heterosexual intercourse between unmarried adults portraying promiscuity as the norm, with little reference to sexually transmitted infections (STIs) and AIDS, pregnancy, or use of contraception.

9.22 The sexually explicit messages daily portrayed by the media have a formative influence on children’s and adolescent’s sexual behaviour, possibly more so than the influence of parents and the educational system. We are therefore particularly concerned about misleading, inaccurate and unrealistic information about sex which will be taken as “fact” by young people. For example, how many people in soap operas—in contrast to “real life”—contract an STI or become pregnant following casual sex?

9.23 Heavy exposure to media sex leads to a wrong perception in that young people wrongly believe that “everyone is doing it”. Exposure to media sex makes young people believe wrongly that sex is more common at an early age and more frequent than in reality. As a result, the media, especially TV may normalise precocious sexual activity and promiscuity.

9.24 The media have consistently depicted sexual adventure and unstable sexual relationships as socially acceptable. In television “soap operas” such as Eastenders, Coronation Street and Emmerdale, all transmitted before the watershed, marital and sexual infidelity is regularly depicted. The constant featuring of sexual activity through television, is the cause of exciting story lines and inevitably leads to sexual curiosity occurring before sexual competence is reached.

9.25 On television, abstinence among teenagers is rarely portrayed in a positive fashion. Modesty is mocked and charity ridiculed. Analyses show that the average American teenager will view nearly 14,000 sexual references, innuendoes, and jokes per year, yet only 165 of the references will deal with such topics as birth control, self-control, abstinence, or STIs. On soap operas—which are extremely popular with teenage and pre-teenage girls—the sexual content has more than doubled since 1980. Soap opera sex is 24 times more common between unmarried partners than between spouses. Music Television (MTV), 75% of concept videos (videos that tell a story) involve sexual imagery, over half involve violence, and 80% combine the two, portraying violence against women. While we are not aware of similar British data, we expect similar findings on British TV, especially since many American series are shown here.

9.26 Advertising uses a significant amount of increasingly explicit sexual imagery. Sex is used to sell many everyday products. Advertising therefore directly contributes to the sexualising of society.

9.27 The link to the media of this explosion in promiscuity and STI’s is clear. Newspapers, teenage magazines and television all actively promote promiscuity and present extramarital sex as the norm. The music industry has rising sales of records which are often based on perverted sexual activity and promiscuity.

9.28 Lyrics such as the examples in Appendix G are being pumped into young people all the time, the industry is totally unregulated and self-censorship has not worked. The net effect of such music is to dehumanise the act of sexual union and to destroy respect for self and others. The contribution of such lyrics must be questioned in the light of the current increase in sexually transmitted diseases as well as sexual crime.

Violence and the media

9.29 There has been a significant increase in the exposure of children to TV and media violence, not only in TV programmes but also through violent computer games.

9.30 Viewing media/TV violence can lead to increased antisocial or aggressive behaviour, desensitisation to violence (becoming more accepting of violence in real life and less caring about other people’s feelings), or increased fear of becoming a victim of violence.

9.31 Exposure to media violence results in many physical and mental health problems for children and adolescents, including aggressive behaviour, desensitisation to violence, fear, depression, nightmares, and sleep disturbances. This all has a direct bearing on the NHS.

9.32 Prolonged exposure to violent media portrayals results in increased acceptance of violence as an appropriate means of solving problems and achieving one’s goals. Television, films and videos normalise carrying and using weapons and glamorise them as a source of personal power in a world which is perceived to be increasingly dangerous and violent.

9.33 Television exposure during adolescence has also been linked to subsequent aggression in young adulthood. A 17-year study concluded that teens who watched more than one hour of TV a day were almost four times as likely as other teens to commit aggressive acts in adulthood.

9.34 In July 2000, the American Academy of Paediatrics, American Academy of Child & Adolescent Psychiatry, American Psychological Association, American Medical Association, American Academy of Family Physicians, and American Psychiatric Association issued a joint statement that concluded: “At this time, well over 1,000 studies point overwhelmingly to a causal connection between media violence and aggressive behaviour in some children.”
9.35 There is a direct link between violent video games and violence and aggression. According to some American researchers it is estimated that playing violent video games contributes up to one-fifth to the increase in adolescent violence. Decreasing the time spent watching TV and playing video games significantly reduces physical and verbal violence in children.

The Regulation of the Media

9.36 With the introduction of the “digital age” there has been a vast increase in viewer and listener choice. Whilst this increase in choice is to be welcomed, there has been considerable relaxation of regulation and an increasing reliance on self-regulation. We would submit that many of the issues highlighted in this document are a direct result of the more lax standards that are now applying to broadcasting. This has now become a major public health issue.

9.37 Young people are particularly vulnerable during their formative years. Research by the Independent Television Commission (ITC now incorporated into Ofcom, as part of the Digital Action Plan in 2003), indicated the number of second and third television sets in households, many of which are watched by children with little or no parental guidance or supervision. In 2002 the ITC found that 19% of households had one television set, 36% had two, 27% had three with 12% having four sets.

9.38 The ITC report “What Children Watch” issued in June 2003 made it clear that children have access to television, and are often watching it during the majority of their “home” time. This access is often unfettered, and may also include use of video recorders with most children having their own video collection.

9.39 The proliferation of channels together with the strong development of the independent production sector has seriously diluted the regulation of individual programmes. The licences granted to platform operators may impose responsibilities for the material carried. However the content provider contracts negotiated with the platform operators will give indemnity to the platform operators and the content providers most often source material from organisations even more remote from the regulatory authorities. Independent producers, often established for a single series with itinerant staff, have bought in packages from music suppliers who will not allow editing of material, or programming sourced from overseas.

9.40 Unfortunately the media has largely lost the sense of responsibility that it once had.

9.41 The sad truth is that most children and young people in the United Kingdom now have direct access to pornography with grave consequences for their future well being.

9.42 As a Christian community we are very concerned at the spiritual impact of violence, sexual promiscuity, and pornography on the young now being transmitted through the media. (See further evidence in Annex G.) [Not printed.]

Recommendations

— We believe that there needs to be an urgent Public Health Summit involving representation from the Government, especially the Departments of Health, Education and Skills, Culture, Media and Sports, Ofcom, representation from professional organisations such as the Royal College of Paediatrics and Child Health, the media including TV, magazines, advertising companies and companies producing computer games and others assessing the impact of the media on young people’s health including legislative control. The areas that need to be examined include those mentioned in this submission: advertising to children, impact of violence and sex depicted on TV and the impact of electronic media on eating patterns as well as general health and physical activity of young people.

— We urge the Government to implement regulation of advertising in the media of products with unhealthy levels of sugar, salt and fat, especially to children, just as the advertising of cigarettes has been regulated. This should be introduced in spite of likely pressure from commercial interests associated with sugar and other commodity production.

— Further consideration should be given, as a matter of urgency, to ways of addressing healthy eating and increasing levels of exercise amongst young people so as to address current increasing incidence of obesity. Maranatha acknowledges that the Government is taking some initiatives on these issues. However obesity is now approaching epidemic levels and emergency action on this issue should be initiated this year.

— We urge Government to work with the media to ensure that drinking, drug-taking, casual sex and violence are not glamourised, and that portrayal of drunkenness is minimised.

— We urge the Government to examine popular television and work with broadcasters to introduce a balance of fidelity into the depiction of relationships in programmes transmitted both before and after the watershed.

— We urge the Government to work with the music industry and broadcasting and media to urgently devise a method of introducing responsibility into the industry and in the promotion of popular music.
— We urge the Government to examine the regulatory framework for content broadcast on all platforms and to ensure that Ofcom is exercising its prime responsibilities in light of the issues raised in this submission.

— The Maranatha Community has suggested in this submission and in previous submissions solutions that should be considered to reduce the incidence of disease related to promiscuity, alcohol consumption and poor diet. In our opinion, the media has a very large part to play in developing and delivering campaigns on these issues. A responsible media can, indeed must, help to build a new generation where health is improving.

10. **Spirituality and Health**

*A neglected area*

10.1 In the Judeo-Christian tradition the healing process embraces body, mind and spirit. The spiritual dimension of life is a fundamental part of the healing process. Modern Western medicine acknowledges the contribution of body, mind and emotions in disease and healing but fails to recognise and totally lacks understanding of the spiritual dimension of health and sickness.

10.2 A very high proportion of the hospitals and centres for healing were originally established and maintained for generations by the Church and Christian bodies.

10.3 Spirituality refers to the relationship between man and God. Spirituality is the means, both for the individual and society, to bring a sense of meaning to “being human”. The spiritual component of the healing process enables patients to have a sense of identity and self-worth, belonging and purpose, even in sickness.

10.4 In comparatively recent times there has been a quite irrational trend towards the dismissal of the central spiritual role both in causing disease and in the healing process. The rejection of spirituality is based on a rejection of a belief in God. However, to claim that there is no God is no more “objective”, “rational” and “scientific” than to claim that there is a God, even though those who base their worldview on the assumption that there is no God often claim to be “rational” and “scientific”. Official documents may refer to the physical, emotional or social dimensions of health without mentioning the spiritual dimension at all. The increased secularisation of society has undoubtedly robbed many of the benefits of spiritual healing. There are now growing signs of a rediscovery of this.

10.5 In many respects we are a sick society and this sickness is manifest in almost every part of our national life. Sickness is seen in our physical, emotional and spiritual condition. Sickness may be self-inflicted due to poverty or unhealthy lifestyles. It may be environmental and may be attributed to toxins/pollution in air, water and food. This sickness may also be rooted in social influences such as poverty or working conditions. While we see a recognition of many of the above factors in public health, we deplore the complete absence of an understanding of the spiritual roots of sickness which we consider very significant contributors to ill health, perhaps comparable to the contribution of nutrition both to ill health and to healing.

10.6 Studies have shown that religious commitment significantly reduces the risk of depression and suicide, and reduces the risk of alcohol, nicotine and drug misuse. Spirituality can positively help patients dealing with recovery from surgery, or with severe or chronic medical or emotional illness including cancer. Faith can play a central role in the lives of those who are terminally ill and allows them to “die well”.

10.7 Spirituality and the practice of religion generally enhance adolescent and adult health behaviours. Adolescents who attend church regularly and report that religion is important to them are much less likely to engage in binge drinking, smoking, or using cannabis. They are more likely to eat in a healthy fashion, to exercise regularly, get adequate sleep, and wear seat belts. Among adults, the practice of religion is associated with increased physical exercise, lower rates of smoking and alcohol abuse, improved mental health including reduced depression, and maintaining marital stability.

10.8 It is therefore not surprising that faith is linked with significantly increased life expectancy. The beneficial effect of spirituality on life expectancy is comparable to the effect of not smoking or taking regular exercise.

10.9 There is very substantial evidence that Christian experience and belief has a powerful and sometimes dominant influence on the healing process. We are today seeing the emergence of a large number of Christian healing centres in which there is a partnership between ordained priests and ministers and health professionals.

10.10 As a Christian community, the Maranatha Community has extensive experience in all aspects of the Christian Healing ministry and over many years we have experienced many healings—sometimes quite dramatic healings—through prayers. These healings have involved many individuals affected by conditions such as advanced malignancies, serious “incurable” medical conditions, infertility and serious mental health problems.
10.11 Perhaps one of the most relevant aspects of spirituality in terms of the healing process is the message of forgiveness, especially in the Christian faith, whether we call it reconciliation, restoration, offering new hope, affirming acceptance etc. Experience has shown that the giving and receiving of forgiveness, personal, individual and corporate, is pivotal to many aspects of healing. The Christian faith gives patients the ability to forgive and to be forgiven. It is vital that the NHS provides facilities for this process to be accommodated.

10.12 The role of hospital visitors and chaplains has been firmly established and much appreciated for generations. There is, however, currently a widespread concern about the drastic limitations which have been placed upon the NHS Chaplaincy. Their role has been diminished by virtue of them not being allowed crucial information about patients on entry into hospital. It has been claimed that this is due to the Data Protection Act. There is no evidence whatsoever of any complaints over access to this information by chaplains and ministers and many patients have expressed their dismay at what they regard to be an unacceptable intrusion of bureaucracy.

10.13 Whereas the acceptance of the spiritual dimension of healing has brought considerable help to countless people there is, sadly, much evidence that there are dangers in allowing occult practices to intrude into the Health Service. Most occult practices are extremely dangerous and have left a trail of casualties. The NHS should never under any circumstances countenance occult techniques such as Reiki, nor the operation of spiritist mediums within the Health Service. Many are disturbed at the possibility of National Health Service resources being diverted to a variety of dubious and potentially damaging “New Age” practices.

10.14 Whereas the Department of Health must clearly meet the needs of the minority religions, sight should not be lost of the fact that in the last national census, 72% of the population of the United Kingdom claimed to have a Christian faith. It is important that the majority of the population should not in any way be deprived of the benefits of Christian prayer within hospitals and clinics, especially as there is very clear evidence supporting the benefits of spirituality in recovery from illness. It needs to be recognised that a very substantial proportion of all patients are in a real emotional and spiritual need and this should not be disregarded.

10.15 As a Christian community, we would like to introduce the biblical term “righteousness” into the discussion on public health. Righteousness means “right relationships” between man and God, right relationship to myself (Jesus’ command is to love your neighbour as your self—there is the command to have a right relationship with others and with oneself) right relationships with others and right relationships with nature and the environment. The right relationship of the individual with God leads to a meaningful life and to healing through experiencing God’s love. The right relationship with oneself leads to a healthy lifestyle, including healthy nutrition, a healthy self-image which is neither corrupted by self-aggrandizement nor self-denigration and no need for drug or alcohol dependencies. The right relationship with others leads to peace and healthy communities. The right relationship with the environment leads to a respect for nature and the environment, reducing pollution and preserving species. We believe that if this concept of righteousness were followed, this would lead to a healing of the individual, of society and of the environment. (See evidence in Annex H.) [Not printed.]

**Recommendations**

— There is a need for greater consideration to be given within the NHS to the spiritual dimension of healing and it is suggested that the church’s experience of the healing process should be shared more widely with the National Health Service. It is, therefore, proposed that there should be a consultation between the Department of Health and representatives of churches and experienced specialist Christian bodies.

— It is proposed that all chaplains within the NHS are given equal professional status with other members of the medical team and enabled to have access to basic information concerning patients.

— Consideration should be given to the carrying out joint studies with doctors and those experienced in the Christian Healing ministry, to explore ways and means of achieving a deeper understanding of the spiritual aspects of the healing process.

**11. Political Factors and Health**

**Who decides?**

11.1 In this section, we wish to look at three areas where we are convinced, that interests of certain individuals or groups have unduly dominated the decision-making process to the detriment of public health. These include the downgrading of cannabis, the current sexual health strategy and the link between drug companies and industry-sponsored research overstating the beneficial effects of their products.
11.2 Often, political decisions are taken upon the advice of “independent” or “expert” committees such as the Advisory Council on the Misuse of Drugs, the Sexual Health and HIV Strategy Integrated Steering Group, the Teenage Pregnancy Unit or the so-called Independent Advisory Group on Sexual Health and HIV. There are grave concerns that these bodies make recommendations, which have widespread implications for public health, based on an unrepresentative membership.

11.3 It is of serious concern that there may be potential serious conflict of interests. Organisations that provide services and are represented on government advisory bodies include among others the Family Planning Association and Brook Clinics. It is surprising to note that these bodies, which directly benefit from the allocation of resources for family planning services, have been appointed to be members of “independent” advisory committees, thus deciding the direction of policies regarding sexual health. Not surprisingly, the policies recommended by these bodies advocate for example the expansion of family planning services.

11.4 The recent reclassification of cannabis caused confusion. It is likely that it already has led to increased use of cannabis with all the detrimental effects on public health. The reclassification was based on incomplete evidence. The recent evidence linking cannabis to severe mental health problems such as schizophrenia and other psychoses could not have been taken into account because this research was published after the Advisory Council on the Misuse of Drugs (ACMD) submitted its report in March 2002. The ACMD report recommended the downgrading (reclassification) of all cannabis preparations from a class B to a class C.

11.5 We are particularly concerned about the composition of the Advisory Council on the Misuse of Drugs (ACMD). A significant proportion of the members of the ACMD are also members of organisations involved in the promotion of “harm-reduction”. The ACMD had no members of leading drug prevention organisations, no expert on schizophrenia and only few scientists on its panel. Even though the majority of research directly linking cannabis with mental illness including schizophrenia was not published until November 2002, the Home Office maintained that this research had been taken into account when recommending the reclassification. In fact, the ACMD as still not give proper consideration to the most recent scientific evidence.

11.6 The Home Affairs Committee in their enquiry “The Government’s Drugs Policy: is it working?” invited many individuals and organisations to give evidence. The committee invited about three times as many witnesses favouring the downgrading of cannabis, decriminalisation or even legalisation of cannabis than witnesses who oppose reclassification or who favour a restrictive drug policy. Not surprisingly, this enquiry therefore recommended that cannabis be downgraded from Class B to C and ecstasy be downgraded from Class A to B.

11.7 Groups such as the Sexual Health and HIV Strategy Integrated Steering Group or the recently formed Independent Advisory Group on Sexual Health and HIV takes decisions regarding sexual health policies upon advice and recommendations. We are seriously concerned about the composition of these bodies. Of the membership of those groups we recognise leading members of “pro-choice” organisations such as the Family Planning Association, Sex Education Forum, National Children’s Bureau, Brook Advisory Service, Marie Stopes, British Pregnancy Advisory Service, and others. The Chair of the Independent Advisory Group on Sexual Health and HIV is Baroness Gould who is also President of the Family Planning Association and Chair of the All Party Pro Choice Group. Significantly, there are no members of “pro-life” groups represented on these panels.

11.8 When the Health Committee of the House of Commons reported its findings in its report into sexual health in June 2003, there was a significant imbalance regarding the printed and unprinted memoranda. Essentially all memoranda published by individuals or organisations that were critical of the current approach to sexual health or were “pro-life” were not reprinted. These unprinted memoranda include submissions by the Maranatha Community, the Council for Health and Wholeness, by SPUC, CARE and others.

11.9 There is now rapidly growing concern that key areas of medical research may be neglected in academic institutions in favour of research into areas which will generate profits for large pharmaceutical companies. There is particular concern that professional advice may be given on important public health matters by those who have interests in commercial organisations involved in the subject of appraisal.

11.10 Richard Smith, the Editor of the British Medical Journal writes in an editorial (31 May 2003): “The pharmaceutical industry is immensely powerful. It is one of the most profitable of industries, truly global, and closely connected to politicians, particularly in the United States. Compared with it, medicine is a disorganised mess. Doctors have become dependent on the industry in a way that undermines their independence and ability to do their best by patients.”

11.11 We are particularly concerned, that medical practice is based on evidence gained from trials that are largely funded by drug companies. Due to the high costs of funding research, there has been a very worrying trend over past decades with more and more research being sponsored by drug companies and less research being funded independently. Researchers participating in research funded by drug companies usually have to sign an agreement which prohibits them from publishing results or data without the permission of the drug company. It is therefore not surprising, that research funded by drug companies is far more likely to find in favour of the company’s drug than independently funded research.
11.12 Whether a medical trial is sponsored by a drug company or not has a major impact on the outcome. In an analysis of 370 studies, the drug under investigation was recommended as treatment of choice in only 16% of trials funded by independent organisations, but in 51% of trials funded by drug companies. Trials funded by drug companies were over five times as likely to recommend the drug treatment as treatment of choice compared with trials funded by non-profit organizations. Studies of cancer drugs sponsored by for-profit organisations were nearly eight times more likely to report unfavourable conclusions than drug company sponsored studies of the same drug. Studies sponsored by manufacturers of a newer class of antidepressants (Selective Serotonin Reuptake Inhibitors) favoured this drug class over the older tricyclic antidepressants more than non-industry-sponsored studies. It is therefore likely that conclusions in trials funded by drug companies are more positive due to biased interpretation of trial results.

11.13 With the advent of evidence-based medicine many reviews of the scientific literature include an assessment of how robust the published evidence is, for example based on the type of study used. For example, anecdotal evidence is considered to be less reliable than evidence from randomised trials. Whether or not a study has industry sponsoring or not is likely to affect the outcome of the trial. We are surprised that there is no widely used scoring system, which classifies medical research according to the degree of independence from industry sponsoring.

11.14 We are particularly concerned that many experts involved in guideline development for medical practice such as General Practitioners or hospital doctors, are not independent of the pharmaceutical industries. Not surprisingly, these guidelines frequently favour a certain approach—for example drug treatment—over non-drug including nutritional approaches.

11.15 There is furthermore the danger that large pharmaceutical conglomerates have an unfair interest on legislation affecting health. An example of this is an EU Directive which may close down most of Britain’s 2000 health shops. It is part of the huge programme of EU legislation which is being “fast-tracked”. Pharmaceutical companies have been lobbying behind the scenes for years to introduce the “Herbal Medicines Products” Directive which seeks to apply to herbal remedies the principle of continental law that things can only be allowed when they are specifically authorised. (See evidence in Annex I.) [Not printed.]

Recommendations

— It is imperative that government advisory groups such as the Advisory Council on the Misuse of Drugs, the sexual health advisory groups and others become truly independent groups. There should be no appointments to those advisory groups of any individuals or organizations that are likely to benefit financially from policy decisions made. All current members of all advisory bodies need to declare their potential conflict of interest publicly. Policy decisions should be made on scientific evidence, not on the basis of political lobbying.

— There needs to be an increase in independently funded medical research.

— We call for the establishment of a scoring system, which classifies medical research according to the degree of independence from industry sponsoring. All guidelines—especially government guidelines—need to incorporate this scoring system in their assessment of new drugs or therapies.

— There needs to be an urgent re-evaluation of national guidelines issued where the authors have had a potential conflict of interest.

January 2005

Memorandum by Philip Morris Ltd (WP 46)

Philip Morris International® welcomes this opportunity to comment on the UK Government’s Public Health White Paper Choosing Health (November 2004). As we have previously provided comments during the Public Health public consultation on Choosing Health, we will focus only on two areas relating to tobacco that we believe are not fully addressed in the White Paper and that will help the Government achieve its public health goals.

LICENSING IS KEY TO EFFECTIVE REGULATION

Both at the EU and national level, we believe that an all-inclusive licensing system is the cornerstone of comprehensive regulation of tobacco products. A licensing system should cover every participant in the tobacco business, including manufacturers, importers, exporters, wholesalers, distributors and retailers. Specific rules should be set by Government regarding each sector of the tobacco business and licenses should be withdrawn for non-compliance with these rules.

® Philip Morris International Management S.A. is responsible for the administrative functions of the tobacco businesses of affiliates of Philip Morris International Inc. including in the United Kingdom.
A licensing system will create a limited and controlled supply network, and give governments the tools to better prevent youth access to tobacco products, monitor information on tobacco products and enforce product standards, curb illicit trade in counterfeit and smuggled products and verify that only legitimate operators are involved in the tobacco trade.

The Government is already considering some form of licensing scheme for retailers, in which we would support a “positive” scheme vs. a “negative” scheme. However, we encourage the Government to consider similar schemes for licensing the rest of the supply chain.

**TAX POLICY MUST SUPPORT PUBLIC HEALTH OBJECTIVES**

As noted in the White Paper, the Government has consistently used tax policy as a strategy to reduce tobacco consumption. We support this strategy, however the current policy discriminates against different types of tobacco products and seriously undermines public health goals. The unequal treatment of taxation on tobacco products has resulted in consumers switching from higher taxed products to cheaper substitutes, such as hand rolling tobacco (HRT).

All tobacco products are harmful and cause disease and there is no public health justification for a taxation policy which simply encourages consumers to switch from one type of product to another. Taxation of tobacco products should support the Government’s policy of reducing consumption rather than encouraging switching. We believe this is a key area where the Government can take immediate action in support of a harm reduction strategy which also fits in the framework of existing EU legislation. We would suggest considering a system whereby products that are competitive and functionally identical, eg cigarettes and HRT products, are taxed at a similar level.

In addition, various other EU Member States are considering—and some have already implemented—a complementary approach to the taxation of tobacco products which closes the price gap and encourages a reduction in the overall consumption of tobacco products. Under this system, the weighted average price of all available cigarettes and HRT products within a country is calculated. This average price is then multiplied by a percentage, eg 95%, in order to determine a reference price, below which a tobacco product may not be sold.

We believe that the minimum reference price is the most effective way to address the government’s objectives related to tobacco excise revenues and public health considerations. This approach is also in line with the WHO’s FCTC recommendation (Article 6) where it asks the countries to introduce tax and price measures as part of a comprehensive approach to reduce tobacco consumption.

Lastly, we believe the EU internal market for consumers is not yet functioning as intended because the original goal of excise duty harmonization has not yet been achieved. We recommend changing the current unsatisfactory situation by proposing measures aimed at substantially reducing cross-border shopping of tobacco products in the European Union until the tax levels (excise and VAT) have come to a reasonable degree of harmonization.

Specifically, the Government should introduce fixed limits on cross-border personal imports replacing the current indicative limits to establish clear, simple rules that can be adequately communicated to consumers and enforced. This should be combined with other measures, including establishing a maximum sales limit of cigarettes; a maximum limit for possession of cigarettes; and requiring a licence for sending cigarettes via mail from one country to another, in order to reduce most negative side consequences of cross-border sales.

Thank you for the opportunity to comment on the White Paper. Philip Morris supports efforts by the Government and public health community to reduce the harm caused by smoking, and we believe that effective regulation and a focused fiscal policy can be significant contributors to this effort. Our intention is to work cooperatively and constructively with the Health Select Committee and others to address the issues that are of legitimate concern to both the government and consumers. We would be happy to provide further input or clarification on our positions on the issues should the Committee deem it necessary.

_February 2005_

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**Memorandum by The Parenting Education and Support Forum (WP 47)**

**INTRODUCTION**

1. This submission is made by The Parenting Education and Support Forum (the Forum) which is the national umbrella body for people who work with parents. It has 1,300 members who are working with about one million parents in England. It provides support, information and quality assurance structures to the sector. The Forum was established at the National Children’s Bureau in 1995 by a group of children’s national voluntary organisations. The Forum has developed the National Occupational Standards for Work with Parents; they are currently being field-tested and will be submitted to the UK Approvals Body in April 2005. There is a draft of the standards and more information about the Forum’s work at www.parenting-forum.org.uk.
2. The Forum strongly welcomes the Choosing Health White Paper. It welcomes in particular the section on mental health and the measures proposed for providing services for parents. While much of the White Paper rightly refers to the role of parents in encouraging healthy eating and exercise for children, the Forum is pleased that the crucial importance of good parenting in enabling mental health and high self-esteem is also recognised. Negative, cold, violent or abusive parenting can lead to risk-taking behaviour such as alcohol or substance abuse as well as self-harm or even suicide.

It is the very authoritarian parenting style that appears to lead to the poorest outcomes for children (after Maccoby and Martin 1983 cit. Sutton et al 2004 “Support from the Start” DfES research report 524).

The US National Longitudinal Study of Adolescent Health has shown that low levels of attachment or connection to family and school are important risk factors for many health outcomes in adolescence, such as emotional distress, suicidal behaviour, violence and substance abuse (Resnick et al 1997 cit. Sanson, 2002).

“Parents are the most important influence on a person’s level of self-esteem. Once parents have had their say, little else in life will be able to modify the opinion of self thus formed” (Prof N Emler, “The Costs and Causes of Low Self-Esteem” Joseph Rowntree Foundation 2001). Parenting education and support can break the cycle of poor parenting and prevent it being passed from generation to generation.

3. The Forum is concerned about a number of issues which could prevent the Government from achieving its public health goals.

The first is a unique opportunity to educate and encourage parents which is currently being missed. This is during the ante-natal period. The expectant parents, fathers as well as mothers, feel nervous and excited; they are anxious to learn about this new phase in their lives and to do their best to be good parents. Research makes clear the benefits of fathers’ involvement in their upbringing of their children “It plays a protective role against psychological problems in adolescents” (Flouri E and Buchanan A (2003) The role of father involvement in later mental health Journal of Adolescence 26(1) 63–78).

Yet the only preparation currently offered is for the birth itself. We should take advantage of this period to prepare the couple for the emotional impact of the new baby, the changes in the couple relationship, to tell them about the amazing capacity for learning of the new-born and of his need to responsive care. Fathers as well as mothers are completely involved at this stage, and we waste the opportunity in practising breathing exercises.

We urge the Select Committee to insist that we train and provide time for midwives and health visitors to deliver much more in depth and comprehensive preparation for both parents for the forthcoming enormous change in their lives.

4. There needs to be specific training for all practitioners in how to provide parenting education and support. Being a parent is not a medical condition. People who have been trained for other areas of work, for example as doctors or nurses, have not ipso facto been trained to work with parents.

David Quinton found that “How we work with parents is as important as what we do.” (Supporting Parents: Messages from Research Prof. David Quinton publ By Dept of Health and DfES 2004 Jessica Kingsley)

Well-intentioned work with parents carried out by untrained practitioners runs the risk of failing to help, of alienating vulnerable parents, and of giving a bad reputation to this work. Providing services for those parents who are most in need of help is difficult and complex. It is not simply a matter of delivering advice or information.

The necessary infrastructure and mechanisms exist to ensure that the goals will be achieved but there is a danger that they will not be adhered to; we therefore urge the Select Committee to insist that services should meet the standards set out in the National Occupational Standards for Work with Parents.

5. Choosing Health refers to the National Service Framework(NSF) for Children which states that:

“Parents and carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.”

We urge the Select Committee to insist that the NSF be provided with the necessary budget to implement its recommendations and be set explicit time-limited targets which will ensure that this admirable goal it sets out is achieved.

6. We are pleased that Choosing Health sets out some proposals for providing support for parents in Sure Start initiatives. Almost all parents want to do a good job of bringing up their children but sometimes need help. The commonly held perception that parents feel they have failed if they ask for help is not true.
Forum is currently a partner in a BBC project which is using TV broadcasts to offer parents the opportunity to attend parenting workshops. The response from parents to the question “Why are you interested in going to a parenting workshop?” indicates that parents aspire to do the best job they can and welcome help.

“I just feel I could still learn a lot about relationships with my child.”
“He is now picking things up from school. Just need a bit of help and advice.”
“I am worried that I am not bringing up my child in a rounded way, struggling with tantrums and generally stressed.”
“To see if I can gain some positive ideas about how to be a more patient parent.”

It is also untrue that the help is available but is rejected by parents who need it. The parents sentenced under Parenting Orders famously said “I had been asking for help for years; why did I have to wait till my child was labelled a criminal to get it?” (Youth Justice Board Report 2001)

7. The Government will be better able to achieve its public health goals if:

Parenting education and support services are widely available for parents of children of all ages as and when the parents need them.
Preparation for the emotional impact of parenthood is offered to both parents before the child is born
Parenting education and support is only delivered by those who are recruited, trained and supported in line with the requirements of the National Occupational Standards for Work with Parents.
The Children’s National Service Framework has the budget and targets to ensure it delivers its ambitious vision.

January 2005

Memorandum by the Fitness Industry Association (WP 48)

INTRODUCTION

The Fitness Industry Association (FIA) was formed in 1991 in response to the need to professionalise the practices of the health club and leisure centre sector. This is a sector that employs approximately 150,000 staff, engaging over 6 million members within 1,982 private clubs and 2,043 public fitness facilities.

The FIA is a non-profit making trade association with just over 1,600 facility operator members. It is run by a democratically elected board of directors representing multi-site and single-site facilities across the private and public sectors.

The mission of the FIA is to improve the health of the UK population by helping to increase the number of regularly physically active individuals. This increase in physical activity does not have to be entirely based within the health club or leisure centre setting, as our case studies will show, but rather using the site as a resource for expert coaching, advice and exercise programming.

Recent initiatives designed to professionalise delivery have included the FIA Code of Practice, the Register of Exercise Professionals (REPs) and the Fitness Charter.

There is a perception within certain circles of government, and certainly the media, that private health and fitness clubs only cater for socio-economic groups A and B in terms of access and that they are solely gym equipment focused.

On the first point, many of the FIA private facility operators actually recruit across all socio-economic groups. In fact, Fitness First, who have 150+ clubs in the UK, recruit their largest percentage of members from socio-economic group E. 27.99% of members come from E as compared to 18% from B and 25% from A.

On the second point, hopefully the case studies of innovative practice will show that FIA members extend their provision beyond gym-based activities.

FIA General Comment on the Public Health White Paper

Whilst the FIA is of the opinion that the White Paper will go a considerable way towards achieving the government’s public health agenda we feel that the focus on physical activity is disappointingly limited. Sir Derek Wanless’s second report and the Chief Medical Officer’s report, both in 2004, clearly evidenced that lack of regular physical activity is detrimental to health. The FIA submitted a number of proposals during the consultation to the white paper and would have hoped for a clearer recognition of the benefits of regular physical activity in its recommendations.
I. Activity in Education

(A) (i) The government has set itself the goal of supporting all children to attain good physical and mental health. The White Paper talks of “new initiatives to promote physical activity and sport inside and outside school” and states that “the components of good health will be a core part of children’s experience in schools through a co-ordinated ‘whole school’ approach to health”.

(ii) Many of the proposed targets, for example for active travel plans, child poverty, the provision of school nurses, curriculum PE levels and reducing the spread of obesity in under 11s have a 2010 focus.

(iii) The FIA and its members are currently involved in two significant projects with regard to the implementation of the government’s proposals. Both “Adopt a School” [Annex 1, not printed] and the Solihull College of Further Education [Annex 2, not printed] offer evidence of models for how the government’s public health goals, with regard to activity, might potentially be achieved.

(iv) “Adopt a School” is an FIA and Youth Sport Trust initiative and a great example of a private/public partnership involving the health and fitness industry, the government, independent agencies and commercial partners in the creative use of health club facilities in order to offer physical activity opportunities to young people. It forms part of “On the move to 2010”, a health and fitness campaign initiated by the FIA.

(v) The FIA’s “Adopt a School” has been jointly funded by Sport England, through the Youth Sport Trust (£40,000 per annum for 2003–04 and 2004–05) and Norwich Union (£25,000 for 2004).

(vi) “Adopt a School” fits many of the government’s proposals as put forward in “Choosing Health”:

— For those who have taken part it has successfully increased children’s awareness of the values of a physically active lifestyle.

— Through a broad range of activities it has encouraged young people, who are not normally attracted to traditional sports, that exercise can be fun—a breakfast skipping club was organised at Dorothy Stringer High School in Brighton; Moberly Sports and Education Centre in Westminster provided street dance sessions.

— Children from schools located within walking distance to the clubs have benefited from walking to and from exercise sessions. This fits with government proposals on active travel plans and has been used to educate children that exercise does not need to take place only in a formal setting.

— The development of long term links between health clubs and local schools—building healthy communities.

(vii) Activity does not just take place in the health clubs and leisure centre. In Birmingham, instructors from the local Living well club ran aerobics and circuit training classes at Calthorpe School.

(viii) The government has expressed concern over the drop-off in activity levels for teenagers. The FIA has recently received funding from the Department for Culture, Media and Sport to run a trial of its “Active Girls” initiative. This is based on the successful “Adopt a School” but focused on teenage girls, a demographic associated with worryingly low physical activity levels.

(ix) In 2002 an innovative partnership was formed between Holmes Place Health Clubs (an FIA member) and Solihull College of Further Education [Annex 2, not printed]. The collaboration led to the opening of the 02 health and fitness club situated at the heart of the college campus. The project is an excellent example of the private sector health and fitness industry bringing its expertise to colleges. In this instance the project helped to attract and retain students. This example of a private/public sector partnership is a model of good practice that should be extended to include schools and universities as well as FE colleges.

(B) (x) The government is committed to making schools the focus for delivering its healthy lifestyle message to children and their parents. This is evident from the proposals to extend the role of school nurses and the government’s PE targets. Such a focus makes sense given that school provides a key time when the attention of all children is assured. However, the implementation of the proposals will have to be bold and innovative in order to be effective and represent value for money. The FIA’s “Adopt a School” initiative is evidence of the success that innovation and variety in PE classes can have in enthusing children with the desire to get more active. Such continuing private/public sector partnerships, as mentioned above, are vital if the government is to achieve its targets for PE in schools (for which it has pledged £1billion).

(xi) If the focus and impetus of a campaign to get young people active should be centred on schools, there is also a role for sports clubs. “Choosing Health” states that “the Government’s national strategy for PE School Sport Club Links is the keystone for a bridge being built from PE to lifelong learning, inter-school sport and school-club links”. It seems important that resources should be shared within communities, for example school sport being focused on a local sports college. The FIA’s proposed family of “Adopt a . . .” schemes helps to provide this centring.
(xii) The FIA’s “Active Girls” has received DCMS funding for a pilot and the Scottish Executive has welcomed a suggested proposal for “Adopt a Youth Club” in Scotland. The successful outreach element of “Adopt a School” shows how the pooling of local resources, across public and private sectors, can effectively deliver improved physical activity opportunities for young people.

(xiii) Encouraging walking to school through such schemes as “walking buses”, where all the children wear bibs, was an element in some of the “Adopt a School” projects. In some case the time spent walking to and from the gym was used for mental arithmetic and language games. Such ideas, which are simple and effective, are key for the success of the Government’s proposals for schools to develop active travel plans. Providing schemes that engage those involved is more likely to produce successful results than just a campaign marketing healthy lifestyles, although this clearly has a role to play.

(C) (xiv) Considerable work needs to be done in order to achieve the necessary public health infrastructure to achieve the “Activity in Education” goals. A cross government departmental approach is essential to create links between school, community and club, links which the Department for Education and Skills initiative (PESCL) has been excellent at initiating. The success of the FIA’s “Adopt a School” is based on the role of local Partnership Development Managers (PDMs) in co-ordinating links between leisure centres and primary schools. The successful delivery of the government’s proposed targets for activity in education is reliant on the effective management of local partnership resources. The infrastructure at local level needs to be expanded and developed for continued and increased success.

II. Activity in the Workplace

(A) (i) “Choosing Health” stresses the importance of people’s work environment in influencing health choices and its potential to be a force for improving health. Recognising that we spend an average of 7 hours and 50 minutes a day at work and that a great deal of this time is probably sedentary reinforces the need to promote physical activity to both employers and employees.

(ii) Many of the FIA’s members invest in the health and wellbeing of their staff, DC Leisure Management and David Lloyd Leisure being two examples. [Annexes 3 and 4, neither printed]. These two companies offer free membership to all their staff, their partners, parents and offspring. Across the two companies this involves 11,300 employees and their relatives. However, currently, employer-provided gym membership is taxed as a benefit in kind. The FIA would like to see an initiative that pushes for fiscal incentives for gym membership, particularly through employer schemes. It would be helpful if the Inland Revenue did not tax those employees who take advantage of employer schemes, such as off-site gym membership, for using that benefit [see Annex 5, not printed, for the FIA’s current proposals in partnership with BISL for tax incentives for physical activity].

(iii) The existing tax-efficient bike-purchase scheme, which the White Paper suggests needs greater advertisement, shows that the Government is willing to make tax concessions to increase opportunities for physical activity.

(iv) Employer health club membership schemes are naturally more available to large enterprises and government departments. Therefore, to build a healthy nation through workplace activity, there need to be schemes that focus specifically on small and medium enterprises (SMEs).

(B) (v) In “Choosing Health” the Government pledges to “establish pilots to develop the evidence base for effectiveness on promoting health and well-being through the workplace”.

(vi) The FIA is currently planning an initiative called “Adopt a Business” in collaboration with Sport England (East), the local Primary Care Trusts, Business Link and six FIA health club members with facilities in the region. The initiative will be based on the “Adopt a School” project where health clubs would offer their staff expertise by sending qualified exercise professionals into workplaces to run activity sessions. These sessions can take place out of doors and simply be walking/jogging in order to fit easily into a lunch break. A pilot will hopefully be launched by the summer. If successful the plan is to roll out this scheme in other regions. The Scottish Executive have again shown an interest, whilst other Sport England regional plans list the FIA as a potential partner for similar projects.

(vii) Physical activity opportunities need to be considered in the design and build of workplace making sure, for example, that stairs are accessible, shower and changing facilities are available and cycle parking is provided.
Moreover, employers need to be encouraged, where possible, to look at the length and structure of their working day and to provide flexibility within this to enable staff to take physical activity breaks. This might enable employees to take advantage of downtime in local health clubs, working in partnership with businesses in their area. Likewise, employers should be encouraged to provide education/information to employees about the local opportunities available for physical activity.

(C)(ix) The current public health infrastructure will not adequately support effective implementation of work-based health initiatives. Links need to be made with the largest employers via trade unions, the Confederation of British Industry, the Institute of Directors and other employee focused organisations. Private sector employers, as well as public, must be engaged in this process. Schemes to raise activity levels in the workplace, such as “Adopt a Business”, need a conduit in the local community to fulfill the role performed by PDMs for “Adopt a School”. The Government’s Business Link is an organisation that could offer a framework for putting businesses in touch with local opportunities for activity and for health clubs and leisure centres to co-ordinate activities with local businesses. Business Link’s potential in this regard is being used in setting up the FIA’s “Adopt a Business” pilot and should be developed.

III. An Active Health System

(A)(i) The Government’s aim is for a health system that proactively promotes good health rather than simply treating the symptoms of poor health. This needs to involve more than just good marketing and place PCT’s into active partnership with other key players in local communities.

One proposal in the White Paper relates to a “physical activity promotion fund” which we are lead to believe will be available from 2006. Criteria for the distribution of this fund have not yet been made public but the FIA strongly advised that it is ring-fenced money whichever agency it is given to for distribution.

(B)(ii) An active healthcare system must involve the NHS, local government, the private and the voluntary sectors working more closely together. FIA members complain that it has been difficult to set up local partnerships with PCT’s which is frustrating as a great deal of professional expertise and other resources could be shared. There is sometimes a breakdown in communication between leisure centres and doctors when potential leisure clients, with known health problems, such as recent cardiac conditions, are asked to consult their GP over whether a particular exercise programme is appropriate.

(C)(iii) FIA member’s experiences of working with healthcare professionals have come mainly through exercise referral schemes. The FIA were a contributory author to The National Quality Assurance Framework (2001) and set up the Register of Exercise Professionals [Annex 6, not printed] in response to the DoH’s demand for a system that listed the skill levels and qualifications of exercise professionals. Exercise instruction as a profession had been largely unregulated until the development of REP’s and healthcare professionals therefore had little confidence in the abilities of those working in the fitness industry. This barrier is now being broken down through the institution of REP’s and other FIA initiatives.

(iv) However, some GPs retain a low opinion of exercise professionals [Annex 7, not printed]. Much work still remains to be done, therefore, before a broad-based community health promotion drive will be truly effective. The FIA is currently making good progress on the development of an industry-wide PAR-Q, in partnership with REP’s, Skills Active and Dr Nick Webborn of the RCGP. It is hoped that the PAR-Q will give GPs confidence in giving medical sign-off to patients wishing to take part in physical activity.

(v) The Excel to Health Exercise Referral Scheme [Annex 8, not printed], which has been running in the North West of England for eight years, offers a useful model for how partnerships in communities can successfully deliver exercise opportunities for those who need them. One of the most innovative aspects is the involvement of both the public and private leisure sectors. Local Authority gyms in the area charge £1 a session on a “pay as you go” basis and private health clubs offer a reduced rate “clinical populations” membership for patients.

(vi) The Government’s proposed Health Trainers could play a key role in referral schemes, thus not further adding to GP’s workload. However, the White Paper is not clear in its description of the roles, responsibilities, skills and qualifications of its proposed “health trainers”. The existing public health networks need to liaise closely with the relevant Sector Skills Councils (ie SkillsActive and Skills for Health) who already oversee vocational qualifications under the guidance of the Qualifications and Curriculum Authority. The FIA would strongly recommend a re-assessment of the National Quality Assurance Framework, which sets out the guidelines for implementation of
referral schemes. The framework is now rather out-dated and overly bureaucratic causing bottlenecks to occur as there is a mismatch in current qualifications and those required on the framework.

(D) (vii) The FIA proposes the development of a “referral in reverse” system, whereby GPs can respond back to the fitness industry when a health risk is identified in a Physical Activity Readiness Questionnaire (PARQ) and the potential client is requested to visit their GP. Currently GP’s often request a fee for such a response, which, in the FIA’s view, is unacceptable.

January 2005

Memorandum by Compass Group PLC (WP 49)

1. INTRODUCTION

1.1 Compass Group PLC is the world’s leading foodservice company, with annual revenues of £12 billion and over 400,000 employees in 40,000 outlets in more than 90 countries. In the UK, the Group has revenues of £2.5 billion and employs more than 90,000 people. The Group’s core business is the provision of food and related services to clients and customers in the workplace, in schools and colleges, hospitals, on the move and in remote and sometimes hostile environments.

1.2 As a global foodservice company we know that we have an enormous influence on what our 20 million customers a day choose to eat and drink and that the purchasing decisions we make—we buy over £3.5 billion of food a year—have implications in terms of food production and sustainability.

1.3 Unlike other links in the food chain, the foodservice sector operates on a very decentralised basis reflecting the different sectors in which we operate and the very diverse requirements of our clients. The nutritional requirements of an office worker are different to that of a manual worker, school child or hospital patient. For example in the education and healthcare sectors we will be working to nutritional guidelines laid down by government or other bodies and agreeing in detail with the client (eg NHS Trust or Local Education Authority) menus that meet these guidelines as a minimum requirement. Conversely, in the workplace or travel sectors, whilst operating specifications may be agreed with the client, menus are designed to appeal to customers in those locations. In both cases this means much of the food we serve is freshly prepared on the premises in which it is served to menus that are developed by chefs locally as opposed to centrally.

1.4 This is an important distinction to bear in mind when considering some of the proposals made by the Government and is reflected in our own approach to wellness and healthier eating. Compass Group has always been at the forefront of developing innovative and high quality nutritious offerings that satisfy our customers’ lifestyle choices whilst meeting the diverse demands of the differing sectors we operate in. Recent initiatives include:

1.4.1 In the workplace environment, and in partnership with our clients, we have introduced a menu planning system—The Healthy Way—which is based on the Food Standard Agency’s balance of good health guidelines. Recognising the growing trend towards grazing or casual dining we have also introduced a range of “grab and go” products, “Food Talk”, that includes a core range of healthy options.

1.4.2 As the world’s largest vending company we have taken the lead in responding to concerns about the role of vending machines in schools by re-merchandising machines to place the emphasis on a more balanced range of products, particularly waters, juices and healthy snacks, and we have removed machines branded with a manufacturers logo and replaced them with glass fronted machines with the emphasis again on healthy products.

1.4.3 As the largest private sector provider of school meals we have for over a decade run programmes to help pupils understand the importance of eating a well-balanced meal based on the key food groups. Since 2002 we have reduced the salt content in primary school meals by 38% and have removed all salt from the cooking process in secondary schools resulting in a reduction of 10,000 kilograms in salt purchases. We also encourage the baking or grilling of products as opposed to frying. In secondary schools we offer children a free portion of side salad or vegetables with every main meal purchased and fruit salad, mixed salads and low sugar drinks are always available.

1.4.4 We are also working with manufacturers and processors to re-specify or re-formulate products to meet our requirements. For example, working with Baxter’s soups we have achieved a 25–50% reduction in the salt content of the standard range of soups used in our business. We have developed a bespoke baked bean with a 25% reduction in the salt and sugar content for use in the education and healthcare sectors.
2. **Can the White Paper Proposals Enable the Government to Achieve its Public Health Goals?**

2.1 The White Paper is an important contribution to raising awareness of the issues affecting public health and to stimulating debate on possible actions, though the goals are challenging, require genuine partnership across the public, voluntary and private sectors and cannot be achieved in one electoral cycle.

2.2 Of particular concern to Compass Group are those proposals in relation to tackling obesity and healthy schools.

2.3 We welcome the emphasis in the White Paper on developing initiatives to bring healthy eating to the forefront of the debate on how to tackle rising obesity levels and the acknowledgement of the economic and social costs of failing to tackle obesity.

2.4 We are also broadly supportive of the Government’s proposals to work with the food industry to improve the information available to consumers of the nutritional content of food whilst recognising that even in the Government’s own survey, Public Attitudes to Health, over 88% of respondents agree that individuals are responsible for their own health. Proposals in relation to food labelling need to avoid simplistic schemes that seek to categorise products into good or bad and which do not emphasise the role of food in a balanced diet and a healthy lifestyle. We are also concerned that the Government’s timescale for implementing a workable scheme by mid-2005 is too optimistic given the wide-ranging nature and importance of the proposals.

2.5 Government’s acknowledgement of the role it plays in promoting healthy eating, particularly through its procurement policies, is also to be welcomed. We have grave reservations, though, as to whether the Government’s objectives with regard to local sourcing can be met if local authority procurement managers continue to interpret “best value” as meaning lowest price and if local is defined within a very narrow context. We would prefer to see the emphasis being placed on supporting the wider British food and farming industry rather than on narrow regional or local definitions.

2.6 The acknowledgement in the White Paper of the importance of educating young people in relation to diet, health and nutrition at an early age is to be welcomed. But we are concerned that there is no mention of the need for structured food education within the national curriculum—embracing both theory and practice—and would urge the reintroduction of compulsory cookery classes for all children up to the age of 11. Whilst the Government proposes the introduction of cooking clubs there is no mention as to how these are to be established or of the numerous initiatives already being undertaken to help children prepare and cook food in a healthy way whilst having fun at the same time. For example, through our specialist education subsidiary Scolarest, we already operate a scheme called “On your marks . . . get set . . . cook!” where two teams race against the clock to create the best healthy meal from mystery ingredients, each team consists of two pupils working with one of our chefs. The meals are then on offer in the school dining room the next day. The cookery demonstration also features a quiz for pupils in the audience, with food- and health-related questions. Many of the answers can be found on Scolarest’s healthy eating and lifestyles leaflet which is given out free and includes information on the best foods for energy, strong bones and healthy skin and hair, plus general advice on how to eat a balanced healthy diet and ideas for staying fit through exercise. We also run a Junior Chef’s Academy for 14–16 year-old school children, this is a 15 week programme that covers all aspects of food preparation and cooking culminating in a four-course lunch prepared for family and friends as part of a graduation ceremony hosted by a celebrity chef.

2.7 The Government’s commitment to improve nutrition in schools over the next three years, in particular to increase the consumption of fresh fruit and vegetables and to decrease the consumption of fat, sugar and salt, is very welcome. We are extremely concerned, however, that there is no accompanying commitment to increase the average food cost per school meal in order to meet the Government’s stated objectives. Even a modest increase in food cost per meal would have a disproportionate benefit in terms of a child’s long-term health and well-being. The average food cost of a school meal in a primary school is just 45p. Whilst this meets the current nutrition guidelines for a relatively modest increase to 65p more fresh fruit and vegetables could be used and an increase to 75p would allow organic and locally sourced products to be used. Any change to nutrient based guidelines would require additional funding to levels similar to these. Media coverage, including recent Evening Standard stories on school meals in North London, often ignores the problems inherent in providing nutritious meals on very low budgets, and is largely unconcerned with the reticence of the majority of local councils to invest adequately in school meals provision. We believe that targeting children’s diets, through a combination of education and improved school meals, is crucial to tackling the obesity and health issue in the long-term and ensuring that a real and effective change in the country’s dietary habits is achieved. Furthermore, there is a wide body of evidence that links a nutritious diet amongst school-age children with improved levels of academic attainment. As such, we believe that government activity, through the Food and Health Action Plan and other forthcoming initiatives, should be concentrated on this area.

2.8 We are also concerned that there is a lack of clarity as to how the Government is going to ensure consistency of message across its various proposals and how it is going to evaluate their effectiveness in the short to medium term. For example, whilst the proposals in relation to improving the nutritional content of school meals is to be applauded it should be remembered that less than 50% of children eat school meals and that children eat less than one fifth of their total meals in a year at school.
3. Are the Proposals Appropriate, will they be Effective and do they Represent Value for Money?

3.1 It is extremely difficult to evaluate either the effectiveness or value for money of the proposals contained in the White Paper, as there is little detail on which a judgement can be based. For example, the White Paper talks in broad terms in relation to for example obesity of “…a new cross-government campaign to raise awareness of the health risks of obesity”; “…campaigns will operate at a national and regional level and use creative social marketing techniques and new technology. They will promote key messages and local services through a variety of channels, for example, in schools and workplaces as well as through health professionals.” The White Paper also mentions campaigns being jointly funded by Government and industry, but again lacks detailed proposals.

3.2 Labelling

3.2.1 There are specific proposals in relation to food labelling, namely the introduction by mid-2005 of a system that could be used as a standard basis for signposting foods and following FSA consumer research a clear, straightforward coding system by early 2006.

3.2.2 Compass Group has a number of concerns in relation to labelling. We have already raised our misgivings about a system that would simply categorise food as good or bad. Whilst we assume that the thrust of the Government’s proposals relate to packaged foods, research undertaken by the FSA in relation to signposting and nutrition profiling acknowledges the need to conduct further research into the application of such a scheme to the catering and restaurant sectors.

3.2.3 We are extremely concerned that the thrust of the Government’s proposals takes no account of the practicality or cost of mandating such a scheme to hundreds of thousands of catering and restaurant establishments of different types, nor how such a scheme would be administered. Whilst we are broadly supportive of the objective of improving the nutritional information available to consumers we believe the Government has failed to take sufficient cognisance of the effectiveness of initiatives already being taken across the food chain to help consumers make more informed choices.

3.2.4 We are also concerned as to how any signposting or labelling would operate in environments such as schools in a meaningful and practical way or how schools with delegated budgets would be able to undertake the analysis required if they were self-operating their school meals service.

3.2.5 We are sceptical as to whether any scheme, whether applied to packaged foods or the catering and restaurants sector, will have any impact if it is not within the context of a more general campaign to raise public awareness of the importance of eating a balanced diet, calorific intake, exercise and guideline daily amounts in relation to fat, sugar and salt. Consequently Compass believes that the burden of compliance may fall disproportionately on SMEs and sole traders. In view of this Compass suggests the Government undertake a Regulatory Impact Assessment to ascertain the impact of its labelling proposals before proceeding with them. Compass is also concerned about compliance verification of the proposal and would like to see more details of how the Government proposes to achieve this.

3.2.6 The White Paper also fails to acknowledge that labelling is an EU competency.

3.3 Food and Health Action Plan

3.3.1 Compass Group welcomes the proposal for a Food and Health Action Plan to co-ordinate and take forward actions contained in the White Paper, but we are sceptical as to whether the Government will meet its target of producing the plan early in 2005. It is unclear in the White Paper the process that will lead to the production of the report and at the time of writing there is no indication that consultation with the necessary stakeholders has commenced. Unless the plan enjoys the support of all stakeholders, particularly the farming and food industries, then it will almost certainly fail to meet its objectives.

3.4 Healthy Schools

3.4.1 Compass Group welcomes the link the White Paper makes between health and education and the commitment to adopt a whole school approach embracing consistent messages in relation to nutrition and healthy eating and the provision of opportunities to learn about all aspects of food. Though we are disappointed that there is no commitment to make practical cookery compulsory, as learning how to prepare and cook food is a key life skill for future generations.

3.4.2 The commitment to invest over the next three years to improve nutrition in school meals and to revise school meals standards is particularly welcome, though it is disappointing that there is no indication of the sum set aside for such investment. We would welcome clarification from government as to the projected levels of investment and the form such investment will take. We are also disappointed that there is not a firm commitment under these proposals to increase the average food cost per meal or to invest in the establishment of breakfast clubs, particularly in disadvantaged areas. Nor is there any acknowledgement of the need to invest in upgrading school kitchens and equipment to meet any new requirements. Over the last two decades there has been chronic under-funding in school kitchens with the consequence that many are simply not fit for purpose and will not be able to cope with any step change in requirements eg more
3.4.3 In secondary schools we are concerned that no mention is made of the need to ensure that sufficient time is allocated to lunch so that pupils can enjoy a nutritious whole meal. In many secondary schools pupils have less than 30 minutes to get from the classroom to the dining hall and back to class again. Also in many schools there is not sufficient space or tables and chairs allocated to dining and this discourages pupils from taking a school meal and almost encourages them to go outside the school gate at lunchtime.

3.4.4 It is also disappointing that the introduction of nutrient-based standards for school meals is not a firm commitment and that the role of Ofsted inspectors in looking at healthy eating is so poorly defined. As one of the leading private sector providers of school meals, through our subsidiary Scolarest, we joined with the Soil Association and Local Authority Caterers Association (LACA) in September 2004 to press DfES to adopt such an approach. We believe that nutrient-based standards are the only way to improve the quality of school meals and drive up participation levels. Unless school meals are appetising, nutritious and represent value for money the numbers participating will not increase. Increased participation, thus reducing the number of children who bring packed lunches or go off-site, is key to meeting the Government’s objectives. Increased participation also leads to a direct economic benefit as the relative costs of administration and preparation are minimised and in time, if participation levels are sustained, the increase in food cost should become self-funding. A target for increasing the number of pupils taking a school meal should have been included in the proposals. The White Paper also provided an opportunity for the Government to commit to establishing the link between nutrition, attainment and behaviour. Anecdotal evidence suggests that there is a clear link and DfES should be urged to set up a research project to investigate this further.

3.4.5 We also wonder whether the Government should not have considered the benefits of making meals free for all primary school children.

3.5 Delegated Budgets

3.5.1 We are concerned that whilst the commitment to support schools to provide the best meal service possible is well-intentioned there has been little consideration given to the possible implications of delegating school meal budgets to the local level, particularly in the primary sector. There are a number of concerns here.

3.5.2 First, there is a marked trend amongst Local Education Authorities to move away from multi-site contracts for meals to schools managing their own arrangements and budgets. We are concerned that if no new money is found primary schools with small pupil rolls will no longer benefit from the “cross-subsidy” they received from larger schools when LEAs negotiated group contracts and as a consequence will not be able to provide a school meal that meets the new guidelines. Loss of such a “subsidy” may lead to cold sandwich lunches in place of hot meals. For some children in deprived areas this could remove the one hot meal they eat regularly every day. A balance needs to be struck between the benefits of devolving the provision of school meals to the local level and the disproportionate burden it could impose on small or remote schools.

3.5.3 Secondly, when companies such as Compass contract with LEAs, some LEAs impose an administration charge of as much as 15p per meal on the price paid by parents. This further reduces the funding left to be spent on meals as the revenue raised from the administration charge is rarely reinvested in the school meals service.

3.5.4 Thirdly, head teachers and school governors need more than just advice on food procurement. They also need guidance on drawing up tender specifications for a school meal service, selecting a provider and managing the service. We would suggest that DfES should work with LACA to produce such guidance.

3.5.5 Fourth, where LEAs are still managing school meals contracts there is clear evidence that best value is still being interpreted as lowest price. This is either a consequence of a squeeze on school meal budgets or local authority procurement managers being unable to define what “best value” means when procuring a service or because there is no requirement to take into account the long term implications of the decision they make. For example, a contract in Wokingham was awarded recently solely on the basis of price with no other factors being taken into consideration eg nutrient content, local sourcing etc.

3.5.6 Finally, we support improved training and support for catering staff. Scolarest, our specialist education subsidiary, has pioneered a unique distance learning healthy eating qualification for school cooks. Our school chefs and catering assistants in 1,700 state schools have been enrolled for a new NCFE Intermediate Certificate in Nutrition and Health which could be made available to any LEA who wanted to provide such an opportunity for their staff.
4. Does the Necessary Public Health Infrastructure and Mechanisms to Ensure Implementation Exist?

4.1 The White Paper is ambitious, many issues are addressed and the actions proposed require partnership across the public, voluntary and private sectors. The key to success will be ensuring that those actions that are taken forward are given the time and resources to yield results and are not subject to political whim.

4.2 In relation to the fight against obesity Compass Group believe that there are no magic bullets that will provide a whole population solution. Raising awareness of the risks associated with obesity is one thing but changing peoples eating habits is going to take time. We would suggest that particular focus be given to actions relating to the health and wellbeing of young people, particularly school children.

5. Compass’ Key Recommendations

5.1 The Government needs to increase the average food cost per school meal in order to meet its stated objectives. Currently Compass receives an average of 45p to provide each primary school meal, imagine trying to buy a nutritious lunch for 45p from the local supermarket. For only 65p per meal Compass could provide an extremely healthy nutritious meal with more fresh ingredients and cooked on site. Compass believes that such a modest increase in food cost per meal would have a disproportionate benefit in terms of a child’s long-term health and wellbeing. Considering the public health benefit over a whole life costing this could amount to a considerable economic benefit for a small investment.

5.2 The Government should undertake a Regulatory Impact Assessment to ascertain the impact of its labelling proposals before proceeding with them.

5.3 The Government should reintroduce compulsory cooking classes.

5.4 Any changes to food labelling and nutritional information should seek to avoid basic schemes that classify products as either good or bad and do not emphasise the role of the food in a balanced diet and a healthy lifestyle.

5.5 The Government should set a target for increasing the number of pupils taking a hot school meal.

January 2005

Memorandum by the Pharmaceutical Services Negotiating Committee (WP 50)

Introduction

1. The Pharmaceutical Services Negotiating Committee (PSNC) is the body that represents community pharmacy on NHS matters in England and Wales.

1.1 PSNC is the body that has negotiated a new contract for community pharmacies, with the Department of Health and the NHS Confederation. The new contract is due to be introduced on 1 April 2005.

1.2 PSNC believes that community pharmacy has a valuable role to play in improving public health and is pleased that community pharmacy is included as part of the Government’s Public Health White Paper.

1.3 Improving public health is not new to community pharmacists and their teams. Indeed, due to the convenience and accessibility of community pharmacies, many people visit their pharmacy to acquire health information, to help them make choices about their healthcare and to manage their own medical conditions.

1.4 The White Paper highlights that the new pharmacy contract will allow PCTs to work with pharmacies to shape services to meet local need and local demand for health and it will give people support on healthy lifestyles (chapter 6, p 126). In particular, community pharmacy is highlighted as a resource in the areas of smoking cessation (chapter 3, p 53) (chapter 6, p 121), CHD and sexual health (chapter 6, p 146).

1.5 However, it is important to note that community pharmacists’ roles in terms of public health can extend beyond these areas. It is hoped that this will be recognised in the Department of Health’s pharmaceutical public health strategy that is currently being developed and is due to published in 2005.

Response to Specific Questions on the Government’s Public Health White Paper

2. Will the proposals enable the Government to achieve its public health goals?

2.1 The proposals in the White Paper are an important step in helping to improve the health of the nation. However, as recognised by Secretary of State for Health Rt Hon John Reid MP, in the preface of the White Paper, people do not want Government or any one else making decisions for them. Instead, people want support in making choices.

2.2 Community pharmacy offers one of the best places for these choices to be made. The non-threatening environment of pharmacies together with their convenience and accessibility should be fully appreciated.

2.3 The introduction of the new contract will formalise many roles that pharmacists are currently undertaking. One of the core themes of the contract is to improve public health. From 1 April patients will be able to visit their pharmacy and get advice on healthy lifestyles, one of the essential services in the new contract that all pharmacies will provide. Pharmacists will give advice on smoking cessation for example and other major areas of public health concern. Pharmacists will also be involved in six public health campaigns each year, organised by PCTs. Examples of campaigns may include promotion of flu vaccination uptake or educating the public about the appropriate use of antibiotics.

2.4 However, it is important to raise awareness that community pharmacies will be offering advice on health promotion. As Health Minister Rosie Winterton MP stated at an All Party Parliamentary Pharmacy Group meeting, “Pharmacy’s contribution to improving the health of the population is already recognised by many. But this needs to be given a higher profile.”

2.5 The new contract for pharmacy is designed so that it is a rolling contract and in this way new services can be developed according to need.

2.6 For example, although weight management is not part of the current list of new contract services, it is important to recognise that pharmacy has a role in helping prevent and treat obesity, one of the key areas targeted by the Public Health White Paper. There are examples of pharmacists already carrying out weight management clinics. In Elora Chemist, South Benfleet, Essex, a local weight management clinic combined with CHD risk assessment has been established to provide the local community with advice from their local pharmacist Bharat Patel. Weight checks, weight management advice, blood pressure monitoring, cholesterol and glucose testing are carried out and the service aims to educate, advise and motivate individuals as they work towards a healthier lifestyle. Patients attend the clinic once a month and their progress is monitored. They are advised on healthy eating, smoking cessation and physical activity. PSNC would like to see weight management incorporated as a service in the contract in the future.

2.7 As well as giving advice on health promotion, pharmacists will have an important role in encouraging self-care. The “support for self care” essential service in the pharmacy contract will initially focus on self-limiting illness, but support for people with long-term conditions is also a feature of the service. The possibilities are endless and as the Government decides which health conditions to target, new services within the contract can be developed.

2.8 Self-care is fundamental to achieving the Government’s public health goals. Therefore the Government’s policy of encouraging self-care should be implemented in tandem with any of the proposals in the Government’s public health White Paper. The recent publication of the Department of Health’s guidance, “Self Care—A Real Choice” highlights that self-care covers a wide spectrum of care, from the care of minor-ailments and physical health through to long-term conditions. In the recent Department of Health publication, “Supporting People with Long Term Conditions”, an example of a project in Greater Manchester is cited, where pharmacists will be a first port of call for people managing their long-term conditions. Pharmacists in this scheme will provide accurate results for tests such as blood glucose, cholesterol and anticoagulant status on site at the pharmacy.

2.9 One of the focal points of the White Paper is children and young people. The role of pharmacists educating children about public health issues and encouraging them to self-care from an early age so that good practice continues into adulthood, should be recognised. In Dorset, Roger King, Secretary of Dorset Local Pharmaceutical Committee (LPC) visits schools to talk about healthy living and the importance of a balanced diet and the health risks associated with being obese. This role could be extended, with pharmacists being able to treat children who are overweight by giving them exercise prescriptions and advising their parents on diet and nutrition.

3. Are the proposals appropriate, will they be effective and do they represent value for money?

3.1 Pharmacists are a cost-effective resource and are free at the point of use for patients. Although the White Paper does refer to pharmacist’s role in giving advice on CHD, smoking cessation and sexual health, community pharmacy should be considered in greater detail in the Government’s proposals.

3.2 In the area of mental health for example, community pharmacists have more contact with the general public than any other health professionals, and are therefore well placed to provide support in the care of those with mental health problems, identify signs of relapse, help develop medicines taking concordance, and provide an easily accessible resource for patients and carers.

3.3 The medicines use review (MUR) service within the new contract will enable pharmacists to assess patients’ medication and any side effects or problems associated with its administration. As a first port of call adults with mental health problems should visit community pharmacists to learn about the medication

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92 Health Minister Rosie Winterton MP, speaking at a joint all party pharmacy group and all party group on men’s health meeting, 19 April 2004.

93 Self Care—A Real Choice, Department of Health, January 2005.

94 Supporting People with Long Term Conditions, Department of Health, January 2005.
they have been prescribed and possible side effects. If patients are aware of the side effects in advance they are more likely to continue to take their medication. Relapse is five times more common if the patient does not take their prescribed medication. Community pharmacists should therefore be integrated into the Government’s proposals to improve mental health within the Public Health White Paper.

3.4 Adverse reactions to medicines are implicated in 5–17% of hospital admissions. The MUR service of the new contract also aims to reduce the likelihood of drug reactions.

3.5 The MUR service is particularly important for older people since 80% of people over 75 take at least one prescribed medication, with 36% taking four or more medicines. A study found that 28% of older patients are admitted to hospital because of non-compliance or adverse drug reactions. Ensuring that medication is taken properly and not wasted represents a cost-saving to the NHS, helping to prevent adverse reactions and reduce hospital admissions.

4. Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

4.1 The post of “Director of Public Health” that has been established within PCTs in recent months is encouraging and highlights that the issue is a focus of the work of many PCTs. This illustrates that PCTs are more likely to be in a position to implement the Government’s proposals and ensure that goals are achieved.

4.2 PSNC is encouraged by the establishment of a “Public Health Network” by Harrow PCT and feels that this practice could be rolled out across other PCTs. This is where healthcare professionals including pharmacists meet on a quarterly basis with other groups including school teachers, environmental officers, students etc to discuss public health.

CONCLUSION

5. Community pharmacists already make an important contribution to public health by providing appropriate information, advice and support to a wide variety of people on subjects ranging from contraception to medicines and alternative treatments to healthy lifestyle issues. They also play a vital role in sign-posting people to other appropriate health and social care professionals. Community pharmacists however have a lot more to offer.

5.1 There has been an increasing recognition of the contribution that community pharmacy can make to improving the public’s health and the need to integrate pharmacy into the wider public health workforce in the UK.

5.2 PSNC looks forward to the pharmaceutical public health strategy that is currently being developed by the Department of Health and is due to be published later this year. It is hoped that this will highlight opportunities to develop and enhance the contribution that pharmacists can make to reducing health inequalities by providing advice on health promotion, health improvement and harm reduction.

5.3 Further details on local pharmacy services and the new contract are available from the PSNC website at www.psnc.org.uk/contract

5.4 For further examples of how community pharmacy can improve public health please refer to PSNC’s response to the Government’s initial consultation on public health at: http://www.psnc.org.uk/uploaded—txt/PSNC%20response%20to%20Choosing%20Health%20consultation%20-%20May%202004.pdf

January 2005

Memorandum by The Prince of Wales’s Foundation for Integrated Health (WP 51)

1. INTRODUCTION

(i) The Prince of Wales’s Foundation for Integrated Health was formed at the personal initiative of HRH The Prince of Wales, who is now its President.

(ii) The Foundation aims to facilitate the development of safe, effective and efficient forms of healthcare by supporting the development and delivery of integrated healthcare. In short, this means encouraging conventional and complementary practitioners to work together in order to integrate their approaches.

95 NSF for Mental Health, Department of Health, Standard 4, care planning and review.
96 Room for review: A guide to medication review, Medicines Management Services programme and the Task Force on Medicines Partnership, section 1.
2. **Whether the proposals will enable the Government to achieve its public health goals?**

(i) The Foundation broadly welcomes the Government’s Public Health White Paper, and agrees with its statement that the UK needs “policies and approaches which reflect the realities of people’s lives today”.

(ii) However, The Foundation also believes that it is essential that the Public Health White Paper addresses **complementary healthcare and traditional medicine**.

(iii) The UK public’s use of, and interest in complementary healthcare shows no sign of diminishing. A recent survey revealed that one in five of the UK population is now choosing to use complementary therapies.\(^9^8\) A survey published by The Diagnostic Clinic\(^9^9\) also revealed that 68% of British adults believe that complementary healthcare is as valid as conventional medicine.

(iv) It is therefore clear that more and more people are taking responsibility for their health and as result are demanding more choice. The Foundation therefore believes that the Government cannot afford to ignore the need for an integrated healthcare system, which will provide people with the treatment of their choice: safe in the knowledge that it is effective and well-regulated.

(v) We all—Government, Health Agencies, Doctors, Complementary professionals and all other health practitioners and experts have one goal in mind for now and for the future: **the optimum health of individuals in the UK**. Optimum health is an integration of body, mind and spirit, and emphasises health and healing as well as disease and treatment. It is an approach that takes into consideration environmental, psychosocial and nutritional aspects of health, and recognises that different traditions, treatments and methods all have a place.

(vi) The philosophy that underpins both public health and complementary healthcare is a similar one: both place the individual at the centre; both look at the underlying causes of ill health as opposed to just the symptoms. Both attempt not only to cure ailments but also to change lifestyles: in so doing, emphasising the importance of a preventative approach to healthcare: one that incorporates exercise, nutrition, mental wellbeing, stress reduction, sleep and so on—as well as a curative one.

(vii) But The Foundation believes, as does the Government, that it is imperative to work together in order to achieve our common and important goals. The White Paper states that, “The public are clear that Government and individuals alone cannot make progress on healthier choices. Real progress depends on effective partnerships across communities”. The Foundation believes that only through working with all healthcare practitioners and all healthcare traditions, can we collectively achieve a new blueprint for the future of the UK’s healthcare.

(viii) The Government has identified the following key public health goals. The Foundation believes that complementary healthcare can support these goals in the following ways:

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**Obesity:** There are many causes of obesity. Contributing factors include differing emotional issues. Complementary healthcare can address these factors: eg. Tai Chi and Yoga not only produce physical benefits but can also contribute to an improvement in self-esteem and confidence in children and adults. Nutritional therapists can similarly address the underlying reasons for over-eating.

**Mental health:** There is a long history of the use of complementary healthcare to relieve general stress and prevent mental illness. For example there is good evidence that St John’s Wort is helpful for those suffering with mild depression and has an excellent safety record. Many people use complementary healthcare to alleviate mild mental health problems such as stress and anxiety. Aromatherapy, Bach flowers, hypnotherapy, massage, nutrition, reflexology, reiki and yoga are all recommended for stress and anxiety. The Mental Health Foundation’s survey in 1997 stated that many people found complementary healthcare helpful in providing symptom relief and in improving general health.\(^1^0^0\)

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**Sexual health:** Complementary practitioners can provide support to young people—they have the time to listen and can encourage them to talk to their conventional practitioners (eg sexually transmitted infections). Complementary treatments improve self-esteem, confidence, the immune system and to help fight infection.

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**Smoking:** There is evidence that complementary healthcare can help to overcome addictions. Good results have been documented with acupuncture and smoking, opiate and alcohol dependence. Complementary healthcare therefore offers a choice for smokers who wish to stop (eg acupuncture instead of patches).

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\(^9^9\) The Diagnostic Clinic. Press Release. [http://www.thediagnosticsclinic.com/pressreleases.htm](http://www.thediagnosticsclinic.com/pressreleases.htm) 25/01/05

— **A healthy NHS**: Complementary practitioners in primary care already support health improvement in their day-to-day work with patients. They encourage individuals to take more responsibility for their own health and support individuals in changing their lifestyles. It is estimated that there are 17.5 million people in the UK suffering from long-term conditions and people with long standing illnesses are more likely than others to use complementary healthcare.101

An example of a long-term condition is multiple sclerosis. The NICE guidelines on multiple sclerosis states that “people with MS should be informed that there is some evidence to suggest that the following items might be of benefit—reflexology and massage, fish oils, magnetic field therapy, neural therapy, massage plus body work, tai chi and multi-modal therapy.” 102

(ix) In addition, there are other ways in which complementary healthcare can improve the health of the nation:

— **Health of our natural environment**: The Foundation believes that we urgently need to recognise the environment causes of ill-health, such as industrial pollution and household chemicals, which are giving rise to the increasing levels of allergies in the UK. We must acknowledge the undeniable link between the health of the environment and our collective health and adopt far greater preventative measures.

3. **Whether the proposals are appropriate, will be effective and whether they represent value for money?**

(i) The Foundation supports the proposals of the White Paper but believes that they would be more effective if they recognised and incorporated the complementary and integrated healthcare field (see point 1).

4. **Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?**

(i) With nearly half of all GP practices in the UK providing some kind of access to complementary healthcare, and 47,000 complementary healthcare practitioners in the UK, public health should harness the developments in integrated healthcare. This could be achieved by using the practitioners as allies in order to promote and support their messages, and in order to offer more choice about how to “Choose Health”. The Prince of Wales’s Foundation for Integrated Health suggests that the Government recruits some of the 47,000 complementary practitioners in the UK to carry out the role of the suggested “health trainers”.

(ii) Of these practitioners, the osteopathy and chiropractic complementary professions are now statutory regulated on the same basis as doctors and nurses. Acupuncture and herbal medicine are soon to be statutory regulated. The Department of Health has recently granted the Foundation £900,000 for its ongoing work in supporting the regulation of complementary therapies. The three-year grant will begin in April 2005.

(iii) The Foundation also questions why Healthy Living Centres are not mentioned in the Public Health White Paper and why their sustainability are not addressed. The Foundation believes that Healthy Living Centres can provide support in the implementation and delivery of the elements in the White Paper, by contributing to the public health infrastructure and by presenting themselves as advocates of how healthy public policy should be put into practice.

January 2005

**Memorandum by the Mayor of London (WP 52)**

This memorandum addresses the Government’s proposal to introduce a partial ban on smoking in public places and whether, under the terms of reference of the Health Committee inquiry, these proposals will enable the Government to achieve its public health goals.

The Mayor has a duty to consider the health of people in London in planning and delivering strategies and programmes. The GLA Act requires the Mayor to seek to “promote improvement in health” and to minimise any negative impacts on health.

**Summary**

1. A partial ban on smoking in public spaces and workplaces is unacceptable because it:

   — does not afford the same level of protection to all workers;
   — is likely to increase existing health inequalities; and
   — does little to support the Government’s own inequalities targets.

2. I am committed to making enclosed public spaces and workplaces in London smokefree. In the latest MORI poll I commissioned, two thirds of people said they would support a complete ban being introduced on smoking in all workplaces.

BACKGROUND

3. Smoking is a serious public health issue, causing a wide range of illnesses including cancer, respiratory diseases and heart disease. There are marked differences in smoking related deaths between the most and least affluent in London and ethnic inequalities are even greater. In Kingston-upon-Thames the proportion of deaths caused by smoking is less than 14%, while in Tower Hamlets it is 23%.

4. Passive smokers suffer an increased risk of a range of smoking-related diseases. Over a million Londoners are in workplaces where smoking is still allowed in some areas and a quarter of a million workers have no protection at all.

5. Evidence suggests that programmes to create smokefree environments protect people from serious health problems, while providing strong motivation for smokers who are trying to quit. Such programmes have been shown to cause a 30% drop in consumption of cigarettes amongst people who work in smokefree venues. In the long-term, making enclosed public places smokefree will help prevent young people from taking up smoking.

Will the proposals enable the Government to achieve its public health goals?

6. I am of the view that a partial ban is unacceptable because it does not afford the same level of protection from second hand smoke to workers in licensed premises as the rest of the population. These proposals are likely to increase existing health inequalities and they do little to support the Government’s own inequalities targets.

7. Health professionals have criticised the Government’s intention to exempt pubs and bars that do not prepare and serve food, as well as all membership clubs, from legislation to ban smoking. I am similarly disappointed that the Government has not taken this opportunity to propose a complete ban. If there is an overwhelming health case for protecting any one individual worker from the dangers of second hand smoke, then this should be extended to all workers.

8. The Government has estimated that between 10% and 30% of pubs fall into the category of not serving food. However, those pubs that currently do serve food may well decide to stop doing so in the face of pressure from customers who wish to smoke. And it is likely to be in the most disadvantaged areas, where the highest rates of smoking prevail, where customers will put pressure on the pub to continue to allow smoking.

9. Workers in the lowest social classes are likely to be most affected by second hand smoke, since, by and large, they will be staffing the pubs and bars that choose not to ban smoking. This may well serve to increase existing health inequalities.

10. The Government’s proposals will not help individuals who wish to stop smoking. Smokers who wish to give up will not be provided with an incentive to do so if there is a ready supply of pubs and bars in their locality in which they can continue to smoke.

11. The Government has argued that a total ban on smoking in pubs and bars is likely to cause more people to smoke at home, but there is no evidence available to support this.

12. These proposals may jeopardise the Government’s specific smoking inequalities targets to reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010.

RECOMMENDATIONS

13. The Government should make a clear commitment to introduce legislation in the first session of the new parliament, to provide for a complete national ban on smoking in all public spaces and workplaces.

14. Failing this, the Government should give me the power to ban smoking in all public spaces and workplaces in London.

February 2005
Memorandum by the Family Planning Association (fpa) (WP 53)

SUMMARY OF SUBMISSION

fpa (Family Planning Association) is the UK’s leading sexual health charity working to improve the sexual health and reproductive rights of all people throughout the UK. fpa welcomes the sexual health proposals in the Public Health White Paper, and the £300 million funding that has been allocated to implement these proposals.

NB This submission only relates to the sexual health proposals in the Public Health White Paper.

Will the proposals enable the Government to achieve its public health goals?
— The proposals should enable the Government to address current problems in sexual health and thereby achieve short-term public health goals.
— The absence of proposals to introduce sex and relationships education (SRE) as statutory within the National Curriculum means that there is little to ensure that the Government achieves public health goals over the long-term.

Are the proposals appropriate, will they be effective, and do they represent value for money?
— It is encouraging that the sexual health proposals are so wide-ranging.
— However, it is disappointing that both SRE and abortion services have been missed out of the proposals.
— We are unable to comment on the effectiveness or value for money of these proposals as the detailed implementation plan has not yet been published, nor have audits of need (such as the contraceptive audit) yet taken place.

Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?
— Again, we await the publication of the detailed implementation plan in order to comment fully on this question. However, we highlight the following five areas as key in ensuring implementation:
— Expanding workforce capacity to ensure that services are able to meet demand.
— Providing adequate and appropriate training to all professionals involved in delivery.
— Integrating STI testing and treatment across sexual health services.
— Ensuring that there are sufficient local levers for prioritisation and resourcing.
— Retaining central funding for key areas such as training and information provision.

SUBMISSION

About fpa

1. fpa welcomes the opportunity to contribute to the Health Select Committee’s inquiry into The Government’s Public Health White Paper. fpa welcomes the inclusion of sexual health as a central theme in the Public Health White Paper, and the injection of £300 million for sexual health services over the next three years. We are encouraged by the comprehensive proposals within the White Paper and the serious commitment to delivering these.

2. fpa (Family Planning Association) is the UK’s leading sexual health charity working to improve the sexual health and reproductive rights of all people throughout the UK. fpa wants to see a society with positive and open attitudes to sex, in which everybody enjoys sexual health and where sexual and reproductive rights are respected. fpa’s purpose is to enable people in the UK to make informed choices about sex and to enjoy sexual health free from exploitation, oppression and harm.

3. fpa runs a comprehensive information service, including a national telephone helpline, which responds to over 100,000 queries each year on a wide range of sexual health issues. We also produce a variety of publications to support professionals and the public, and provide resources including training courses for those involved in delivering sexual health services and sex and relationships education (SRE). We also contribute to SRE through our series of publications aimed at young people which schools can use as part of their SRE programme.

NB Please note that in this submission we only comment on the Public Health White Paper as it relates to sexual health.
**Will the proposals enable the Government to achieve its public health goals?**

4. The sexual health proposals in the Public Health White Paper should enable the Government to address some of the current problems in sexual health, and thereby to achieve short-term public health goals in this area. Specifically, the proposals should enable the Government to start to tackle:

   — High and rising rates of sexually transmitted infections (STIs).
   — Rates of unwanted pregnancy.
   — Current gaps in contraceptive services.
   — Current lack of sufficient workforce.
   — Specialist needs of young people.

5. However, the fact that the Public Health White Paper does not propose introducing comprehensive sex and relationships education (SRE) as statutory within the National Curriculum means that there is little to ensure that the Government will achieve public health goals over the long-term. The single most important means of ensuring that current and future generations benefit from sexual health and wellbeing is to enable all children and young people to access comprehensive SRE. Without addressing this, the Public Health White Paper can only achieve limited goals over the short to medium-term.

6. In the interim, and particularly in the context of the recent Ofsted report which was highly critical of current provision of PSHE (including SRE) in schools, we feel it would be immensely useful to conduct a thorough audit of SRE and PSHE provision to establish a clear picture of what is currently being delivered. This would then serve as the basis for ensuring that all schools deliver a quality programme of comprehensive PSHE, including SRE, in the future.

**Are the proposals appropriate, will they be effective, and do they represent value for money?**

7. It is encouraging to see that the sexual health proposals in the Public Health White Paper are thorough and wide-ranging. fpa is particularly pleased that the proposals encompass contraceptive services, health promotion, young people’s services and STI testing and treatment.

8. The two areas we are disappointed to see missed out of the proposals are:
   — SRE in the Curriculum (see points 5 and 6 above).
   — Abortion services—these should form an integral part of proposals to improve sexual health in its entirety, and in this context the White Paper proposals have missed an opportunity to be truly appropriate for all sexual health needs.

9. At this point, it is very difficult to assess whether the sexual health proposals will be effective and whether they represent value for money, as the detailed implementation and delivery plan has not yet been published. Moreover, the proposals include an audit of contraceptive services to assess current provision and future needs, and we will not know whether the funding allocated to improve these services will be enough until this audit has been carried out. fpa is therefore unable to comment on these questions until further detail has been issued about how the proposals are to be implemented, and about the results of the contraceptive audit.

**Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?**

10. Again, we await the detail of the White Paper implementation plans for further information about ensuring that the public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved. There must be clear and unequivocal national government leadership to champion these plans, and we highlight the following areas as key to ensuring that the proposals can be delivered:

11. Workforce capacity:
   — GUM—it is clear that many sexual health services currently struggle to cope with their workload, and there is a particular problem with workforce capacity in GUM services. In this context, it is vitally important that plans are put in place to increase the workforce as a priority, particularly given the increased demand in sexual health services likely to be generated by the forthcoming national advertising campaign.
   — Contraceptive services—there is also a significant difficulty in attracting professionals to contraceptive services, particularly because of the poor career structures, status and remuneration levels within this field. These issues must be addressed in order to ensure that there is sufficient expert capacity in the future to deliver these specialist services.

12. Training:
   — Multi-disciplinary workforce—the White Paper proposals outline a broad group of professionals who will be expected to deliver sexual health services, including nurses, youth workers, community workers and pharmacists. While this expansion of the sexual health workforce is to be encouraged,
it is crucial that all those expected to cover sexual health within their remit are adequately trained and supported in delivering this work. In addition, all those who work in a sexual health service should have a basic knowledge of all aspects of sexual health, and of local services to which they can refer people who need services that they do not provide.

--- Training content—Training must include not only factual knowledge and information, but also training in attitudes, values and communication skills to ensure that these professionals are fully equipped to deliver such a sensitive service. In the long-term, sexual health must be included as a core component of qualifications for both medical and other relevant professionals.

--- Health trainers—Similarly, the proposed NHS-accredited health trainers must have adequate training in sexual health as well as other aspects of public health, in order to be able deliver effective support and advice to all groups in communities as envisaged by the White Paper.

13. Integrated GUM services—it is clear that the 48 hour waiting time target for GUM services will only be achieved if there is an adequate network of high quality sexual health services, including general practice and contraceptive services, which are providing STI testing and treatment as well as that provided in designated GUM clinics.

14. Local levers—in order to ensure that the sexual health proposals are implemented, there must be a series of levers at local level to ensure that these proposals are given sufficient priority and resourcing. To date, despite the national prioritisation of sexual health through the National Strategy for Sexual Health and HIV, we have seen very few incentives for this prioritisation to be translated into action at local level. In order to achieve its goals, the White Paper must mark a real shift in health priorities not only at national but also at regional and local levels. This should include a significant role both for Strategic Health Authorities and the Healthcare Commission in monitoring and performance management.

15. Central funding—it is vital that sufficient resources are retained at central level within the Department of Health in order to support a national training programme, the provision of information for the public, and professional practice. It is much more cost-effective for the Department of Health to do this at a national level; to replicate this work within each PCT would be both wasteful and would inevitably result in poorer quality of training and information.

February 2005

Memorandum by The Roy Castle Lung Cancer Foundation (WP 54)

The Roy Castle Lung Cancer Foundation is the only lung cancer charity in the UK wholly dedicated to defeating lung cancer through smoking prevention, research and patient care. There is a direct link between lung cancer and both smoking and exposure to second hand smoke. This is an issue of vital importance to lung cancer patients and their families who suffer the devastating consequences of this disease. For this reason, although the White Paper is a detailed document looking at many areas of public health, this response deals only with the tobacco-related elements of the White Paper and our response takes into account the views the Foundation’s many patient and carer contacts.

The Foundation welcome the Health Select Committee’s Inquiry into the Government’s White Paper on Public Health and is pleased to submit the following written evidence.

Will the proposals enable the Government to achieve its public health goals?

1. We congratulate the Government on several of the White Paper’s proposals including the establishing of a task force to help increase the effectiveness and efficiency of the NHS stop smoking services and the proposal for most workplaces to be free of second hand tobacco smoke.

2. Continued improvement of Stop Smoking Services is needed; the White Paper promises that the Government will establish a taskforce to help increase the effectiveness and efficiency of the NHS stop smoking services. The Foundation welcomes this and, as a provider of one of the successful smoking cessation services, feels that they have a valuable contribution to make to this task group.

3. The Government should seize this opportunity to extend the proposals to impose a complete ban in all workplaces, including pubs and private clubs, thus saving even more lives. The Roy Castle Lung Cancer Foundation do not believe that it can be acceptable for a worker in a non food pub or private members club to suffer the damaging effects of second hand tobacco smoke. The evidence on the harmful effects of second hand smoke is undisputable and we note the comments of the Chief Medical Officer to this effect. We also note that the report of the Scientific Committee on Tobacco and Health, whose report was published with the White Paper, identified bar workers as the occupational group at most risk from other people’s smoke. It is clear that it is often the case that people do not have a choice about where they work and employees in exempted premises would therefore be exposed against their will and they will continue to suffer the same health inequalities.
4. The Roy Castle Lung Cancer Foundation are concerned that a White Paper with the stated aim of reducing health inequalities could actually contribute to widening health inequalities by exempting a vulnerable group of employees from protection from second hand smoke in their workplace.

5. Public opinion supports a total ban on smoking in the workplace as does the evidence contained in the Government’s own Scientific Committee on Tobacco & Health (SCOTH) report.

Are the proposals appropriate, effective and do they represent value for money?

6. Failure to act on the conclusions of the report the Government commissioned from the Scientific Committee on Tobacco & Health (SCOTH), which was published at the same time as the White Paper, must be considered inappropriate.

7. The proposal to prohibit smoking in the “bar area” of exempted pubs cannot provide adequate protection for employees or members of the public. Smoke cannot be confined to one area of a pub. Ventilation systems are expensive and at best only partly effective. A comprehensive end to smoking in all workplaces and enclosed public places would be simpler, cheaper and more effective.

8. It is often claimed by the tobacco industry that ventilation will remove the effects of secondhand smoke from work and public places. However, it is interesting to note that the tobacco companies who endorse ventilation systems have issued disclaimers about such systems having any ability to address the health effects of secondhand smoking. Tobacco companies have a vested interest in maintaining and promoting smoking in public places as it has been shown that effective smoke free policies in public places can reduce smoking prevalence by up to 4%103.

9. Everyday at least three million workers in the UK, unwillingly, become secondhand smokers. Secondhand smoke causes or exacerbates a wide range of adverse health effects, including cancer, a range of respiratory diseases, including asthma, and heart disease. Shockingly, it is estimated that one employee in the hospitality industry dies every week from the effects of secondhand smoke104. There are no safe levels of exposure to secondhand smoke.

10. Ventilation is not effective. Tobacco smoke is a toxic mix of over 4,000 chemicals including over 50 cancer-causing agents105. Ventilation may remove the smell of tobacco smoke but it does not eliminate all the cancer-causing particles and gases from the air. Just because the air is not visibly smoky does not mean it is safe. In the case of separate smoking areas with discrete ventilation systems, pollution levels may be slightly reduced but tobacco smoke drifts and therefore staff and customers will still have no choice but to breathe secondhand smoke106. For ventilation to have any significant effect, it would need to be “tornado strength”. The scientific evidence is strong and robust: Ventilation systems cannot eliminate the risk of disease or death from secondhand tobacco smoke107.

11. Ventilation systems cost tens of thousands of pounds but do nothing to guard against the real health dangers of secondhand smoke. Furthermore, the cost of maintaining and cleaning systems is such that reports have shown that many proprietors leave their ventilation systems switched off, as they find the running costs too high108. Poorly maintained ventilation systems are even less likely to be an effective means of reducing the effects of secondhand smoke109. Recent research in venues in Sydney, Australia, shows that designated “no-smoking” areas in the hospitality industry provide at best partial protection and at worst no protection at all against the damaging effects of secondhand smoke.110 As all environmental health practitioners are aware, in any risk reduction hierarchy, ventilation, whether general background or local exhaust ventilation are techniques of last resort.

12. The tobacco industry and its lobby organisations (particularly FOREST) advocate “ventilation solutions” as a “reasonable” alternative to the establishment of smoke free work and public places. They fully understand that smoke free environments reduce the consumption of cigarettes and they therefore have a vested interest in maintaining the smoking status quo. They seek to mislead the public by maintaining that ventilation systems effectively address the issue of secondhand smoke. And yet, Philip Morris the largest tobacco company in the world admits on it’s website that ventilation systems have “...not been shown to address the health effects of secondhand smoke.”111

110 Cains, T et al. Designated “no smoking” areas provide from partial to no protection from environmental tobacco smoke. Tobacco Control 2004; 13: 17–22. www.tobaccocontrol.com
13. There are many pubs which may be covered by the proposed exemptions, will be in poorer communities. These communities will have higher than average smoking prevalence rates and largely as a result will be at the wrong end of sharp health inequalities.

Does the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

14. The White Paper proposals give no clear definition for “pubs that serve food”, it seems that they would be extremely difficult to enforce and it is clear that many loopholes will be found.

15. The proposals need to be amended to include legislation to make all workplaces smoke free including those pubs which do not serve food in order that reductions in health inequalities can continue to be made.

RECOMMENDATIONS FOR ACTION

16. The Roy Castle Lung Cancer Foundation requests that the committee encourage the Government to legislate to prohibit smoking in all workplaces in the United Kingdom in line with the provisions of the private bills being brought by Liverpool and London.

January 2005

Joint memorandum by the Food and Drink Federation and the National Farmers’ Union (WP 55)

The organisations contributing to this response are the Food and Drink Federation (FDF) and the National Farmers’ Union (NFU). They represent the food production and manufacturing sectors of the food industry.

FOOD AND DRINK FEDERATION

The FDF represents the UK food and drink manufacturing industry, the largest manufacturing sector in the UK. Its members are food and drink manufacturing companies, large and small, and trade associations dealing with specific food and drink sectors.

The UK food and drink manufacturing industry:
— has a gross output of over £66 billion, accounting for 14% of the total manufacturing sector;
— employs some 300,000 people, representing around 13% of the UK manufacturing workforce;
— exports around £9 billion of food and drink, over 60% of which goes to EU;
— members imports around £18 billion of food and drink, of which 64% comes from EU; and
— members buys two-thirds of all the UK’s agricultural produce.

NATIONAL FARMERS’ UNION

The NFU represents the farmers and growers of England and Wales. Its central objective is to promote successful and socially responsible agriculture, while ensuring the long term viability of rural communities.

It is the largest farming organisation in the UK, representing around three quarters of the full time commercial farmers in England and Wales. The sector employing 550,000 people, has a total turnover (value produced) of £15.5 billion.

INTRODUCTION

Both FDF and NFU welcome the White Paper and its overall aim of improving people’s health and lifestyles. However, as the delivery plan (including the Food and Health Action Plan) has not yet been issued, it is difficult to answer some of the specific questions in your Inquiry’s terms of reference and, at this stage, to understand how success will be measured. In this response, we have therefore concentrated on areas of the White Paper which are of the most immediate relevance to the food and drink manufacturing industry.

The White Paper sets out a process of discussion, negotiation and action by a number of stakeholders. It is important to recognise that the food industry can only act within its area of competence and expertise. We therefore welcome and support the partnership approach and, along with the rest of the food chain, will work to achieve the White Paper objectives to:
— help motivate people to be healthy;
— ensure a wide provision of products and services to help consumers adopt healthy diets and lifestyles; and
provide clear information which will help consumers make healthy choices for themselves and their families.

FDF and NFU are pleased that success is acknowledged in the White Paper and examples given (such as the FDF Manifesto). As far as achieving national dietary targets, it is important to recognise that gains have already been made. For example, the population target for total fat intake has been achieved. It will be important to assess how such successes were achieved and to build on them. (For example the fact that most people now drink semi-skimmed milk has played a significant part in bringing down fat levels in the diet). We hope that the eventual White Paper delivery plan will not disregard lessons to be learnt from such successes.

We should also like to see measurements made on health improvements so that cost effectiveness of the White Paper proposals can be estimated. This will be the only way of checking that the recommendations are appropriate and that delivery methods are clear, in relation to the White Paper proposals. We see the establishment of a robust dietary survey programme as an essential tool for evaluation. We are currently involved in discussions with FSA on what kind of dietary survey would be feasible as a replacement to the National Diet and Nutrition Survey (NDNS).

**Comments on Areas Relevant to the Food Manufacturing Industry**

**Food Labelling, “Signposting” and Nutritional Profiling**

Our two organisations see no value, and some dangers in simplistic and subjective systems of labelling/signposting, especially if it is based on some kind of profiling scheme. For real behaviour change to take place, consumers need to understand and “own” a system of labelling. There is little rationale or value in a system which labels foods in a narrow subjective way, such as a traffic light type of scheme which labels foods as “eat sparingly”, “in moderation”, etc. Trying to distil the overall nutritional value of a single food into one “signpost” is unscientific and potentially misleading.

The food manufacturing and farming industries support the development of a “Guideline Daily Amount (GDA)” scheme, based on government targets for population nutrient goals. Such a scheme will allow consumers to see how much of which key nutrients are present in a portion of the particular food and able to compare this with the recommended levels of that nutrient for a day (the GDA). Such a GDA scheme would also allow consumers to assess objectively the nutritional value of each food product in their own diet.

FDF and NFU are preparing detailed comments on the profiling model developed by FSA for submission by the 25 February deadline questioning its scientific validity and value to consumers.

**Food Advertising and Marketing**

Two important principles are stressed in the White Paper—the need for information and the role of individual choice. For both choice and information to be maximised, advertising and other forms of consumer communications should not be unjustifiably restricted. This is because advertising communicates product benefits to consumers and is a key feature of a market economy. Without it, consumers would not become aware of the availability of products, and be able to exercise effective choice. Manufacturers would also have little incentive to meet different consumer tastes or needs if they were unable to communicate value-added benefits to them.

Mandatory codes on advertising, as currently in existence, can react quickly to specific issues and are more flexible than legislation. They need to be evidence-based and regularly reviewed. FDF and NFU, along with the rest of the food chain and advertising industries, is committed to working with Ofcom and Government on an evidence-based review of the codes, as well as discussing the whole range of concerns relating to advertising to children.

**Changes in Food Composition and Portion Sizes**

We agree that consumers should have choice. Being able to choose a lower fat or sugar option, as well as the original option, is important from the point of view of taste as well as health: dietitians agree that it is inappropriate for all consumers to have a low energy dense diet.

An increase in the range of lower fat and sugar products must go hand in hand with activity to motivate consumers to purchase and eat these foods. Industry will not be able to increase the range of these foods if consumers do not buy them.

As set out in FDF’s Food and Health Manifesto (not printed), our industry is committed to exploring new approaches to portion sizes.

**Public Health Education Campaign on Obesity**

The food chain and advertising organisations wrote to the Prime Minister in May 2004 offering to participate in a Government-led campaign of public education on healthy eating and lifestyle. This offer still stands and we await Government’s response.
Public Procurement

It will be important that Government both sets an example and takes the opportunity to make a substantial contribution by ensuring that the £1.8 billion spent on public procurement of food and drink products supports the aims of the White Paper.

CONCLUSION

FDF’s Food and Health Manifesto sets out our industry’s commitment to working with FSA and Government on more informative nutrition labelling; and to working with Government and Ofcom on tightening the advertising codes, particularly in relation to children, within competition law.

Both food manufacturers and farmers, along with the entire food chain, are committed to playing their role and look forward to clarifying the detail of White Paper proposals; discussing ways forward; and implementing co-ordinated policies.

THE UK FOOD AND DRINK MANUFACTURING INDUSTRY

Our industry is socially responsible and has been so from its founding years. Examples include the Quaker traditions of Rowntree and Cadbury’s and the vast number of current community projects that industry supports.

Food safety is the number one, non-negotiable priority for food and drink manufacturers and we work closely with the safety and regulatory authorities to bring that about.

We have a role to play in tackling problems of obesity and non-communicable diseases in society and believe the best approach is to help encourage consumers to adopt a balanced diet and healthy lifestyle.

February 2005

Memorandum by The Portman Group (WP 56)

1. The Portman Group (TPG) was set up in 1989 by the UK’s leading alcohol producers. Its purpose is to promote sensible drinking; to help prevent alcohol misuse; to encourage responsible marketing; and to foster a balanced understanding of alcohol-related issues.

2. TPG welcomes this opportunity to respond to the Health Committee’s inquiry into the Government’s Public Health White Paper. Our response is confined to health issues relating to alcohol use and misuse. It should be noted that our activities are restricted to education and prevention. We do not play a role in the counseling, treatment and rehabilitation of those with alcohol dependency problems.

3. TPG has a strong shared agenda with Government to promote responsible drinking choices. We are pleased to note that the Government intends to work with us in partnership to deliver consumer information campaigns to tackle binge drinking amongst young adults. We stand prepared and fully committed to working with Government and the public health community in doing so, building on the success of our existing campaigns. Government endorsement of our new “drinkaware” website (see paragraph 8) would be helpful in helping to publicise the site.

4. In our view, the current proposals are right as far as they go but there are some omissions and weaknesses. One weakness relates to education and training for health professionals. Although we were pleased to note that the White Paper promises “guidance and training to ensure all health professionals are able to identify alcohol problems early” the Paper falls short of recommending a mandatory component of the training received by all student doctors, nurses and other health professionals, to cover alcohol-related issues.

5. Another omission relates to the absence of any proposals for further research into alcohol misuse. It is our view that Government action on alcohol misuse should be underpinned by a rolling programme of research in key areas which in turn should inform and possibly update or amend the sensible drinking guidelines. We have identified a need for further research into a number of areas, including the health effects of binge-drinking; patterns of drinking and breast cancer; and alcohol and the over 65s.

6. The proposals represent value for money in that there is an implicit expectation that the alcohol industry, in the form of TPG, should fund the development of public information campaigns on responsible drinking. We do not, however, think that it is the responsibility of the industry alone to fund such campaigns. This would appear to suggest that the industry alone is responsible for alcohol misuse. Whilst the industry accepts its share of the responsibility to tackle misuse, we believe there is also a responsibility for Government and, of course, for individuals themselves.
7. TPG recommends that, in order to achieve any measurable impact in attitudes/behaviour, the Government should commit to a high profile communication strategy to promote the notion of responsible alcohol consumption, using mass media with financial backing on a par with the current drink drive campaign. TPG recommends further that there should be a long term Government commitment to maintaining and developing any such strategy.

8. TPG is working closely with the Home Office to help develop a social responsibility scheme. In respect of the White Paper’s stated intention that alcohol containers and adverts should include information reminders about responsible drinking, TPG’s “drinkaware” materials provide a useful model. The www.drinkaware.co.uk website was launched by TPG on 12 November. It is designed to give consumers helpful information about alcohol units and information about how the Government’s responsible drinking message relates to their lifestyle and circumstances. Traffic to the site is averaging around 17,000 hits per day. The Portman Group has produced a range of promotional material to alert consumers to the site. Diageo is promoting the website through their above and below the line advertising; Newcastle Brown Ale, Carling, WKD and Bacardi Martini feature the website address alongside responsible drinking messages on product labels. A number of supermarket chains, including Tesco, Asda and Waitrose are promoting the site both in store and through direct consumer communications. We expect a number of companies to promote the site via labels on their key brands and major retailers and pub and bar chains to promote the site in the near future.

9. The Home Office deals with the issue of sales to minors. TPG operates a PASS-accredited proof of age card. We believe that uptake of our scheme and other PASS accredited schemes would be greatly helped if the Government could go on record with a prominent public statement commending the PASS scheme to retailers.

10. Paragraphs 62 and 63 of the White Paper relate to Ofcom’s new rules on alcohol advertising. Overall, we were pleased with the revised Code rules following Ofcom’s consultation. The new rules reflect fairly closely the recommendations we made.

February 2005

Memorandum by Rethink (WP 57)

We are pleased to have the opportunity of contributing to this inquiry. Rethink, formerly known as the National Schizophrenia Fellowship, is the charity for people who experience severe mental illness and for those who care for them. We are both a campaigning membership charity, with a network of mutual support groups around the country, and a large voluntary sector provider in mental health, helping 7,000 people each day. Through all its work, Rethink aims to help people who experience severe mental illness to achieve a meaningful and fulfilling life and to press for their families and friends to obtain the support they need.

It is essential that a key emphasis of any proposals to improve the health of the nation should focus specifically on initiatives to improve the lives of people with severe mental illness. It is well documented that people with severe mental illness are more likely to experience chronic physical health problems than the rest of the population. Recent research by the Disability Rights Commission suggests that they are also four times more likely to die from a treatable illness than other patients and 58 times more likely to die before the age of 50. This is unacceptable, and it is only through integrating health services for people with severe mental illness into the mainstream that gaps in services can be closed.

We shall contribute on the sections of the White Paper on:
— support for mental health and well-being (pages 131 to 144); and
— making it happen (chapter 8);
and will comment on the general principles of the paper, with specific reference to issues affecting people with severe mental illness.

SUPPORT FOR MENTAL HEALTH AND WELL-BEING

We make the following points:
— we welcome recognition of promoting mental health as an issue in the White Paper (paragraph 37) but feel that more emphasis needs to be placed on meeting the needs of people with severe mental illnesses like schizophrenia. Such people need regular physical health checks given their poorer than average physical health, which is recognised in paragraph 42 for people with mental health problems generally;
— we also welcome the coherent approach set out in paragraph 38. The latter para is in tune with the recent Social Exclusion report on Mental Health and Social Exclusion (referred to in paragraph 45);
— the training offered for mental health staff should involve service users and carers (paragraph 41);
— the paragraphs on support for smokers (paragraphs 46–57) seem to be aimed at smokers in general but for people who experience a severe mental illness, the incidence of smoking is significantly higher than the average. Statistics show that 44% of adults surveyed who had a psychotic disorder living in a private household and 74% of people in institutions who have schizophrenia smoke. Therefore smoking for this group needs specific attention, eg it may well be worthwhile having smoking cessation pilots for people with a severe mental illness, especially bearing in mind that it may be more difficult for people who experience a severe mental illness to quit smoking. This is because:

— they are less likely to be in employment than the general population; they may have a lot of time on their hands, which is available for smoking;
— they may smoke to abate the physical side-effects of medication such as poor concentration, anxiety and hunger;
— people with a severe mental illness are more vulnerable to stress; an adverse incident may cause them to resume smoking;
— smoking is part of the culture of mental health services;
— tobacco smoking has a stimulating effect on people who have negative symptoms of mental illness, including apathy, inertia and withdrawal; quitting smoking would reduce their personal activity;
— they may lack self-esteem and see the future as bleak; as a consequence, they may not bother to look after their physical health.

— Likewise, obesity (paragraphs 58–72) is a particular problem for people with a severe mental illness:

— they may gain weight as a side-effect of the anti-psychotic medication they take;
— they are 2.2 times more likely than the general population to die from respiratory diseases and 1.8 times more likely to die from digestive problems;
— there is often a lack for the opportunity for physical exercise, especially in inpatient settings; and
— people with severe mental illness are often affected by poverty, which can limit access to healthy food choices and leisure and exercise facilities.

— Dual diagnosis: people who have problems with both mental health and misuse of drugs or alcohol can require extra support:

— the availability of drugs such as cannabis on psychiatric wards can impact on the service users health; and
— vulnerable people on wards are targeted by drug dealers.

M A K I N G  I T  H A P P E N

— Resourcing delivery (paragraphs 9–10 on pages 176–176) is unspecific about the amount of new money to be allocated to improve public health. To improve the mental health of the nation it is crucial to know exactly how this will be resourced.

We welcome the government’s commitment to achieving its public health goals of sustaining an ethos of fairness and equity—good health for everyone in England. We feel that some of the proposals will help towards achieving the goal of enabling people to make healthy, informed choices about their health. With specific reference to mental health, we welcome the following positive features of the paper as follows:

— The Recognition that MH promotion is about encouraging positive mental well-being as well as preventing mental illness. It also acknowledges the relationship between physical and mental health, with a welcome emphasis on the promotion of a more joined-up approach to NHS support for people with poor mental health.
— The recognition that the physical health of people with mental illness is often neglected.
— Social exclusion is a key obstacle for people with mental ill-health.
— The expansion of Child and Adolescent Mental Health Services and more school-based work.
— Increased support to parents facing difficulties, such as the Sure Start programme.

However, we are concerned that there need to be more specific interventions and approaches to improve the lives of people with severe mental illness if the goal to “improve the mental health and well-being of the general population, reduce mortality rates from suicide and undetermined injury by at least 20% 2004 Government PSA target” is to be achieved. Some specific points to consider are:

— NHS Health Trainers: more clarification is needed over how they will work effectively across all health/social care agencies to ensure joined up working. Equally there needs to be more clarification about how the community matrons will work with people with severe mental illness.
— Access to real opportunities for physical exercise for people with severe mental illness in psychiatric units is not addressed.
— Whether the mental health elements of the proposals will require a new stream of funding.

We feel that in order to ensure that the goals to improve the health of the population are achieved, the government needs to clarify the issues we have discussed above, and to use the following principles and recommendations as a basis for moving forward:
— people with severe mental illness should be a top priority for programmes on obesity, exercise and smoking cessation, because of the very high levels of these problems among this group;
— the annual physical health check for people with severe mental Illness should be a priority, and solutions should be sought to reduce the high death rates among this group offered in the new General Medical Services Contract;
— a massively increased programme around stigma is essential, accompanied by adequate and long term funding, backed by clear policy commitment including an end to damaging political statements and a change in the Mental Health Bill;
— a public education programme around the mental health risks of cannabis;
— social inclusion and employment measures, with a focus not just on those who can relatively easily find work, but which recognise the full range of experience of severe mental illness; and
— a large scale expansion of talking treatments on the NHS, so that people with common mental health problems have the option of an effective non pharmaceutical treatment, but also as secondary prevention for people with the early stages of more severe mental illness.

We welcome this inquiry into the White Paper and a commitment to improving public health, and recognise the opportunity to ensure that improving the lives of those affected by severe mental illness is a fundamental principle to achieving these goals. We would be willing to give oral evidence at any future inquiry meeting.

January 2005

Memorandum by the Children’s Play Council (WP 58)

“Opportunities for spontaneous play may be the only requirement that young children need to increase their physical activity”. (BMJ Editorial, 10 February 2001)

SUMMARY

1. Children’s Play Council welcomes the focus of the Government’s Public Health White Paper on children’s health, in particular exercise, but we are extremely concerned that the White Paper under-values the importance of outdoor play in providing the vital exercise children need. In doing so it risks missing one of the most obvious and cost effective solutions to improving not only children’s physical health but also their opportunities for social, emotional and creative development.

2. There is clear evidence that primary school children expend more energy per minute in free outdoor play than in any activity other than school PE lessons. Yet play, as a vital form of exercise, is glossed over in the White Paper and no policy proposals or mainstream resources to promote outdoor play are offered. Although brief mention is made of Lottery Funding for children’s play provision this is, by definition, short-term and should not be seen as a substitute for long-term planning and resourcing of good opportunities for children to play outdoors. Below we summarise the evidence base and policy solutions we hope the Committee will recommend to the Department of Health.

CHILDREN’S PLAY COUNCIL EVIDENCE

3. The following information refers to children of statutory school age. It shows that:

4. During children’s play and free-time:
— To increase their energy expenditure children need to spend less of their free time at home.
— The best free-time exercise is walking and playing informal ball games.
— Children get more exercise from outdoor play than they do from clubs and formal sports activities.
— Children who walk to their leisure activities and school are more energetic when they get there.
— But not all children get involved in these energetic activities.
— Children enjoy and would like more physically active play.
— Children do not play out as much as they would like because their parents are worried about them. Parents’ fear revolves around traffic and “stranger” danger.
— Other reasons children do not play out include their fear of bullies, being told off by adults and poorly maintained play areas.
— Children are frequently prevented from playing in active ways.

5. In school:
— Play/break times are a crucial time for children to take exercise.
— PE and games lessons are the most energetic part of the school day but last for only 70 minutes a week.
— Any attempt to reduce the length of play/break times in school is likely to have a significant effect in reducing children’s activity levels.

6. Simple measures by local authorities, Primary Care Trusts and schools could significantly increase the amount of exercise children get through playing out.

CHILDREN’S PLAY AND LEISURE TIME\textsuperscript{112}

7. To increase their energy expenditure children need to spend less of their free time at home

Out of school hours children spend less than 40\% of their time away from home. There is a clear, negative correlation between the time spent at home and energy expenditure. Those children in Hertfordshire who spent most time in their homes had the lowest energy expenditure and those who spent the least time at home were the most energetic.

8. The best free-time exercise is playing ball games and walking

Whilst playing informal ball games children used, on average 2.8 Activity Calories/minute (AC/m). This compared with 2.4 AC/m in structured ball games and 2.3 AC/m whilst walking. In other unstructured sporting activities children used 2.1 AC/m but only 1.8 AC/m in other sports clubs and lessons. During other types of outdoor play children used 1.6 AC/m compared with 1.4 in other clubs. At home and during lessons in school children used only 0.6 AC/m.

9. Children get more exercise from outdoor play than they do from clubs and formal sports activities

Children spend more time playing out than in more formal activities. During term time the Hertfordshire children spent, on average, a third of their waking hours in school. Forty two per cent of the rest of the time was spent in their own or other people’s homes. The remainder of the time was spent in organised clubs and activities (20 minutes a day), playing out with their friends (30 minutes a day), going out with their parents (33 minutes a day) and travelling (1 hour a day).

10. Children who walk to their leisure activities and school are more energetic when they get there

For example: the children who walked to school used an average of 3.5AC/m during PE whilst those going to school by car used 2.4AC/m. This was true for all activities including formal clubs (1.7 compared with 1.6) and playing out (2.4 compared with 2.0) Children playing were more likely to walk than those going to formal activities who were more likely to go by car.

11. But not all children get involved in these energetic activities

However, although virtually all the children spent time at home, at school and travelling, fewer than half (48\%) attended organised activities and fewer than two in three (61\%) played out.

12. Children enjoy and would like more physically active play

Most children enjoy outdoor play and frequently say they would like to have more opportunities to play out. In an analysis of over 100 consultations with children and young people in 2002, about their free-time and out-of-school provision, the Children’s Play Council found that children, overwhelmingly, wanted more opportunities for physical activity and outdoor play.\textsuperscript{113} Over the past three years, surveys for PlayDay, by Children’s Play Council and The Children’s Society, have confirmed this view. The 2003 survey, of over 2,000 7- to 11- year olds showed the outdoor activities children enjoyed most were playing with friends, playing ball games, bike riding and running about. When asked to describe other outdoor activities they enjoyed, of 152 comments 85\% were energetic activities.

13. Children do not play out as much as they would like because their parents are worried about them

PlayDay surveys in 2001 (800 children) and 2003 (over 2,000 children) both found that the main reasons children do not play out as much as they would like is their parents’ fears for their safety. In both years one in three children cited this as the main reason. Parents’ fear revolves around traffic and “stranger” danger.

\textsuperscript{112} Making children’s lives more active, Prof R Mackett, Centre for Transport Studies, UCL 2004.
\textsuperscript{113} Something good and fun, in Making the Case for Play: gathering the evidence, Children’s Play Council 2002.
14. Other reasons children do not play out include their fear of bullies, being told off by adults and poorly maintained play areas

Safety is also an issue for children themselves. The PlayDay surveys show that almost one in four children are put off playing out either because they have been or are afraid of being bullied by other children and young people. But they are also frequently told off by adults and responses to media coverage around PlayDay 2003 suggest that children playing ball games are frequently, and often aggressively, stopped by irritated adults.

15. Children are frequently prevented from playing in active ways

“No ball games” signs proliferate in urban parks, housing estates and other open spaces. Low branches are cut off tress to stop children climbing and there are frequent anecdotes in the press of children being prevented from physical play. Fears that, if a child is injured, parents will sue, often mean that local authorities and other providers are reluctant to install physically challenging and exciting play equipment. Under resourcing of parks and playgrounds means that many have become run down, unused and finally closed.

IN SCHOOL

16. Play/break times are a crucial time for children to take exercise

The research at University College London has shown that play/break times are an important time for exercise for children. During this time children expended more energy than they do during the whole of the rest of the school day (excluding PE lessons) and almost as much as when PE is included. Although PE and games lessons are more energy intensive they take up a much smaller portion of children’s school time than play/break times.

Over a week 17% of children’s activity energy expenditure is during play/break although it accounts for only 5% of their time. For the children who spend most of the rest of the time in their own homes, school play is their main form of exercise.

17. PE and games lessons are the most energetic part of the school day but last for only 70 minutes a week

Over a week children expend approximately 37% of their activity calories whilst at school. Of this:

- 11% is during PE and games lessons (3.1 Calories/minute).
- 42% is during other lessons (0.6 Calories/minute).
- 47% is during play/break-times (1.9 Calories/minute).

These findings confirm similar findings from the UK, Portugal and Australia which show that, for most children, the most energetic time of the day is their school play/break-time.

Any attempt to reduce the length of play/break times in school is likely to have a significant effect in reducing children’s activity levels.

18. Simple measures by a number of local authority departments, PCTs and schools could significantly increase the amount children play out

If children are to be encouraged and allowed to play out more:

(a) Steps must be taken to make streets, neighbourhoods, parks and other open spaces feel and be safe. This can be achieved by, for example:

- Improving, maintaining and cleaning parks, play areas and open spaces regularly so they become attractive and well used.
- Increasing the number of 20 mph zones and home zones in residential areas.
- Training park staff and street and neighbourhood wardens in the value and importance of children’s outdoor play and ensuring they understand the difference between children and young people’s play and criminal anti-social behaviour.

(b) Supervised play provision should be available for children whose parents do not want them playing out without adult supervision. This can be through, for example:

- Employing trained playworkers as “rangers” in parks and open spaces to attract and support children’s play.
- Providing staffed play spaces such as adventure playgrounds and play centres which offer a range of indoor and outdoor activities and act as focal points for children and communities.
- Ensuring long-term revenue funding for play projects which offer children a range of outdoor, physical activities.

(c) During the school day children should be encouraged to play out as much as possible in their break times and should be offered a range of physical activities.
**THE CHILDREN'S PLAY COUNCIL**

19. The Children’s Play Council is the leading national play organisation, working under the aegis of the National Children’s Bureau, in England. We represent the views of our member organisations and promote more and better play opportunities for children and young people, primarily of schools age. Our members include national and regional voluntary organisations, local authorities, play associations and networks and EYDCPs. We currently hold a play policy development and research contract with the Department for Culture Media and Sport.

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**Memorandum by the Food Advertising Unit (WP 59)**

The Food Advertising Unit (FAU), under the auspices of the UK Advertising Association (AA), is a centre for information, communication and research on food advertising. It represents manufacturers, advertising agencies and media involved in food advertising.

The FAU welcomes the great majority of the far-reaching proposals and recommendations in the Government’s White Paper on Public Health. It considers that many of these will help to support healthier choices. This submission will however concentrate on proposals and recommendations relating to the provisions on advertising and promotions (Chapter 2, “Health in the consumersociety”).

The White Paper marks the beginning of a process of discussion, negotiation and action by a number of stakeholders to tackle a raft of public health issues, among which is obesity. The FAU and its member organisations will be providing further input to the Department of Health as the process develops and looks forward to playing its part.

**Summary of Memorandum**

— Partnerships with clear aims, objectives and mechanisms for discussion and action will be appropriate, effective in achieving public health goals and value for money.
— A sustained behavioural change campaign could be appropriate, effective and value for money and would greatly benefit from industry backing and participation.
— The necessary infrastructure exists to regulate advertising but mechanisms to promote and facilitate partnerships and cohesive actions are needed.
— Disproportionately restricting advertising will be neither appropriate, effective or value for money because:
  — Evidence does not show correlation or causality with obesity, or effectiveness in tackling it.
  — Would restrict innovation and choice.
— Has cost implications not considered by the White Paper.

1. **Will the proposals enable Government to achieve its public health goals?**

The FAU welcomes proposals to make healthy lifestyles easier to achieve, through the provision of clear information and education and through motivating people to want to lead healthy lives.

Partnership with industry—food manufacturing, advertising, media and broadcasting—and coordination of actions is a clear objective of the White Paper proposals. Industry has been advocating such an approach for some time and welcomes the opportunity to work with Government. The FAU considers that this approach will be effective but only if there are agreed aims and objectives as well as clarity of purpose. For example, there is some confusion in the White Paper on the extent to which actions on advertising are intended to tackle obesity or improve nutrition more specifically. Whilst obesity is about the calorie equation, nutrition is about nutrient intakes, therefore, solutions and actions will differ.

The White Paper has acknowledged the advertising industry’s calls to be used as a force for good, and proposes a constructive approach to help “market health” in order to create lasting behavioural change. The industry is sympathetic to a public education campaign and considers that its involvement and backing could add value to such a campaign. Such backing may allow for more effective communication of key messages for example, carrying agreed and co-ordinated messages on packs, on websites, in-stores or on interactive television. Partnerships must be based on collaboration on equal terms however: the advertising industry will offer its support provided the role of advertising is considered objectively and not overstated. Making healthy living more widely accessible through partnership would be able to achieve greater reach than a Government campaign on its own.
2. Are the proposals appropriate, will they be effective and do they represent value for money?

The White Paper bases its proposals in the context of an “enabling and supportive” Government that does not “nanny”, but creates the environment in which people can make informed and healthier choices. The FAU supports this approach but does not consider that this will be achieved by restricting communications.

The White Paper is accompanied by a partial RIA which overestimates the effectiveness/benefits of advertising restrictions and seriously underestimates the costs of those restrictions.

The partial RIA overestimates the benefits of restrictions on advertising through partial use of the evidence, inaccurate extrapolations and misunderstandings about the role of advertising. For example, although the size of the effect of advertising on obesity and diet is unknown, it is recognised as having a “modest direct effect on food preference, consumption and behaviour...but it is small compared to other influences” (Ofcom, 2004). As a result, the benefits to health of restrictions on advertising would be at best “modest”.

Disproportionately restricting advertising in the belief that it will help to tackle the growing levels of obesity will not be appropriate, effective or value for money. There is no evidence to show a correlation between food advertising and obesity, even less a causal relationship.

The partial RIA also underestimates negative impacts of proposals by not taking into account the effect on small firms, such as independent programme producers, or on the non-broadcast advertising sector, which would be affected by the White Paper proposals. It underestimates costs by misunderstanding how advertising price is determined and how it is affected by viewers/consumers. Among other issues, the partial RIA fails to take into account the possibility of alienating industry from taking part in discussions and solutions, the resulting costs to achieving success, and the costs to competition both in the broadcasting and food manufacturing sectors.

Two important principles, which the industry is supportive of, are repeated in the White Paper—information and choice. Both of these require that advertising and communications are not disproportionately restricted because:

— advertising communicates product benefits to consumers;
— advertisers would lose the incentive to meet different consumer tastes or needs if they are unable to communicate these value-added benefits to them. Consequently, such restrictions on communication would limit innovation and choice; and
— advertising pays for, or subsidises, the media—a valuable source of information on diet, nutrition and healthy lifestyles for many consumers.

All the available academic evidence demonstrates that advertising promotes innovation and choice. The premise of the White Paper and its accompanying partial RIA, however, implies that the Government believes the opposite would be true—restricting advertising would accelerate innovation.

Restricting advertising will have a negative impact on activities and investments which may help to promote behavioural change and which could, in the long-term, lead to savings for the NHS and other obesity-related costs. The FAU supports the need for solutions that will bring long-term benefits and cost effectiveness such as behavioural change campaigns and partnerships, rather than short-term knee-jerk reactions.

The FAU will be feeding into the Department of Health’s work into the RIA as the process evolves.

Advertising definitely has a positive role to play in creating positive health outcomes but changes to food advertising rules will not of themselves bring about a major shift in dietary behaviour. The industry supports evidence-based and proportionate reviews of the codes but cautions against bans or severe restrictions that are unlikely to help Government achieve its public health goals.

Nutritional Profiling

The industry recognises that different foods play different roles in an individual’s diet, but the evidence does not support the proposition that restrictions on advertising will decrease the consumption of certain foods.

While rates of obesity have been increasing over time, the consumption of targeted food categories (eg confectionery and soft drinks) has remained stable or has switched to diet/low calorie variants. It is also the case that calorific intakes, on average, have been decreasing although calorific intakes for parts of the population remain too high relative to falling levels of calorific expenditure.

Hence, the advertising industry does not believe that nutritional profiling is an appropriate or effective solution. Indeed, it is likely that attempting to treat individual nutrition at population-wide level will be counter-productive, as it does not take into account differing individual dietary needs.

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114 For example, Keith Boyfield “The effects of advertising on Innovation, Quality and Consumer Choice”. Advertising Association Economics Committee.
3. Does the necessary infrastructure exist to ensure that proposals will be implemented and goals achieved?

In terms of regulating advertising, the infrastructure already exists to enable a review of the codes and their use.

The industry is pleased to see that the White Paper acknowledges the important role that codes of conduct play in the advertising sector and statutory legislation should only be used as a last resort. Legislation cannot adapt to changing environments as rapidly as codes. This is particularly important in the case of advertising—the media environment can change significantly in a short period of time, due to technological advances for example, and codes can therefore provide more effective protection.

Additionally, current advertising regulations are effective in ensuring strict codes of conduct are complied with across broadcast and non-broadcast media. Despite the use of the word “voluntary” in describing advertising regulations, the codes are in fact mandatory and penalties can be incurred for non-compliance:

- The codes governing non-broadcast advertising are self-regulatory, but all advertisers must adhere to them. Non-broadcast media are committed to refusing to publish any advertisement that the Advertising Standards Authority (ASA) has ruled against. Advertisers that defy the ASA’s decisions may be referred to the Office of Fair Trading (OFT).
- In broadcast, the code administered by the new ASA co-regulatory system is supported in law and adherence is a condition of broadcast licences. Advertisements may only appear on television and radio if pre-cleared by the Broadcast Advertising Clearance Centre (BACC) and the Radio Advertising Clearance Centre (RACC) respectively. The ASA will adjudicate on complaints and can demand amendment or withdrawal of an advertisement. If necessary, the ASA can refer a broadcaster that continues to carry non-compliant advertising to Ofcom, which can issue fines to the broadcaster and withdraw their licence to broadcast.

However, the mechanisms for achieving effective partnerships and cohesive actions need to be defined. The idea of creating a body that will work at arms-length from Government on implementing the wide range of proposals to support healthier lifestyles is positive, but it must not duplicate the work of bodies already in existence.

CONCLUSION

The food advertising industry can help achieve the objectives of the Public Health White Paper. In order for this to happen, clear goals and objectives need to be set to ensure coordinated action. The Government should avoid ineffective policies that will simply serve to alienate such partnerships.

The White Paper’s proposals on changes to food advertising are yet to be decided and detailed in a process that will be led by Ofcom. If, however, accurate estimates of the likely effectiveness of severe restrictions on advertising are placed against the costs or losses of implementation, it is clear that they would be neither appropriate nor cost effective.

Public education campaigns, which have different aims, objectives and outcomes to competitive brand advertising, have been shown to be effective, over time, in changing behaviours. The industry considers that investment in such a campaign, with support from a wide range of partners, would be both appropriate and effective.

Whilst the infrastructures are already in place for regulating advertising and reviewing the codes as well as enabling public education campaigns (eg through the Central Office of Information), there is a need to ensure that the means are in place for coordinating action and partnership.

The advertising industry is committed to playing its role and looks forward to clarifying the detail of the White Paper proposals; discussing the ways forward; and, implementing policies that will produce a successful outcome. This will be a ‘fully engaged’ scenario where: people are motivated to be healthy; there is a wide provision of products and services to help them achieve good health; and, they have clear and relevant information available upon which to make healthy dietary choices for themselves and their families.

February 2005

Memorandum by MRC Collaborative Centre for Human Nutrition Research (WP 60)

MRC Collaborative Centre for Human Nutrition Research (hereafter HNR) was established in 1998 to advance knowledge of the relationships between human nutrition and health by providing a national centre of excellence for the measurement and interpretation of biochemical, functional and dietary indicators of nutritional status and health. HNR conducts basic research in relevant areas, focusing on optimal nutritional status and nutritional vulnerability in relation to health, including the development of innovative methodologies. HNR responds to the strategic priorities of the wider scientific community by conducting research projects, within the scope of HNR’s activities, in collaboration with, and on behalf of: other MRC establishments and groups, Government departments, industry, national and international agencies, universities, research foundations and charitable organisations. HNR also acts as an independent,
authoritative source of scientific advice and information on nutrition and health in order to foster evidence-based nutrition policy and practice. In light of the work carried out at the HNR and the expertise of our staff, our comments are confined primarily to the role of nutrition in securing good health for the whole population.

1. Whether the proposals will enable the government to achieve its public health goals?

1.1 In general terms we believe that the “Choosing Health” White Paper is a useful step towards establishing a framework for improvements in public health in the UK. We look forward to the delivery plans which need to set out more details of the procedures for monitoring, evaluation and review, together with the resource implications. This is essential if the good intentions are to be converted into concrete progress towards public health goals.

2. Whether the proposals are appropriate, will be effective and represent value-for-money?

2.1 The White Paper sets out actions in relation to the major public health targets. HNR scientists have a particular interest and expertise in food and health aspects and obesity and our comments reflect this perspective.

2.2 It is difficult to comment on the proposed actions in relation to nutrition until the details of the Food and Health Action Plan are released. We look forward to further engagement in the development of a Food and Health Action Plan and being able to contribute independent and authoritative scientific expertise in the links between nutrition and public health.

2.3 In broad terms, we welcome the commitment to changing people’s diet. However there is a real need to establish some consensus around the dietary targets for action in order to develop a coherent framework for public health nutrition. Additional resources will be required to support solid research programmes to evaluate dietary interventions.

2.4 We note with some concern that the priority areas are all treated in a rather discrete manner, which ignores the potential for synergistic activities. This is particularly true for diet and physical activity. Physical activity impinges upon nutritional requirements and there is a need to better understand the integrated impact of diet and physical activity on public health. Certainly in the context of obesity prevention (perhaps more usefully considered as weight control) it would be appropriate to consider the two lifestyle issues in an integrated manner.

2.5 We broadly welcome the PSA target to halt the year-on-year increase in obesity among children under 11y by 2010 and the associated initiatives. However there is a concern that 2010 is overly ambitious. There is a danger that if targets are not achieved in this short time frame the efforts to prevent obesity in young children will be abandoned whereas they may yield significant benefits in the longer term.

2.6 We are pleased to note the recognition that clear guidelines are required for the prevention and treatment of obesity. However we believe that the development of guidelines for the broad public health prevention of obesity will require a paradigm shift for NICE and this may not be a workable solution. Evaluating interventions for the prevention of obesity requires a move beyond the traditional medical paradigm of RCTs.

2.7 The effective treatment of obesity requires a range of different approaches including medical and surgical interventions, underpinned by changes in lifestyle. We welcome the decision to develop appropriate services and pathways of care for the treatment of obesity, particularly in children. This will require additional resources for training and specific medical and surgical interventions, even to meet current NICE guidelines.

2.8 Until details of the delivery plans are released it is difficult to comment in detail on the likely effectiveness and value for money. Certainly money will have to be found in the short-to-medium term to support the new initiatives, and formal evaluations. However, as the Wanless report identified, this may be expected to lead to cost savings in the longer-term.

3. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

3.1 There is a pressing need to strengthen the expertise and infrastructure in public health research. We welcome the new NPRI, but it represents a very modest investment in behavioural research. It will be necessary to invest much more heavily in research to evaluate the impact of interventions in order to build the evidence-base in public health research.

3.2 There are a large number of local initiatives on various public health issues underway. However they remain uncoordinated and many are running on an ad hoc and unsustainable basis. We would encourage government to take a lead on the coordination of these initiatives within a framework which fosters and disseminates best practice.
3.3 It is essential to ensure that health professionals and others who are charged with delivering health advice are appropriately trained and the structures are in place to support continued professional development.

3.4 In the light of the existing skills shortage within the NHS and the poor training of health professionals in nutrition, consideration should be given to schemes to support the training of a diverse range of health professionals and other individuals in core nutrition skills, to help with the development of accurate and appropriate information.

3.5 The development of NHS “health trainers” will require a clear programme to ensure that they are appropriately trained and competent to give advice and provide support. This is a complex role given the clustering of adverse health behaviours and the complexity of individual advice required.

3.6 We strongly believe that there is a need for the government to champion the formal (British Dietetic Association) and informal (Nutrition Society) registration process. There is now a chronic shortage of registered dietitians nationwide which has delivery implications to ensure that the proposals will be implemented. Nutritionist remains an unprotected term and until this is rectified the public cannot be adequately protected. As the public increasingly recognises the importance of a healthy diet it is vital that they have access to competent practitioners.

January 2005

Memorandum by The Royal College of Midwives (WP 61)

The Royal College of Midwives (RCM) is the professional association and trade union representing 95% of all practising midwives in the United Kingdom. The vast majority of midwives work within the NHS, and the RCM is recognised in every Trust that provides a midwifery service.

In submitting evidence to the Committee, the College has confined its comments to those areas of expertise represented in its staff and membership.

Midwives Involvement in Public Health

Good maternity care is key to providing good public health and the RCM firmly believes that pregnancy and early childhood should be put at the heart of the Government’s public health agenda. Intervention early on can make a real difference to the health of the baby long term and can reduce the need for action later in life. For example:

— breastfeeding has been shown (amongst many other things) to reduce the instances of childhood obesity and allergies;

— reducing exposure to tobacco smoke while pregnant reduces the chances of a low-birth weight baby; low birth weight babies have been shown to be at risk from a variety of long term health problems including heart problems and respiratory infections. In addition babies raised in environments where smoking occurs are at an increased risk of respiratory problems and sudden infant death; and

— pregnancy provides an ideal time to work with mothers and families to improve their health behaviours. Healthy choices made in pregnancy can often continue after birth and be taken up by the whole family. This provides an excellent example to children as they grow up and can break cycles of bad health behaviours within families.

Midwives already do a great deal to address health issues surrounding birth and pregnancy and will provide advice and guidance on a number of issues such as diet and nutrition, exercise and smoking in pregnancy. The RCM’s response to the Government’s consultation “Choosing Health” outlined some of the specific projects which maternity services across the UK are undertaking to improve the health of pregnant women.

However, concerted action is also needed from the Government if real improvements are to be made. The RCM has welcomed many of the proposals in the Government’s White Paper and believes that they represent appropriate and effective ways of achieving the Government’s goal of ensuring the NHS acts to improve peoples overall health as well as treating those with an illness. In particular the RCM believes that the Government’s proposal to introduce more children’s centres is an excellent way of ensuring an integrated approach to maternity service care. Providing that this is done in a way which recognises the value which each group of professionals can bring to the service, then it should work to provide real joined up attitude to the care for a particular child and family.

However, there are some areas of the white paper where the College believes that the action proposed by the Government is either inappropriate or inadequate to produce real improvements. This evidence focuses on those areas and provides specific recommendations that the RCM believes the committee should make to improve the Government’s proposals.

Areas where we feel changes are needed are, increased action to:
— reduce pregnant women’s exposure to tobacco smoke;
— provide a real increase in breastfeeding rates and the length of time women continue to breastfeed; and
— improve the diet of mothers, particularly those in lower income brackets.

THE GOVERNMENT SHOULD INTRODUCE A TOTAL BAN ON SMOKING IN ENCLOSED PUBLIC PLACES

Exposure to tobacco smoke whilst pregnant places a number of risks on to a pregnant woman and her baby. Along with the risks which any smoker faces such as increased chance of cancer and heart disease, tobacco smoke has additional risks to the unborn foetus. Smoking when pregnant increases the risk of spontaneous abortion and placenta praevia. Smoking also increases risks of pre-term delivery and means there is an increased risk that the baby will be born at a low birth weight. Low birth rate babies are put at a significant risk of a number of diseases and disabilities including heart problems and respiratory infections it can also be linked to delayed cognitive development.

The RCM have long recognised that midwives have a role to play in helping pregnant women to give up smoking. In 2003 the RCM produced its own guide for its members—“Helping Women Stop Smoking—a guide for midwives”. This provided midwives with information as to why pregnant women should be encouraged to give up smoking, practical tips of how to approach the subject with women, and identified the sources of help available to midwives involved in helping women to quit.

However, exposure to environmental tobacco smoke remains a key concern. Firstly because woman exposed to smoky environments will find it harder to give up as she will be more likely to be tempted to smoke and secondly because research shows that exposure to environmental tobacco smoke can have harmful effects on the unborn infant. Action on smoking and Health (UK) recently collected together a summary of some of the evidence relating to the effects of exposure to passive smoking\textsuperscript{115}. This highlighted evidence from the WHO which identifies passive smoking as a potential risk factor in causing low birth weight. This is backed up by a number of other scientific studies including one published in 1999 in Evidence Based Obstetrics and Gynaecology\textsuperscript{116} which indicated that:

“Chronic exposure to environmental tobacco smoke during pregnancy results in a mean decrease in birth weight of 25–30g and a 10–20% increase in the risk of low birth weight or small for gestational-age infants”.

The public health white paper recognises the risk of exposure to environmental tobacco smoke and proposes introducing a ban on smoking in all enclosed public places and workplaces (paragraph 76). Unfortunately, it undermines this principle by proposing exceptions to this ban for some licensed premises which do not prepare or serve food and private clubs—the RCM fails to see the reason for this exception and calls on the committee to recommend its removal.

If the proposal was to be adopted in its current form it would mean that pregnant women would still be exposed to environmental tobacco smoke (particularly so if they are employed there) and the risks this represents. The only option for a pregnant woman in these circumstances would be to avoid going to places where smoking was not prohibited. This is an unreasonable and unrealistic option for a number of reasons:

— firstly, because many women do not know that they are pregnant until 8–12 weeks into the pregnancy, so during these first stages the women may be unknowingly exposed to the risks of environmental tobacco smoke, with no opportunity to make an effort to avoid it;
— secondly, because it is unrealistic to expect a pregnant woman not to take a full and active part in social activities with friends and family during her pregnancy; and
— thirdly because, if employed in such an environment the reasonable adjustments required by the employer may not be possible and the woman would face the choice of giving up her job or continuing with all the attendant risks.

Pregnant women do not have an illness and pregnancy itself is a normal physiological condition. Therefore pregnant women should on the most part be encouraged to continue to take an active part in their community, rather than be restricted from large areas of it because of the risk to the unborn child.

MORE RADICAL ACTION IS NEEDED TO INCREASE UK BREAST FEEDING RATES—WHICH REMAIN TOO LOW

The positive effects of breastfeeding on the long term health outcomes of both mother and baby are well documented. Research has shown that artificially fed babies are at increased risk of gastro-intestinal infection, respiratory infections, necrotising enterocolitis, urinary tract infections, ear infections, allergic


\textsuperscript{116} Exposure to environmental tobacco smoke during pregnancy is associated with decreased birth weight; Windham GC; Eaton A; Hopkins B. Evidence for an association between environmental tobacco smoke exposure and birthweight: a meta-analysis and new data (Paediatr Perinat Epidemiol 1999; 13: 35–57. Commentary by Khan, Khalid in Evidence based Obstetrics and Gynaecology (Harcourt, 2000) 2.5.
infections and diabetes and later cardiovascular disease. Mothers who breastfeed also benefit and have a decreased risk of breast cancer, ovarian cancer, and hip fractures and bone density problems.

Despite these advantages the levels of breastfeeding in the UK remain extremely low. Only 69% of women initiate breastfeeding and the number of women who breastfeed for the recommended six months after the birth is only 21%. These rates compare unfavorably with many other developed countries, for example countries such as Sweden and Norway have breastfeeding initiation rates of 98% and about 55% continue to exclusively breastfeed to six months of age.

Evidence suggests that women do not breastfeed in the UK for a variety of reason, often related to difficulties getting breastfeeding established or with milk supply. However, there is worrying evidence that one of the possible reasons is that they feel uncomfortable about doing so outside of the privacy of their own homes. During the passage of the recent Breastfeeding etc Act in Scotland, evidence was cited which suggested that there is a stigma attached to breast feeding a baby in a public place. For example:

- the Health promotion agency for Northern Ireland recently published research on attitudes to breastfeeding in NI, this revealed that 54% of respondents felt that breastfeeding should always take place in a private place;\(^{117}\) and
- a Scottish study conducted in 1999, surveyed a group of parents (half of which had breast fed their baby themselves). Of these nearly a third thought that a mother should not feed her baby in a public restaurant.\(^{118}\)

Midwives have a clear role in making women aware of the health benefits of breastfeeding and helping women who want to breastfeed get breastfeeding established. The College has developed a number of resources aimed at encouraging breastfeeding and we will be playing an active role in breastfeeding awareness week from 8 to 14 May 2005.

However, this work needs to backed up by support from the Government. The Government’s new extended maternity leave rights have been a very positive measures which helps women to breastfeed for longer and the public health white paper also contains some policies to encourage more breastfeeding. These are:

- providing that infant formula milk will no longer be made available through healthcare premises; and
- providing further restrictions on the advertising of infant formula (assuming agreement of legislation at an EU level).

However, the RCM believes that these proposals do not go far enough to address the problem. The RCM would like to see more support from the Government for breastfeeding to back up the advice provided by professionals this action should particular aim to promote breastfeeding as a social norm. The committee should recommend that the Government takes the following action:

- conducting media campaigns to include television adverts like those used in Norway and more recently in Scotland to improve public awareness and acceptance of breastfeeding; and
- clarifying the law in the UK to make it clear that it is illegal to prevent a woman from breastfeeding in a public place—similar to the legislation which has been passed in Scotland and in a number of states in the US.

**Good Nutrition and a Healthy Lifestyle in Pregnancy is Essential to Ensure a Healthy Infant, but the White Paper Reforms are Unlikely to Produce Significant Improvements**

Ensuring good health while pregnant is essential in ensuring a healthy infant. It is therefore essential that pregnant women are encouraged to maintain a general healthy lifestyle throughout pregnancy with good nutrition and appropriate exercise.

Poor nutrition in pregnancy is a particular cause for concern. Some studies suggest that poor diet is the second biggest cause of low birth weight in babies in developed countries\(^{119}\). By providing the mother with advice on good nutrition during pregnancy there is also the possibility that she will establish good eating habits which will be passed on to her children, thus working to improve the health of society in the long term.

Pregnant women need to be encouraged to eat a varied diet which contains all of the essential nutrients. In particular pregnant women should be encouraged to consume foods which are high in calcium and plenty of fruit and vegetables—which provide essential vitamins and minerals. In common with the rest of the population pregnant women are advised that they should eat a minimum of five portions of fruit and vegetables a day. However evidence suggest that adults in general are getting nowhere near that amount and


younger women of childbearing age are even less likely to eat the recommended allowance than women in the 50s or 60s—women aged between 25 and 34 eat on average only 2.4 portions a day, compared to 3.8 for older women.\textsuperscript{120}

An area of particular concern is the diet of low income families and teenage mothers. Women in a household in receipt of benefit have on average only 1.9 portions of fruit and vegetables per day compared to 3.1 in non benefit households.\textsuperscript{121} Research done by Maternity Alliance into the diet consumed by teenage mothers confirmed that many teenage mothers (who often have less money) have a poor diet, including high sugar levels and low fruit and vegetable intake.\textsuperscript{122} In this survey lack of money was often cited as reason for missing meals or eating cheap unhealthy, filling food like biscuits or chips. Women aged 18–24 on income support receive around £11 less per week than women over 25, women aged 16–17 can receive even less income. This contributes significantly to the poverty levels and thus poor diet of teenage mothers.

Clearly pregnant women will benefit equally from many of the proposals contained in the public health white paper generally aimed at improving the overall health and diet of the nation. Pregnant women will benefit from having greater information about the content of their food and from the advice of health trainers/Health direct if they require further assistance. However, given the special nature of pregnancy specific reforms are needed to ensure that all pregnant women are given the best opportunity of having a healthy diet.

The public health white paper recognises this. It recommends working to improve the diet of pregnant women in low income families through the healthy start scheme. This will provide pregnant women, breastfeeding mothers and parents of young children with vouchers that can be exchanged for fresh fruit and vegetables, milk and infant formula. However, while recognising the good intentions behind this scheme the RCM believes that it is inadequate to produce real improvements in maternal nutrition. This is because:

- mothers often find the use of vouchers patronising and often will not feel comfortable about using them because of the social stigma which is attached;
- the vouchers will not be accepted in places where people on low incomes are most likely to shop—most notably markets and local stores; and
- the vouchers will not be worth enough to produce real improvements in diet—currently the vouchers are only worth £2.80 a week.

Instead the RCM calls on the committee to recommend a different approach aimed both at promoting good diet during pregnancy in a way which is acceptable to expectant mothers, and improving income in the lowest income families so that they can afford to eat better.

The RCM would make the following specific recommendations:

- A scheme aimed at putting free fresh fruit into all places where expectant mothers and young families are likely to go, for example children’s centres or doctors waiting rooms.
- Paying mothers under the age of 24 the full rate of income support, increasing the income level of the most deprived group to provide the money available to buy healthy food.

CONCLUSION

The Royal College of Midwives believes that the Government’s public health white paper represents some positive proposals which should go along way to implementing the Government’s public health goals. However, in the areas of smoking, breastfeeding and general health in pregnancy the Government has failed to introduce the radical reforms necessary to produce real improvements and further reforms are necessary—as outlined in this response.

The RCM would be happy to attend the committee to give oral evidence to expand on the issues contained in this evidence in more detail.

\textit{February 2005}

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\textbf{Memorandum by the Nutrition Professions Confederation (WP 62)}

\textbf{SUMMARY}

The Nutrition Professions Confederation is concerned about the lack of defined standards for training in nutrition in many of the health professions, and hence wide variety in the competence of those who need to deliver nutritional advice or care in their professional practice. There is a need for a coordinated and coherent approach to incorporating nutrition and dietetics within health delivery. This might be achieved

\textsuperscript{120} Office of National Statistics 2002 \textit{National Diet and Nutrition Survey}—adults aged 19 to 64 years available at \url{www.food.gov.uk/multimedia/pdfs/ndnsprintedreport.pdf}

\textsuperscript{121} See above.

\textsuperscript{122} Maternity Alliance/Food Commission, 2003 \textit{Good Enough to Eat—The diet of pregnant teenagers} available at \url{www.maternityalliance.org.uk/documents/good_enough_to_eat.pdf}
by development of a National Service Framework for Nutrition which would take responsibility for setting
standards, curriculum development, improving delivery of nutrition and dietetics services in public health,
primary, secondary, and tertiary care, and for integrating science and research into clinical practice.

1. We are a confederation of professionals from the disciplines of medicine and nutrition science
dedicated to the nutritional health of people, both in the community and as patients in the healthcare system.

We represent the following organisations:

Intercollegiate Group on Nutrition

A grouping of 14 Medical Royal Colleges with representatives from the British Dietetic Association,
British Dental Association, Faculty of Public Health, British Pharmaceutical Nutrition Group, and the
Chief Nursing Officer—the remit is to improve the knowledge and skills of doctors in the principles and
practice of nutrition, and hence provide improved nutritional care in hospitals and in the community.

Nutrition Society

The Nutrition Society is the learned and professional association which represents the science and practice
of nutrition in the UK. Its aim is to advance the scientific study of nutrition and its application to the
maintenance of human and animal health.

British Dietetic Association

A professional organisation with the aim to advance the science and practice of dietetics, promote training
and education in dietetic practice and support individual dietitians in their professional practice.

Association of Professors of Human Nutrition

The Association of Professors of Human Nutrition is an association of Professors and academics of
distinction, who are committed to exercise leadership and to safeguard and enhance the integrity and quality
of the academic discipline of human nutrition.

2. We agree with the Government’s position that nutrition is a major determinant of the health of people
and populations and welcome the prominence of these considerations in the formulation of government
policy.

3. In the context of current evidence, future research and evolving government policy it is pertinent to
consider the readiness of the health sector in effecting and implementing government policy in this area.

4. Services for the delivery of health, including public health, are provided by a variety of health
professions who may have only modest, if any, nutritional training and work in a non-integrated way in
the NHS for the benefit of the individuals and the population. Further, those who are currently engaged in
delivering services in nutrition are not always trained to explicitly recognised standards, other than in the
case of Registered Dietitians and Public Health Nutritionists.

5. We believe that this lack of an interprofessional competency framework limits the great potential for
health improvement, both preventive and therapeutic, that exists within the UK.

6. Health services at primary, secondary and tertiary care level will all be involved in the implementation
of policy and this may be illustrated by the consideration of the experience of a patient and or the public in
the context of a nutritionally related issue, such as obesity or undernutrition.

7. Vulnerable groups in the UK population such as the old, the very young, those on low income and
ethnic groups are of particular concern.

8. There is potential not only for health gain but also for economic savings—considerable evidence exists
that better nutrition before or during illness improves outcome and reduces hospital stay.

9. These two factors, inadequately defined standards across the health professions, and a range of greatly
varying competences for those who need to access nutrition in their professional practice, limits the great
potential offered by nutrition for health improvement and for economic savings.

10. We have identified several opportunities for incorporating nutrition components within the training
of health professions both at undergraduate and postgraduate levels, and within service delivery.

11. We envisage a co-ordinated, integrated and coherent approach to incorporating nutrition and
dietetics within health delivery.

12. We recognise three major domains underpinning effective health delivery—training, practice and
research. Nutrition and dietetic practice should be integrated within a coherent framework in each of these.
In order to do this, the different nutrition professions engaging with the development of these various
activities should do so in a coherent way. We have come together in order to promote this coherence and
consistency.
13. All health professionals should be able to demonstrate safety and competence to practise, including in nutrition, at an appropriate level for their practice. Currently several political and professional initiatives offer singular opportunities to coordinate and integrate the place of nutrition and dietetics in professional training and health delivery.

14. We consider that this will be best achieved by a development along the lines of a National Service Framework for Nutrition. This would inevitably be cross-cutting with other Service Frameworks, and would enhance the delivery and success within these other areas of consideration. We identify below initial steps that we believe will help achieve this:

- setting standards;
- curriculum development;
- services in public health nutrition, primary, secondary and tertiary care; and
- science and research.

15. **SETTING STANDARDS**

The Healthcare Commission document “Standards for Better Health” sets out a generic framework of performance indicators to which different professions are aligning their statements of professional standards through concordats. We would develop a set of nutrition standards congruent with this core activity, applicable for nutrition across a range of professions.

With a focus on the patient’s clinical journey, we will develop scenarios to help identify the personnel, skills and competencies required to ensure a seamless provision of nutrition and dietetic related care across the primary, secondary and, where necessary, tertiary care.

16. **CURRICULUM DEVELOPMENT**

We have already identified in the Core Curriculum for Health Professionals a minimum set of nutrition and dietetic knowledge that all health professionals should appreciate by the time they graduate. Within postgraduate general medical training the curriculum for the new F1/F2 training years has been released for consultation and we will be offering constructive proposals for incorporating nutrition without overburdening an already crowded curriculum. Nutrition is well suited to providing a horizontal conceptual underpinning in support of a systems-based, vertically integrated framework.

17. **PUBLIC HEALTH NUTRITION**

Developing and endorsing healthy eating practices and diets throughout the community, using healthy settings approaches in strategic partnerships with other agencies charged with promoting public health for all sectors of the population.

18. **PRIMARY CARE**

The RCGP is in the process of developing a curriculum for general practice within the new primary care context. We will engage with this process to ensure a coherent presence for nutrition within this, and build on it in relation to other health professions in the primary care team. The development of GP specialists might also offer opportunities for development of the necessary nutritional skills.

19. **SECONDARY CARE**

We will work with the medical Royal Colleges, both individually and through the Academy, with the PMETB, and with other professional bodies to develop nutrition-related standards that could be applied in developing specialist and sub-specialist training in nutrition for other health professionals, to complement those of registered dietitians. These standards would cover the essential knowledge, skills and competencies required by health professionals operating within secondary care, who profess a particular interest in nutrition.

20. **SCIENCE AND RESEARCH**

We represent the principal academic and learned bodies concerned with the science of nutrition, both basic and clinical, and its application in human health. We will ensure that our structures and procedures will be open and transparent, and meet the highest standards of professional practice. We are already far along this road, but it is not yet possible, outside the hospital system, for the public to identify easily amongst individuals who offer professional nutrition and dietetic advice, those who have undergone an appropriate structured training of sufficient quality and duration together with professional supervision.
21. CONCLUSION

Given the very wide sweep of nutrition, the challenge of developing a co-ordinated approach to the delivery of service to the public is considerable. Nevertheless, there is a clear need for better and more effective co-ordination, and for regulated mechanisms through which the public can be assured of the professional competence of those in practice. Our ultimate ambition is that The Nutrition Professions Confederation will provide this assurance and thereby enable the public to identify with confidence the nature and level of service which they might expect from different groups of health practitioners.

January 2005

Memorandum by Smoke Free Liverpool (WP 63)

INTRODUCING SMOKE FREE LIVERPOOL

SmokeFree Liverpool is a partnership which comprises Central, North and South Primary Care Trusts, Liverpool City Council, the Roy Castle Lung Cancer Foundation, Liverpool Chamber of Commerce, North West TUC, Health@Work, Scarman Trust and Liverpool Health Promotion Service.

Our aim is to restrict smoking in all enclosed workplaces in Liverpool—for the benefit of all who live and work in Liverpool. As you may know, Liverpool City Councillors voted in October by an overwhelming cross-party majority to seek the powers to restrict smoking in enclosed workplaces places, by a local Act of Parliament. This cross-party majority vote was confirmed by a further vote on the 26 January.

Smokefree Liverpool welcomes the Health Select Committee’s Inquiry into the Government’s White Paper on Public Health and is pleased to submit written evidence.

Will the proposals enable the Government to achieve its public health goals?

1. We congratulate the Government on the White Paper’s proposal for workplaces to be free of second hand tobacco smoke. Smoking is the major cause of preventable death in our city. We are also deeply concerned by the serious health and safety risk other people’s smoke poses to employees and the general public, particularly but not exclusively in the hospitality trades. The White Paper offers a golden chance to provide protection to non-smokers and to achieve a sharp cut in smoking prevalence rates.

2. However, we believe that the Government has missed an opportunity to save lives by not imposing a complete ban in all workplaces, including pubs and private clubs. Smoke Free Liverpool does not believe that it can be acceptable for a worker in a non food pub or private members club to suffer the damaging effects of second hand tobacco smoke. We believe the evidence on the harmful effects of second hand smoke is clear and we note the comments of the Chief Medical Officer to this effect. We also note that the report of the Scientific Committee on Tobacco and Health, whose report was published alongside the White Paper, identified bar workers as the occupational group at most risk from other people’s smoke. In Liverpool, people frequently do not have a choice about where they work and employees in exempted premises would therefore be exposed against their will and they will continue to suffer the same health inequalities.

3. Smoke Free Liverpool are concerned that the proposals in the White paper will actually contribute to widening health inequalities both locally and nationally and for Liverpool we believe that these proposals will be a disaster.

Are the proposals appropriate, effective and do they represent value for money?

4. The Government has failed to act on the conclusions of the report it commissioned from the Scientific Committee on Tobacco & Health (SCOTH), which was published at the same time as the White Paper, these are:

   “knowledge of the hazardous nature of second-hand smoke (SHS) has consolidated over the last five years, and this evidence strengthens earlier estimates of the size of the health risks.”
   “This is a controllable and preventable form of indoor air pollution.”
   “It is evident that no infant, child or adult should be exposed to SHS”.
   “This update confirms that SHS represent a substantial public health hazard.”

5. The proposal to prohibit smoking in the “bar area” of exempted pubs cannot provide adequate protection for employees or members of the public. Smoke cannot be confined to one area of a pub. Ventilation systems are expensive and at best only partly effective. We believe it would be cause significant economic damage in Liverpool if hospitality venues were required to install expensive and inefficient systems of this kind. The proposed exemptions would add unnecessarily to the regulatory burden on business. A comprehensive end to smoking in all workplaces and enclosed public places would be simpler, cheaper and more effective.
6. We believe that most pubs in Liverpool, which may be covered by the proposed exemptions, will be in poorer communities. These communities will have higher than average smoking prevalence rates and largely as a result will be at the wrong end of sharp health inequalities. Liverpool has the highest lung cancer rates in England. The communities where those rates are highest are those in which the vast majority of pubs do not serve prepared food. SmokeFree Liverpool is currently undertaking a piece of research in conjunction with Liverpool John Moores University to provide clear evidence that this is the case.

7. The social and economic costs of smoking in Liverpool are unacceptably high:
   — Smoking prevalence in Liverpool is well above the national average—at 34%.
   — Around 1,000 people in Liverpool die each year from smoking.
   — Around 100 people in Liverpool who have never smoked, die each year from cancer or heart disease because of exposure to second-hand smoke.
   — Smoking costs the NHS in Liverpool about £12.7 million per annum.
   — The economic costs to employers of smoking amongst the Liverpool workforce is approximately £28.5 million per annum.

8. There is strong support across the city for smokefree legislation: 71% of people in Liverpool stated that they would support or strongly support a law to make all enclosed workplaces smokefree—including restaurants and pubs.

Does the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

9. The proposals in the White Paper give no clear definition for “pubs that serve food”, would be extremely difficult to enforce and leave many opportunities for loopholes to be found. The Chartered Institute of Environmental Health has judged the Government’s proposals to be unenforceable and contrary to the principles of health and safety legislation.

10. The goal of reducing health inequalities cannot be achieved unless the proposals are amended to include legislation to make all workplaces smoke free including those pubs that do not serve food and all private clubs. Indeed health inequalities in cities like Liverpool can only be increased.

RECOMMENDATIONS FOR ACTION

11. While SmokeFree Liverpool welcomes the Government’s proposals, we must continue to pursue a Local Act of Parliament to ensure all workers in Liverpool are protected. As our understanding is that other cities are considering the same legislative route, we urge the Government to reconsider and strengthen its proposals.

12. We ask the Committee to urge the Government to include a commitment to legislate to prohibit smoking in all workplaces in the United Kingdom in its first legislative programme after the General Election.

January 2005

Memorandum by SkillsActive (WP 64)

This letter is SkillsActive’s response to the Health Select Committee inquiry on the Public Health White Paper. SkillsActive is the Sector Skills Council for the Active Leisure and Learning Sector. For further background information please visit: www.skillsactive.com.

We have focused our response on the areas of the white paper which mention SkillsActive specifically and which directly affect our work. Therefore we have refrained from submitting a more detailed response and from going over the information in our original submission to the DoH consultation “Choosing Activity”. However, should you wish to see this submission we would be more than happy to supply it.

Whether the proposals will enable the Government to achieve its public health goals?

SkillsActive contributed a lengthy submission to the Choosing Activity consultation which led to the Public Health White Paper. As a result we were asked to elaborate on elements of our response relating to workforce development for the white paper.

SkillsActive is of the opinion that the white paper will go a long way towards achieving the Government’s public health goals and the vision of a society fully engaged with the public health agenda. However it is felt that there was not enough emphasis on the role of physical activity in the Public Health White Paper. The partnership between health and active leisure is an important one in preventative healthcare and must be fully utilised if the Government is to realise its goals.
Whether the proposals are appropriate, will be effective and whether they represent value for money?

With regards to the effectiveness and appropriateness of proposals which relate to the SkillsActive area of expertise, it is difficult to comment at this stage as the role of the new NHS Health Trainers is not yet fully defined. SkillsActive is working with Skills for Health and the DoH Public Health White Paper implementation task force to reach an agreement on the detail of the role of the new health trainers which will pave the way for developing qualifications and standards for the new role.

Early indications suggest that the role of the NHS Health Trainers will be a signposting role, focusing upon giving general lifestyle advice and suggesting regular exercise as part of this. This would only require qualifications up to level 1. However SkillsActive sees a level 1 qualification as an assistant working under supervision. While we agree that a definite role for this kind of lifestyle advice it means that the health trainers will not be able to work with specialist populations (such as the morbidly obese or diabetics) which requires qualification of level 3 and beyond.

We must therefore ensure that the training and qualifications for Health Trainers is designed to avoid duplication with the exercise referral process. At a minimum we would suggest that these new NHS Health Trainers should be able to guide an individual through the use of a PARQ (Physical Activity Readiness Questionnaire) which are in general used in gyms and leisure centres to identify whether an apparently healthy person has any conditions that would require a consultation with a GP before they embark on an activity programme. It would be counter-productive if an individual was encouraged to take up exercise only to be turned away at the gym door. Such knowledge could be within a unit at level 1.

Evidence suggests that only 35% of the current fitness workforce is qualified at the level required to work with people with specialist fitness needs. At the moment there is simply not enough adequately trained staff to fulfil the special roles required to get the nation active. It must also be a priority of Government to support the development of this element of the public health workforce in light of the new demands being made on the workforce in relation to preventative health care.

RECOMMENDATION

To this end it is essential that the National Quality Assurance Framework (NQAF) is reviewed. SkillsActive will be able to oversee this project but needs the appropriate injection of funding to execute it. The review must be accompanied by a plan to make the NQAF more effective and a strategy for its promotion and implementation to ensure the framework is used and that good practice is disseminated amongst, and championed by, the sector.

February 2005

Memorandum by the Biscuit, Cake, Chocolate and Confectionery Association (BCCCA) (WP 65)

The BCCCA includes in its membership all of the major UK manufacturers of biscuits, cakes, chocolate and confectionery and over 70 smaller businesses, and together they account for more than 90% of the UK sector. They employ some 60,000 people in this country.

The BCCCA welcomed the publication of Choosing Health. As socially responsible businesses, many with a proud tradition of activity in their communities, BCCCA members share the widespread concern about the increasing incidence of obesity. For some time now they have been reviewing along with other food sectors and with government what action they can take to help overcome this challenge. Some of the actions which have resulted are set out below:

- Around 80% of products already display data on energy, protein, carbohydrate and fat, BCCCA has recommended to its members to display these plus saturates, sugar, fibre and sodium by the end of 2005 (with the exception of small packs for which different arrangements are needed and those items without nutrients).
- BCCCA members have agreed to abide by the GMA (US) and CIAA (European) industry guidelines on promotion of foods to children, as a minimum.
- Major manufacturers provide a range of portion sizes for their products, and have already announced their intention to either discontinue or redesign king-size products to address the issue of over consumption.
- Members have agreed to support the Automatic Vending Association’s Code of Practice, which includes providing a choice of non-branded machines and products and to secondary schools alone. BCCCA members do not offer vending to primary schools.

1. Will the Government be able to achieve its objectives?

The BCCCA believes that any further action taken by industry must be part of a wider Government programme to combat obesity. We want to be part of the solution, but believe we can be only just that—a part of the solution. For this reason, we welcome the breadth of approach in the White Paper and believe that if Government is to succeed in this endeavour then all parts of Government must act coherently and that every stakeholder must be involved.
Equally, the importance of personal responsibility—in what we eat, how we feed our children, how much exercise we take and encourage others to take—should be strongly emphasised. We note, for example, that the NOP poll for Ofcom revealed that food manufacturers and schools came a distant second and third respectively to parents and other family members as influences on children’s healthy eating habits.

We agree with Government that in order to underpin personal responsibility, consumers should have straightforward access to accurate and helpful information about the food they eat. We do not, however, believe that the proposals in Choosing Health (and as subsequently developed for consultation by the FSA) to codify foodstuffs using over-simplistic categories in order to describe the role they may play in a healthy diet will be effective or workable.

It is important for consumers to understand that it is not simply a matter of balance of Nutrients, within food but how many calories are eaten and used which affects weight.

2. Are the proposals appropriate?

The BCCCA has the following specific comments on proposals in Choosing Health.

(a) “Reverse the trend towards bigger portion sizes”

Our customers welcome the opportunity to choose different product formats. However, we agree that manufacturers should make it clearer that larger formats are designed for sharing, or for consumption over time, or for those who have a more active lifestyle. Some major manufacturers have already announced their intention to discontinue or re-design larger-format products.

(b) “Government will work with industry to develop voluntary action to reduce sugar and fat levels in different categories of food”

BCCCA members already offer a range of low-fat, low-sugar and sugar-free alternatives. In 2003, we recommended to members that they reduce salt in biscuits and cakes, even though they account for less than 4% of salt in the average diet. We welcome the acknowledgement in the White Paper that it can take a considerable time to change the composition of foods in a way which will gain acceptance from consumers. The White Paper also appears to acknowledge that different categories of food will be able to achieve varying reductions of different ingredients.

Other regulations may also constrain reductions of some ingredients: for example, the use of artificial sweeteners is forbidden by EU directives in biscuits and cakes; and a minimum level of fat is prescribed by the Chocolate Directive.

(c) “By early 2006, there should be a ‘clear, straightforward coding system’, on the basis of which consumers could understand ‘which foods make a positive contribution to a healthy diet and which are recommended to be eaten only in moderation or sparingly’”

The BCCCA is concerned at the implication that a food which should be enjoyed in moderation cannot also contribute positively to a healthy diet.

Over-simplistic labelling schemes, such as most of those proposed for consultation by the FSA since the publication of the White Paper, do not take into account people’s different nutritional requirements, or the fact that these products often contain valuable micronutrients such as iron and calcium; and do nothing to convey the fact that it is the amount eaten that affects weight, not whether a single chocolate bar or cake has been consumed. It is also important to eat a broad range of foods, including those that are enjoyable.

The BCCCA has recommended to its members that all packs (except small packs and those items without nutrients size) should, by the end of this year, display information on energy, protein, carbohydrate, sugars, fat, saturates, fibre and sodium. In addition packs should display Guideline Daily Amounts (GDAs) for calories and the contribution to the GDA per portion of the product.

The BCCCA believes that GDAs are an objective standard, readily understood by the public. We therefore support the GDA option as providing accurate, accessible and clear information to consumers.

(d) “Revised nutritional standards will be extended to school vending machines”

The BCCCA supports the Automatic Vending Association’s Code of Practice, which also covers machines which vend our members’ products but which the member does not control. This provides for a choice of non-branded machines and products. We also support the integration of vending into “Food in School” health and nutrition strategies. BCCCA members do not offer vending to primary schools.
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(e) “Restrict further the advertising and promotion to children of those foods and drinks that are high in fat, salt and sugar”

BCCCA members have already agreed to abide by both US and European food industry guidelines, as a minimum. They are recommended to have their own clearly-stated policies on promotion to children, and major manufacturers have introduced new policies.

Industry groups will be working with Ofcom to update the rules on broadcast advertising, sponsorship and promotion. Ofcom itself has said that a ban on advertising to children would be “ineffective and disproportionate” and would “reduce choice and innovation for younger audiences”.

(f) “The Government will discuss with industry how it might contribute to funding national campaigns to promote positive health information”

We agree with the importance of such campaigns, but believe that nutritional labelling and even providing healthy eating messages on pack are different from funding national information campaigns. The BCCCA will discuss with its members and with government whether members could provide healthy eating messages on packs (again size and layout permitting), but health promotion and education is a core government programme and should be paid for out of tax revenues, which, of course, include the £1 billion of VAT receipts from this sector of the food industry alone.

3. Conclusion

The average consumption of biscuits, cake and confectionery in the UK has started to fall, after a decade of remaining static. The lack of correlation between consumption of these products and the increased incidence of obesity is borne out by international comparisons. This in turn illustrates the dangers of demonising particular foodstuffs.

Our members do not, however, support the proposals for industry-funded public information campaigns or for severe restrictions on advertising to all young people. What is important is empowering consumers to make informed choices, and the BCCCA supports those proposals in the White Paper that would underpin consumer choice and personal responsibility.

February 2005

Memorandum by The Chartered Society of Physiotherapy (WP 66)

Introduction

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the 45,000 chartered physiotherapists, physiotherapy assistants and students in the UK.

The CSP welcomes the opportunity to respond to the Health Select Committee’s inquiry into the Government’s public health white paper. While physiotherapists are involved in a wide range of public health work, our submission will focus on occupational health and vocational rehabilitation, active self management through self referral and NHS staff development. Our submission to Choosing Health is available at www.csp.org.uk/libraryandinformation/publications/view.cfm?id=344 and refers in addition to the CSP’s position on chronic disease management; improving the health of children; maintaining active and independent lives for older people; access to sports and leisure facilities for vulnerable groups; extension of exercise referral programmes; and leadership roles for physiotherapists and other allied health professions.

The CSP congratulates the Government on the publication of Choosing Health. The white paper restores some of the balance towards primary care after sustained focus on hospitals and acute conditions. We support the aims and objectives of the paper and hope that public health will remain at the top of the Government’s agenda.

Physiotherapists are involved in the improvement of public health at every stage from prevention, to diagnosis and treatment and on to the development of sustainable programmes for patients after treatment to maintain and improve general good health. Physiotherapists also play a vital role in the promotion of improved quality of life through occupational health, exercise advice, fall prevention and smoking cessation. A greater focus on preventative measures to improve public health, rather than merely treating symptoms, will inevitably highlight the contribution that is being made by professions such as physiotherapy.

123 Source 2002 BCCCA; Department of Health.
OCCUPATIONAL HEALTH AND VOCATIONAL REHABILITATION

The Government is right to focus on improving workplace health in the white paper. Health and Safety Executive figures show that sickness absence costs British society up to £30 billion a year and 40.2 million days are lost each year. A third of these are due to musculoskeletal conditions and both the Association of British Insurers and Trades Union Congress have stressed the importance of early access to physiotherapy services that can provide proper assessment and rehabilitation for workers.

Vocational physiotherapy and rehabilitation not only allow for a quick return to work and therefore economic benefits of increased productivity, they can also provide fast access to treatment, increase confidence about work abilities and improve the general wellbeing of people who have had work-related illness or injury.

However, the CSP is concerned that the emphasis on returning to work as the ultimate goal could be counterproductive in some circumstances and might overlook the needs of the long term sick. The aim of rehabilitation should be restoration of independence and resumption of normal daily life alongside prevention of illness or injury in the workplace.

The CSP supports the introduction of a new dimension to the Investors in People scheme to address employees’ health and wellbeing at work. This kind of voluntary scheme would enable employers of all sizes to seek accreditation based on the provision of early access to rehabilitative treatment for work-related illness, a range of preventative measures and referral pathways to services such as physiotherapy. It is vital that the scheme be based on clear evidence and goes beyond superficial or cosmetic measures.

SELF REFERRAL PROGRAMMES

While there is much that the Government, NHS and healthcare professionals can do to improve the nation’s public health, it will only be when the public are able to take more responsibility that health inequalities be reduced and significant inroads be made. The white paper does not focus enough on developing the skills needed by the public when using the health service. Empowering patients to access healthcare when, how and when they want it must be a major thrust of the public health agenda. The Expert Patient Programme has begun to alter the way patients interact with the NHS and how they manage their condition on a day to day basis. Furthermore, there is growing evidence that patients are more likely to undertake active self-management of their conditions if they refer themselves for treatments such as physiotherapy rather than being referred through many parts of the healthcare system. Furthermore, it is also possible to introduce self referral schemes for many other treatments, such as midwifery, podiatry and occupational therapy.

The CSP argues that the extension of forms of direct access, such as self referral to NHS physiotherapy, would encourage people to seek clinical advice more quickly than otherwise, and can promote healthy lifestyle and behaviour choices as part of their clinical and medical diagnosis.

The Scottish Executive has supported a substantial multi-site pilot to assess the detailed impact of self referral in a range of settings. This project is due to report imminently but initial research (Holdsworth L K. Webster V S. Direct access to physiotherapy in primary care: now?—and into the future? Physiotherapy 2004; 2: 64–72) demonstrates the difference self referral can make to patient experience, GP consulting time and outcomes. Patients were significantly more likely to attend their appointment and to comply with treatment (this was particularly marked amongst young men who are the least likely group to adhere to their treatment plans). As patients were seen earlier in the patient journey, their condition tended to be less chronic and require fewer interventions. Furthermore, as such a large proportion of GP appointments are for long term and musculoskeletal conditions, the amount of time saved was a month’s consulting time a year for an average five GP practice.

Self referral for patients to physiotherapy services is an eminently deliverable way to make patient choice a reality, especially for those with long term conditions. We are happy to make further costings and results available to the Health Select Committee as well as statements of support from the Royal College of General Practitioners, the Long Term Medical Conditions Alliance and NHS Confederation.

STRATEGIC, SYSTEMS AND WORKFORCE DEVELOPMENT

For public health to improve across the spectrum, multidisciplinary working must be more common, both at strategic and implementation level. It is imperative that service delivery is based on the experience and expertise of a wider range of healthcare professionals, not just doctors and nurses, so that it reflects the needs of all patients during their whole engagement with the NHS and other government agencies.

The CSP very much welcomes the Government’s commitment to introduce training modules for all NHS staff. We believe that continuing professional development is necessary to underpin the white paper’s objectives. It is important that protected time for learning is available for all staff to ensure take up is high. We recognise that staff training is not limited to the NHS. As the professional body representing 98% of physiotherapists in the UK, the CSP is currently undertaking a project to assist our members in incorporating public health into their working lives and if necessary redesign services so that they will more actively promote public health.
The Public Health Institute of Scotland fosters networks which bring together the full range of healthcare professionals to develop its evidence base. The CSP believes that this attitude to NHS staff will filter through to better standards of healthcare and better outcomes than if only a limited range of people were involved in the development of public health strategy and its implementation. The white paper is not explicit about which healthcare professionals will deliver on their proposals. We would like assurances that the Government is not restricting roles, so that for example physiotherapists, as well as nurses, would be considered for the role of community matron. It will be crucial for the Government to address this for workforce planning to be effective.

CONCLUSION

The CSP endorses the approach taken by the Government in its white paper, but would like to see more substantial proposals and improved consultation with all the professional bodies. Improved public health very much depends on partnership working, Government, trusts, NHS staff and patients alike, and the Department of Health must formulate policy with all stakeholders. There is widespread commitment to delivering the Government’s goals and it is vital that public health remains high on everyone’s agenda.

January 2005

Memorandum by Barnardo’s (WP 67)

INTRODUCTION

Barnardo’s works with more than 100,000 children, young people and their families in 361 services across the UK. These services are located in some of the most disadvantaged neighbourhoods where child poverty and social exclusion are common features. We work with children affected by today’s most urgent issues: poverty, homelessness, disability, bereavement and abuse. Many of our services have a specific health focus and we have strong working relationships with local health agencies.

Our response to the questions set out in the memorandum is set out below.

Question 1. Whether the proposals will enable the Government to achieve its public health goals?

1.1 Tackling childhood obesity by improving school meals

For the purposes of this evidence we will focus on one of the key aims of the White Paper—to tackle childhood obesity. Within that this submission examines the specific proposals aimed at improving school meals to tackle obesity as well as health inequalities.

We will be drawing primarily on the findings in our report “Burger boy and sporty girl—children and young people’s attitudes towards food in schools”. (November 2004) This report was based on interviews with 174 children in nine schools across Great Britain: three nurseries, three primaries and three secondary schools. These interviews investigated the views of children and young people about their food preferences and choices in school. A qualified nutritionist from The Food Commission analysed the nutritional content of school meals and packed lunches in three schools: a nursery, a primary and a secondary school.

1.2 The White Paper: tackling childhood obesity

The White Paper sets a national target: “to halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole.”

The following strategy for improving school meals is set out:

— revising both primary and secondary school meal standards to reduce the consumption of fat, salt and sugar and to increase the consumption of fruit and vegetables and other essential nutrients. We will strongly consider introducing nutrient-based standards. Ofsted inspectors will be looking at healthy eating in schools and will take account of any school meals provided in doing so;
— subject to legislation, extending the new standards to cover food across the school day, including vending machines and tuck shops; and
— supporting schools to provide the best meal service possible—for example through new guidance on food procurement for heads and governors, and improving training and support or school meal providers and catering staff.

The White Paper sets a target for half of all schools to be healthy schools by 2006 and for the rest to be working towards that status by 2009.

Most importantly, one of the key principles of the White Paper is to reduce inequalities in health.
1.3 Response to the strategy for improving school meals

Our response to the points in the strategy is as follows:

Revising primary and secondary school nutritional standards

We welcome the proposal to revise the nutritional standards for school meals. However, it is disappointing that they fall short of a commitment to introducing nutrient based standards. The research findings from our report “Burger boy and sporty girl” showed that none of the school meals or packed lunches analysed met the Caroline Walker Trust guidelines.

For example in the primary school researched, it was possible for children to make healthy choices from the food provided. However, as older children served themselves with side dishes, none of their meals included significant portions of vegetables or salad and only one of the four recorded school meals included fruit. Estimated values for energy, fat, saturated fat, carbohydrate and fibre failed to meet the Caroline Walker Trust guidelines. Estimated micronutrients were low for iron, calcium, vitamin A and folate.

The estimated nutritional values for lunchboxes were too high in saturated fat and too low in fibre. Most of the lunchboxes contained crisps, chocolate and almost all sandwiches were made with white bread.

In the secondary school researched, all the school meals analysed consisted of a cheeseburger, and/or chips and/or a fizzy drink. The energy contents of these meals failed to meet one-third of the young people’s daily requirement and none included any fruit or vegetables. None of the school meals or packed lunches analysed met the Caroline Walker Trust guidelines.

Just within the canteen area pupils had 27 opportunities to choose different brands of sugary soft drinks and 21 opportunities to buy low-sugar artificially, sweetened soft drinks. In comparison there were four opportunities to choose water and five to choose pure fruit juice. In total there were 28 opportunities for pupils to purchase different brands of chocolate and confectionery compared to 5 to purchase fruit or fruit salad. There were 18 options to choose different brands and flavours of crisps. Our research indicated clearly that when presented with a range of choice young people usually made unhealthy choices. A number of social and environmental factors played a key role—especially peer pressure, and the desire to “conform”. Additionally, branding and advertising was significant in guiding food choices.

In both the primary and secondary school children were also influenced in their food choices by cost. In the secondary school a two course meal cost about £2.00 compared to about £1.45 in a primary school—on top of this the young people had to purchase a drink. The option of a burger/chips/fizzy drink was much cheaper at between £1.00 and £1.50. However, despite the costs incurred by children only between 31–35 pence is spent on school meals by caterers compared to £1.74 spent per prisoner per day on food ingredients (Soil Association 2003).

1.4 Our recommendations for improving nutritional standards

Our research indicates very strongly that any improvement in the nutritional content of school meals can only be achieved by:

— Revising school meals standards in line with the Caroline Walker Trust Guidelines—the current National Nutritional Standards go some way towards promoting healthy food choices but these need to be improved. Choice must be restricted to a range of healthier options based on menus balanced over one week, and the provision of fizzy drinks as a part of a school meal should be phased out as is the case in Scotland.

— The government should ensure that the Food Standards Agency’s recommendations on the balance of less healthy food are properly implemented. These include setting criteria for levels of salt, sugar and fat in schools promoted to children and introducing point-of-sale information and clear labelling for salt, sugar and fat.

— The improved nutritional standards must be compulsory and monitored on a regular basis and cover all food provided on school premises, including vending machines.

— Setting guidelines for packed lunches which head teachers together with school governors and parents can ensure are followed

1.5 The role of Ofsted inspectors

We welcome the proposal for Ofsted inspectors to take account of school meals. This should be linked to the overall performance of schools and included in the school’s Ofsted report. We would strongly recommend that when Ofsted inspections take place a qualified nutritional analyses the nutritional content of both the school meals and packed lunches and advises the inspectors of the findings.
1.6 Improving the quality of food throughout the school day, including vending machines

The proposals in the White Paper to improve the quality of food provided throughout the school day, including vending machines need strengthening if they are to have an impact. This is especially important as schools become extended schools and it is likely that many children, especially those from the most disadvantaged families consume a significant proportion of their meals at school. Our research found that the obesity-causing environment has infiltrated schools, especially secondary schools, through vending machines, and the promotion of energy-dense foods.

1.7 Our recommendations for improving the quality of food throughout the school day

We would recommend that:

— Branding on school vending machines should be banned in England as is the case in Scotland and Wales.
— School vending machines should only offer healthy food and drink choice.

1.8 Healthy Schools

The Government’s vision is that half of all schools should be healthy schools by 2006 with the rest working towards healthy schools status by 2009. Local Healthy Schools will be encouraged to target deprived areas. These timescales are very long and it is difficult to see how levels of obesity will start to decrease by 2010 even if all schools become “healthy” by 2009. Furthermore, reaching this target will require legislation and tighter guidelines. It is doubtful that it can be reached by relying on individual schools to participate in the Healthy Schools Programme on a voluntary basis. This will result in differing standards between schools with a mixture of both good and poor practice.

1.9 Tackling inequalities in health — our recommendations

Schools have a pivotal role to play in ensuring that all children, regardless of parental income, eat a healthy diet when they are school. If the White Paper is to tackle health then it is imperative that school meals are affordable for all children. As we pointed out earlier in this submission, our research showed cost was a determining factor in the food choices children and young people made.

Our recommendations for tackling health inequalities are:

— The government should set up a committee to review school catering arrangements with the aim of implementing a policy which enables all children, including those on free school meals, to purchase a healthy two-course meal.
— Funding for school meal provision must be ring-fenced so that a minimum amount is spent per child per meal.

Question 2. Whether the proposals are appropriate, will be effective and whether they represent value for money

2.1 The proposals in the White Paper are appropriate and provide an adequate framework within which to improve the quality of the food provided in schools. However, it is unlikely that they will be effective unless they are strengthened to reflect the recommendations set out above. In particular, the Government has the opportunity to ensure that primary and secondary school meals are revised so that they are nutrient-based. Nutrient-based standards are the key to ensuring that the diet and health of children when they are at school is improved. These nutrient-based standards will then apply to all food provided across the school day, including vending machines. We would urge very strongly that primary and secondary school meals are revised in line with the Caroline Walker Trust guidelines.

2.2 The proposals represent value for money. The costs of not investing in improving the quality of food in schools is much higher—especially in terms of dealing with a growing population that has health problems associated with inadequate diets. However, we feel that the £1m that the Government has allocated is insufficient. In contrast the Scottish Executive has earmarked £63m to improve school meals over the next three years.

2.3 Extra resources also need to be earmarked to support schools in becoming “healthy schools”. The funding of schools should be reviewed so that schools do not find themselves in the position of having to rely on income from vending machines and promotions to fund core teaching activities. All schools should have sufficient funding without recourse to sources of funding which are detrimental to the health of children and young people.
Question 3. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved

3.1 There is no clear strategy in the White Paper on the structures and mechanisms that will support schools to improve school meals. There will be a school nurse for every PCT who work with a cluster of primary and related secondary schools. However, roll-out will not start until 2006–07. This resource is far from adequate and school nurses will not have the skills necessarily to advise on the nutritional content of school meals and packed lunches.

3.2 We would recommend that each school is allocated sufficient resources to employ the services of a qualified dietician/nutritionist who can in the first instance analyse the nutritional content of school meals, food in vending machines, and packed lunches and who can work with the school on drawing up their nutritional plans. Ofsted inspectors should also be advised by a qualified nutritionist when inspecting the provision of food in schools.

3.3 The White Paper acknowledges that catering staff need training. We support this and recommend that specific monies from the Healthy living blueprint for schools is ring-fenced for this.

CONCLUSION

The proposals in the White Paper provide an appropriate framework. However, we do not feel that they will meet the Government’s own targets unless the following key steps are taken:

— Nutritional standards become nutrient-based, are compulsory, and subject to inspection and reporting by Ofsted.
— The promotion of foods high in fat, salt and sugar and branding on vending machines is banned and that schools are required to offer only healthy choices in vending machines.
— There is sufficient funding for schools so that they are not put in a position of relying on income from vending machines, and food promotions.
— All children and young people can afford to purchase a healthy two course school meal.
— There is adequate funding for schools to buy in the resources, such as training for catering staff and the expertise of dieticians as they become healthy schools.

February 2005

Memorandum by the British Beer and Pub Association (WP 68)

SMOKING IN PUBLIC PLACES

INTRODUCTION

1. The pub industry has always led and been responsive to customer preferences introducing and expanding food offerings, family friendly areas and most recently developing no smoking sections in dining areas (52%—Source: The Publican Market Report 2004).

2. Government surveys and individual pub company research show that only a minority of customers (20%) want to see a total ban on smoking in pubs. The majority (51%) want to see non-smoking pubs with smoking areas.

3. Bars and pubs have always maintained a preference for voluntary action seeking to provide customer choice whilst enabling managed change across this diverse, primarily small-business led industry. Owing to the lack of a contractual relationship between publicans and the general public, the industry believes it is essential to educate customers on new policies, so that they can adapt their behaviour, providing the support required for new measures to work prior to their implementation. This approach helps to minimise the potential negative effects such measures could create.

4. With the above factors in mind, in September 2004, five of Britain’s leading pub companies representing over 22,000 outlets (over one third of the sector), set out a new no smoking policy. The aim was to dramatically increase no smoking areas in the nation’s pubs and bars, leading towards a presumption of no smoking. The action programme was expanded in October with a further 18 companies signing up to the plan. Twenty-six managed and tenanted pub companies, representing over 40% of the industry are now actively pursuing the policy.

124 The pub industry is very diverse made up of managed, tenant, leased and independent operations. Over 18,000 pubs are independently operated. Members of the BBPA account for 35,000 venues, both managed and tenant.
The Industry Programme

5. The action programme, identifies company commitments and an action timeframe. By the end of December 2005, signatories to the plan will have in place:
   - No smoking at the bar.
   - No smoking in back of house areas.
   - No smoking trading floor space increasing from a minimum of 35% to a maximum of 80% by December 2009.
   - A minimum of 50% of restaurant/dining area floor space to be no-smoking, moving rapidly to a much higher proportion.
   - Companies will also continue to develop exclusively smoke-free pubs and bars where appropriate and practical.

6. This action:
   - demonstrates the industry’s commitment to finding a progressive and deliverable solution;
   - is in the interests of staff and customers;
   - upholds the principle of choice reflected by general public opinion;
   - seeks to minimise the possible negative effects upon the economy; and
   - places responsibility on industry and staff where appropriate.

The Public Health White Paper

7. The industry action plan and timetable was determined following serious consideration of the potential consequences of various smoking ban options. Many calls have been made for both national and/or local bans to be implemented in the UK, but there were strong grounds to reject each approach.

8. Applying a ban linked with food, similar to that outlined in the Public Health White Paper, was one of the options considered by the industry. Such an approach is expected to risk the creation of an incentive for venues not to serve food in order to attract a predominately smoking clientele. A minority of venues that do not serve food, or who may choose to no longer serve it, would not be subject to any action under such a plan. This could create “smoking dens”, which would lead to an uneven playing field and would not provide universal enhancement of staff work environments nor customer choice.

9. There may be alternative options available, which could provide a more workable solution and warrant further exploration.

Conclusion

10. Application of the voluntary programme will see the provision of no-smoking areas for both staff and customersexpand dramatically within the current year, and at an accelerated pace over the next four years, without legislation.

11. The pursuance of the industry action plan avoids time-consuming, costly and inflexible legislation; minimises the negative effects upon the economy; ensures a practical, manageable approach; takes into account local, customised solutions—no two pubs are the same; enables targeted options to be developed in a consistent manner eg no smoking at the bar, no smoking in designated food areas; and places responsibility on the industry where appropriate.

12. However, if legislation is the preferred Government route, this needs to be implemented nationally and must be applied equally across all sectors of the hospitality industry. The staff and customer issues faced by licensees are no different in public houses, private clubs, restaurants, hotels, or workingmen’s clubs, and preferential treatment or exemptions remain illogical in a public health context.

13. Publicans should not be forced to make the choice on whether to serve smokers or non-smokers.

125 The following companies have made this commitment: Arkell’s Brewery; Barracuda Group; Bathams; SA Brain & Co; W H Brakspear; Burtonwood Brewery; Enterprise Inns; Fuller, Smith & Turner; George Gale & Co; Greene King; Hardys & Hansons; Heron & Brearley; Joseph Holt; Laurel Pub Co; Mitchells & Butlers; Mitchells of Lancaster; Punch Taverns; Scottish & Newcastle Pub Enterprises; Shepherd Neame; Spirit Group; Daniel Thwaites; Charles Wells; Weston Castle; Wolverhampton & Dudley Breweries; Yates Group; Young & Co’s Brewery.

126 No smoking at the bar—To be imposed while customers are being served and while they are standing or sitting at the bar. Customers will be advised that the bar is a no-smoking area through the use of signage above or on the bar and by communication with staff.

127 No smoking in back of house—Includes back of house areas where staff work including kitchens, cellars, storage areas, offices, corridors and staff rooms. This does not include accommodation.

128 Dining/restaurant areas—An area exclusively used for dining or as a restaurant. In larger venues this could be a separate room or section. Customers will be advised in which areas smoking is allowed through the use of signage as appropriate and by communication with staff.
14. If the objective is to move to primarily no smoking venues and the creation of a universal presumption of no smoking, we need to advance a solution that reflects the profile of society, enhances the work environment of staff. This should also encourage the adaptation of customer behaviour before implementation whilst maintaining customer choice.

*February 2005*

**Memorandum by Help the Aged (WP 69)**

**SUMMARY OF COMMENTS AND RECOMMENDATIONS**

— The interests of older people are often excluded from measures to address the wider determinants of health and wellbeing.
— The Public Health White Paper does not adequately address the needs of older people.
— Mainstreaming services and support for older people in to a whole-population approach neglects the specific needs of an ageing population.
— An unhealthy ageing population will have a dramatic impact on health and care services within a relatively short period of time.
— The White Paper misses an opportunity to address the wider determinants of health in older age.
— The focus on children and young people should be mirrored by co-ordinated efforts to improve the health of older people.
— Many of the proposals contained within the White Paper will fail to reach older people.
— The White Paper does not recognise the importance of health and work for older people, and for those approaching retirement.
— The mechanisms contained within the White Paper to implement the proposals do not adequately reflect the need for action to promote health in older age across the NHS, local government, the public, private and voluntary sectors.
— Local communities should ensure that action plans to promote population health are reflected in local strategies to improve the lives of older people.
— The National Institute for Health and Clinical Excellence must give equal weight to the prevention and treatment of poor health.

**ABOUT HELP THE AGED**

1. Help the Aged’s vision is of a future where older people are highly valued, have lives that are richer and voices that are heard. Working with older people, we champion their needs so that they can better their lives. Through research, campaigning and fundraising we develop solutions, drive activities and inspire others to do the same. Our strategy is to attack and remove the major barriers to active and fulfilled later lives, and to concentrate our efforts on those older people most at risk of disadvantage or social exclusion. Our four urgent priorities are combating poverty; reducing isolation; defeating ageism; and promoting quality in care.

2. Help the Aged does this by providing a range of direct services in the UK to help older people live active and independent lives, funding vital research into the illnesses and social context of ageing, and funding international activities.

**OLDER PEOPLE AND PUBLIC HEALTH**

3. There is considerable evidence to support the assertion that improvements in health and lifestyle pay dividends in all ages, and to highlight the importance of taking steps to improve health in mid-life and beyond. 129

4. Help the Aged’s response to the HM Treasury consultation, *Securing Good Health for the Whole Population*, highlighted the importance of focusing attention not just on life expectancy, but also upon healthy life expectancy. It also set out our view that improving the health of older people requires a co-ordinated effort across Government, at local, regional and national level.130

5. Help the Aged also submitted a response to the Government consultation on the Public Health White Paper in May 2004 which set out our view of the importance of developing a public health strategy which adequately addressed the wider determinants of health in older age.131

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6. Our submission set out what we considered to be the essential elements of a public health strategy that would address the needs of an ageing population. These included:

- Removing the barriers to active healthy life in older age (such as poverty, poor housing and social isolation).
- Investing in services to promote and support health in older age (such as basic community health services, and social care).
- Tackling unfair age discrimination and introducing anti-age discrimination legislation.
- Introducing periodic “health, wealth, work and wellbeing” checks.
- Developing integrated policies to promote the inclusion of older people in community life (such as transport, exercise, neighbourhood renewal, housing and education).
- Promoting the participation of older people in local, regional and national public health strategies.
- Targeting efforts to address fuel poverty.
- Investing in fundamental ageing research.
- Securing a commitment across Government to implement standard eight of the National Service Framework for Older People.

It is upon these criteria that we assess how well the Government’s Public Health White Paper addresses the interests and needs of England’s older population.

7. Older people’s interests are often excluded, or otherwise seen as a low priority, in activities to address the wider determinants of health such as neighbourhood renewal initiatives, developments in education and skills or the drawing up of local transport plans. Help the Aged has consistently urged the Department of Health to build on the progress made so far in tackling health inequalities, in implementing the National Service Framework for Older People, and in developing the Department for Work and Pensions Link-Age programme.

HELP THE AGED’S RESPONSE TO THE GOVERNMENT’S WHITE PAPER

8. Although Help the Aged has welcomed the publication of the White Paper, Choosing Health, and the general direction that it sets out, we remain concerned that the needs and interests of older people have not been adequately recognised or addressed in the Government’s plans.

9. In our view, action to promote population health must have a specific focus on ageing, and should encourage activity across Government, under the leadership of the Department of Health, to tackle the wider determinants of health in older age. To date, the debate has focused on young people and adults of working age, highlighting action to reduce the incidence of disease and disability among those populations. For older people, the solution must be in the development of integrated policies to promote their full inclusion within their local communities as active citizens. These include good transport, safe streets, access to exercise and sport, neighbourhood renewal, a versatile range of housing options and equal access to education and life-long learning.

10. Mainstreaming activity to improve the health of older people in to a whole-population strategy is a laudable objective. However, we believe that it is unrealistic to presume that older people will necessarily be reached by such mainstreamed services, and that there remains a need for targeted activity to help overcome the barriers to healthy older age. Such barriers might include physical access, the psychological stigma associated with seeking help, or age discrimination. In our view, the lack of attention given to the specific needs of older people is a significant gap in the Government’s proposals.

11. The attention being placed upon children and young people is to be commended. We accept the assertion that patterns of behaviour are set early in life, and that therefore childhood is a critical stage in development. However, we compare this with the lack of attention to the needs of today’s increasingly ageing population. There is a tendency, it seems, to concentrate efforts on younger people as paying potential dividends in the long term improvement to health across the life course. While this is to be welcomed, Help the Aged believes that it is short-sighted to overlook the needs of today’s older population, and those soon to enter older age.

12. If present patterns of population ageing continue, the impact on health and care services will be profound in a relatively short space of time. For example, it is estimated that an additional 2 million older people will require social care support by 2031, and that over the same period the number of home care hours will need to rise from just under 2 million to around 2.9 million hours each week.132

13. Taking steps today to improve the overall health and wellbeing of older people and to reduce the incidence and impact of avoidable disease and disability in later life is therefore crucial to improve the population’s health, and to reduce the potential demand on public services in the future.

Q1: *Will the proposals enable the Government to achieve its public health goals?*

14. In his report to the Secretary of State for Health in November 2004, the National Clinical Director for Older People’s Health stated that “*The forthcoming White Paper on public health will need to emphasise the benefits of health promotion for older people, with incentives for the NHS and councils to work together and invest in health promotion activities for people as they enter, and throughout, later life. In particular, opportunities to increase physical activity need to be encouraged and to be inclusive of marginalised groups of older people: those living alone, the socially isolated or those with specific needs based on their culture or race*.”133 Help the Aged is concerned that the White Paper has failed to do this.

15. Help the Aged has welcomed the Government’s stated goals in public health, as set out in the Health & Social Care Standards and Planning Framework 2005–06/2007–08, and in the 2004 Public Service Agreements. In particular, we welcome its commitment to improve population health and simultaneously to reduce health inequalities.

16. In our view, the proposals set out in the White Paper will assist in the attainment of these goals, but significant gaps remain.

17. We question whether these goals adequately incentivise specific activity on older people’s health within the health and care system.

18. In our view, the determinants of poor health and health inequalities, and therefore of health improvement and equity, lie outside the territory addressed by the current Public Health White Paper, and by the National Health Service more broadly. Poverty, poor housing, and social isolation in later life, for example, are recognised as contributing to poor health in later life, and yet are not addressed in the proposals. In our view, this is a significant missed opportunity to create an integrated package of measures that could improve the health and wellbeing of older people.

19. Help the Aged is also disappointed that the White Paper does not make explicit connections with existing policy developments on health improvement. Standard Eight of the National Service Framework for Older People,134 published in March 2001, sets out action to promote health and active life in older age. The framework highlights issues of poverty, housing, fuel poverty, public transport and access to community facilities as among the important factors contributing to health in later life.

20. The White Paper sets out the Government’s proposals for the next stage of the Sure Start scheme for children. Help the Aged has previously set out the case for a similar approach to health and wellbeing for the older population, which would be capable of targeting those older people who are the most disadvantaged.135 We continue to believe that such an initiative is needed, and that it would help the Government to meet its stated objective of assisting more older people to remain living independently in their own homes.

21. We are also disappointed that the White Paper has not more explicitly made the link between improving health in mid-life (and indeed across the life course) and health in later life. We return to this point below.

Q2: *Are the proposals appropriate, effective, and do they represent value for money?*

22. As stated above, Help the Aged believes that the lack of attention given to older people’s health and wellbeing is a significant gap in the White Paper, and that many of the proposals are likely to fail to reach older people, or those entering older age.

23. For example, in the section on “Work and health”, the lack of attention placed upon the opportunity for targeted health and wellbeing messages through the workplace, and more specifically at the point of retirement, is a significant missed opportunity. The White Paper does not emphasise the opportunities for improving health in mid life and beyond through action in the workplace, or the impact of retirement from paid work as a pivotal point of transition in mid life.

24. Help the Aged believes that the introduction of a mid-life “health, wealth and work check” could use the point of transition at retirement to create an opportunity to consider future well-being and to encourage individuals to make positive changes to their health and lifestyles. Such an approach would build on the work that the Health Development Agency have undertaken on the pre-retirement pilot programme, and the work of other organisations who have been exploring the scope of such activity in mid-life and beyond, such as the Pennell Initiative for Women’s Health.

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133 Department of Health (2004) *Better Health in Old Age: Report from Professor Ian Philp, National Director for Older People’s Health to Secretary of State for Health*.


25. As part of the implementation of the National Service Framework for Older People, the Health Development Agency ran a series of pre-retirement pilots designed to target health messages at people between 50 and 65 and to give individuals time to reflect on their impending retirement. The evaluation concluded that this cohort of people were a distinct generation with specific needs, and were likely to be key to reducing health inequalities and improving healthy life expectancy.136

26. Similar work undertaken by the Pennell Initiative for Women’s Health has sought to target health messages through a simple health and lifestyle check for women aged 45–55. This cohort of women were identified as key to improving health in later life for themselves and also for their families. In follow up studies, almost 80% of respondents had made positive changes in their lifestyles. The health and lifestyle check has been made available to women through community networks and their workplaces with considerable success.

27. Unfortunately, the White Paper does not clearly state the value of these simple checks. It also fails to recognise that the needs and interests of older workers could be missed by the proposals on health and work.

Q3: Does the necessary health infrastructure and mechanisms exist to ensure that the proposals will be implemented and the goals achieved?

28. Help the Aged looks forward to the publication of the delivery plan to describe in more detail how the Government proposes to implement the commitments made in the White Paper.

29. However, we remain concerned that the infrastructure and mechanisms proposed in the White Paper remain “NHS dominated”. While the NHS undoubtedly has a key role to play in improving population health, we believe that more needs to be done to encourage a truly “whole systems” approach to health and wellbeing, bringing the NHS, the functions of local government, communities, employers and providers together to make progress in improving health and, importantly, in reducing inequalities.

30. We believe that it is critical for local stakeholders from the public, private and voluntary sectors to work together at local level to ensure that local strategies to deliver improvements to population health are reflected in strategies under development in many areas to improve the lives of older people. Failure to produce targeted, appropriate and effective measures to improve the health of older people will significantly undermine potential progress in taking forward the Government’s aims.

31. We welcome the creation of the National Institute for Health and Clinical Excellence brought about by the merger of the National Institute for Excellence and the Health Development Agency. In particular, we are pleased that the new agency will address both prevention of ill-health and treatment of ill-health. However, we hope that the new agency will give equal weight to the two elements, and will be able to make progress on the wider determinants of health which have been overlooked by the White Paper, but which are so crucial to health in later life.

February 2005

Memorandum by Royal College of Physicians of Edinburgh (WP 70)

The College is pleased to respond to the request of the Health Committee for evidence on the Government’s Public Health White Paper. The College also welcomes the White Paper “Choosing Health: Making healthy choices easier” as an important start to a Governmental commitment to “promote physical and mental wellbeing and prevent illness”.

SUMMARY OF KEY POINTS

— Critical to the success of this strategy will be a combination of individual commitment to lifestyle change and governmental policy to support individual choices.

— Failure to support challenging choices for individuals will add to the inequalities of health in deprived communities.

— A European dimension is essential in the planned Food and Health Action Plan.

— Legislation on banning smoking in all public places is essential.

— The public health infrastructure and evidence-base require support to target limited resources in a cost-effective manner.

1. Whether the proposals will enable the Government to achieve its public health goals?

The College considers that there are serious limitations in the proposals that will constrain the success of the strategy. The following comments are pertinent to food and nutrition, and tobacco.

(a) Food and Nutrition

This encompasses risk factors for many of the most prevalent diseases presenting public health challenges in the UK: improving nutrition in the UK should be seen as the most important of all our public health challenges. There is no real dispute regarding what needs to be done—the population should consume:

- less saturated fat (and therefore less fat in the diet overall);
- unsaturated fats rather than saturated fats;
- less beef (and other mammalian meat);
- less sugar;
- less salt;
- more fish and vegetable protein;
- more fruit and vegetables;
- more fibre.

Detailed proposals for how to achieve these objectives have been published in local strategies and the College cites as an example of good practice the Food and Health Strategy for Greater Merseyside as published by “Heart of Mersey”. This is available at: http://www.heartofmersey.org.uk/uploads/documents/hm_412r_HoM_foodstrategy_Jan05.pdf).

Proposals such as these demonstrate how such regional and sub-regional projects can become involved in “upstream” interventions such as in food procurement, in work with the food industry including caterers, and in contract specifications. In addition, they can work with local communities through promotional campaigns etc.

However, the foundations of food policy are to be found within the Common Agricultural Policy (CAP), within the context of which so many key decisions are made in food subsidies and support for farmers. These subsidy arrangements determine the relative quantities of different foods produced, and what they cost to the consumer. Massive over-production of saturated fat-rich dairy products and of beef results from the continuing subsidies for production of these, resulting in the over-availability of cheap burgers, and in the Commission disposing of dairy fat into cakes, biscuits, pies etc, almost by subterfuge (in that the consumer cannot know of this when these products are purchased). Meanwhile, there is no subsidy on fruit and vegetable production, these being the foods for which we need to increase consumption.

The population will always wish to purchase food which is both cheap and easily available. Because of the need to address this, public health experts believe that a major reform of the CAP is required in which food production is clearly related to the health needs of the consumer. Without such reform, the College fears that all the well-intended projects to improve nutrition at a more local level may be doomed to failure. Unreformed, the CAP is a major hazard to public health, and a major contributor to the high death rates from CHD suffered by the UK population. The Faculty of Public Health of the Royal Colleges of Physicians (FPH) has published a booklet “Health at the Heart of CAP”. This is available at: http://www.fphm.org.uk/publications/publications_general/Health_at_the_Heart_of_CAP.

There is a huge contrast between allocations in the CAP budget and the dietary targets of the World Health Organisation (WHO) and the Food and Agricultural Organisation (FAO) and which illustrate the urgent need for reform. In particular, there should be a switch from animal-based to plant-based production and towards more sustainable production.

The College therefore considers that, while a major omission in the White Paper, it is essential that this “European” dimension is considered in the planned Food and Health Action Plan.

However, the College supports the moves already made towards clearer food labelling and controlling the marketing on “junk” food to young people. Nevertheless, we believe that more regulation is required if there is to be more success in controlling some of the advertising excesses of the food industry. The College supports fully the Children’s Food Bill and its commitment towards better food and a healthier future.

The College also believes that national legislation is required to support a reduction in salt, fat and sugar in all processed food products manufactured and sold in the UK.

Finally, in supporting the public sector to carry out its role as a corporate citizen, the College urges the Government to develop nutrient-based guidelines for public sector procurement.
(b) Tobacco

Prevention of tobacco-related ill-health should be seen as the second public health priority throughout the UK. The College is therefore pleased that tobacco has received a high profile in the White Paper and supports the Government’s continuing action to further curtail the advertising and production of tobacco products. The College believes this has helped to reduce the prevalence of smoking and supports those smokers who have given up. However, the College is concerned that the proposed legislation on smoke-free legislation is inadequate and potentially ineffective. The College applauds and supports the proposed legislation in Scotland as a more appropriate response to this public health challenge.

It has been shown clearly that across the UK there is a clear mandate for public places to be smoke free. The College believes that by permitting those public houses not serving food to allow smoking, there is a danger that this will have a disproportionate effect in some of the poorest areas, and that this may result in increased health inequalities. The College urges a reconsideration of the wording of the new legislation to give a clear and unambiguous message to the pub and hospitality trade.

2. Whether the proposals are appropriate, will be effective and whether they represent value for money?

Public health and other NHS agencies and others will continue to develop social marketing campaigns to engage with local communities to create more informed choices. However, to increase their effectiveness such activity needs to be supported by Government campaigns promoting healthier food choices and a smoke-free environment.

As previously noted, national legislation is necessary in certain situations. Tobacco is a good example. Voluntary agreements simply do not work. In many cases, people are very clear on the healthiest choice. For example, most people feel strongly about food in schools but legislation will be necessary to require food companies to produce healthier processed foods (with less hidden fats, sugar and salt) and at the same time advertising targeting children must be restricted.

If individual and informed choices are not supported we run the real risk of increasing inequalities as it is always those from the most disadvantaged areas who find it hardest to make the changes towards a healthier lifestyle.

It is difficult to say if the proposals represent value for money and the research base is limited. However, for example, studies have shown that investment in reducing risk factors (such as promoting a healthier diet to reduce serum cholesterol) for coronary heart disease is a much cheaper and more effective method of reducing the burden of this disease in our UK communities than cardiological treatments can ever be (see, for example, Kelly and Capewell, HDA, 2004: http://www.hda.nhs.uk/Documents/CHD_Briefing_nov_04.pdf).

3. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

The College believes that it is essential that adequate funding is provided to support the work described in the White Paper. This should include national social marketing campaigns linked to local and regional programmes and support for research to strengthen the evidence base for public health interventions.

February 2005

Memorandum by the Commission for Patient and Public Involvement in Health (WP 71)

INTRODUCTION

1. The Commission for Patient and Public Involvement in Health (CPPIH) welcomes the Committee’s inquiry into the Government’s Public Health White Paper and the opportunity to present evidence.

2. CPPIH is a Non-Departmental Public Body established in January 2003 through primary legislation to ensure the public is involved in decision making about health and health services and to report to Government on the effectiveness of the PPI system. CPPIH has a specific remit enshrined in legislation to support the engagement of marginalised communities.

3. The Commission has established 572 Patient and Public Involvement Forums, one for each PCT, NHS Trust and NHS Foundation Trust in the country. Forums consist of around 5,000 volunteers nationally and have now been in operation for just over one year.

4. There are 68 Forum Support Organisations from the voluntary and community sectors working under contract to the Commission providing direct local support to Forums and strengthening the opportunities for community engagement through their expertise and community knowledge.
5. CPPIH supported the engagement of Forum members in the Choosing Health Consultation by running 25 workshops across England in which 835 members participated. A response (annex 1) [Not printed] was submitted to the Department of Health on behalf of Forums. This response was, perhaps unique because it directly reflected the views of patients and the public through the Forums, demonstrating very real and independent patient and public involvement. A substantial number of members responded directly to the Department of Health.

6. This memorandum reflects:
   — The extent to which the White Paper does or does not accord with the views expressed by Forum members;
   — The views of the Commission on the patient and public involvement issues relevant to the White Paper.

**WILL THE PROPOSALS ENABLE THE GOVERNMENT TO ACHIEVE ITS PUBLIC HEALTH GOALS?**

7. **Health as a public good**

   The responses of Forum members indicate that there is a widely held view and level of understanding that improvement in public health can only be maximised by a fundamental commitment to health as a collective public good. Supporting healthy choices through individual decision making is clearly an essential component of the strategy. However, we are concerned that the White Paper relies too heavily on a consumerist model of health with its emphasis on individual decision making and fails to propose measures to support growth in infrastructure necessary for collective community action. Collective community action is a means through which significant additional health gain can be achieved, particularly amongst those social groups currently experiencing the poorest health outcomes. We would suggest that the White Paper proposals are reviewed to reconsider the interventions necessary to support this development.

8. **Sustainable community engagement**

   Patient and public involvement in its widest sense is a valuable component in an effective strategy for health improvement. Bodies ranging from those supporting community development (such as the Community Development Foundation) to international agencies (such as the World Health Organisation) have put forward the evidence base to show that involvement in one’s own community and decisions about important aspects of one’s life and social context, is health enhancing in its own right and improves health outcomes. The Commission perceives an absence in the White Paper of evidence of a coherent approach and genuine cross government commitment to mobilising the power of local communities. Effective cross Government action to support and resource active citizenship is the means through which sustainable improvements to health could be realised beyond the short lived improvements achieved by time limited interventions.

   The Wanless report “Securing Good Health for the Whole Population” highlighted the importance of this issue. “The importance of public engagement is incorporated into the Review’s three scenarios . . . The core difference between the health outcomes in the fully engaged and solid progress scenarios is not the way in which the service responds over the next 20 years, but the way in which the public and patients do . . .” We are concerned that the action proposed will not maximise sustainable patient and public engagement and therefore will not maximise the possible long term gain in public health outcomes.

9. **Disadvantage and Health**

   Forum Members indicated in their response the importance of placing sufficient emphasis on the link between income and health. The Prime Minister’s Strategy Unit paper on “Life Chances and Social Mobility” which reviews the latest evidence concludes that “there has been no narrowing of differences in life expectancy by social class over the last thirty years”. Income is an indicator of social disadvantage. The White Paper does not adequately address the impact of disadvantage, and particularly multiple disadvantage on the capacity of individuals to pursue positive health choices. There is significant evidence of the impact of multiple disadvantage on individual behaviour. For many people living with disadvantage there are additional costs associated with making healthy choices. This compounds the challenges they face in pursuing health promoting behaviours. The pursuit of health improvement based on a strategy of individual choice has the potential to widen inequalities.

10. **Information Appropriate to Need**

   The white paper suggests that information and advice is tailored to meet people’s needs. Members would wish to highlight the specialist needs of some individuals such as the sensory, physically and mentally impaired for whom there are substantial barriers to access to information and to opportunities for healthy lifestyle activities appropriate to personal needs and preferences. This important aspect receives only a passing mention and there are no specific proposals for action.
11. *Intervention by Government*

There is much in the White Paper that accords with the views expressed by Forum members. However, as a general point the Committee might be interested to note that the extent to which members felt that Government should act to control and restrict unhealthy activities or options was greater than the scope and extent of the controls proposed, particularly in the areas of food and smoking. Members identified a variety of fiscal measures that they felt would be effective and supported such as tax on unhealthy foods and the advertising of such foods and subsidies on healthy foods.

12. *Neglect of the role of collective action in health improvement*

In our view the proposals will not maximise health gain as they fail to adequately support active citizenship and collective action by local communities as we set out in section 8 of this memorandum.

13. *Addressing disadvantage*

In our view the proposals will not maximise health gain as they fail to sufficiently address the impact of social disadvantage on health choices as we set out in section 9 of this memorandum.

14. *Assessing the effectiveness of implementation*

The Department of Health document “Standards for Better Health” contains Public Health as one of the seven domains against which the Healthcare Commission will evaluate progress. Neither the core standards nor the developmental standards contain explicit reference to community engagement. We feel that this is a potential omission that will hinder assessment of the effectiveness of implementation.

**DO THE NECESSARY PUBLIC HEALTH INFRASTRUCTURE AND MECHANISMS EXIST?**

15. *A role for Forums*

The Patient and Public Involvement Forums (PPIFs) established in 2003 by CPPIH offer the only comprehensive mechanism for community engagement in health.

In support of Forum members CPPIH has initiated a programme of work to support Forums to engage with the issues and action set out in the White Paper. There is significant scope for Forums to make a worthwhile contribution to implementation of the White Paper, not least through sharing knowledge with local populations as a step towards improving health and transferring knowledge from communities to decision-makers. There is scope for action in partnership with other stakeholders to bring a unique contribution to this work to highlight issues, to stimulate local debate and discussion on public health issues and through this, enable sustainable engagement with other local stakeholders and communities.

The Commission has always interpreted its founding legislation, and that establishing the Forums as embracing this wider view of the role of Forums. The Board of CPPIH have championed the idea of a wider “Our Health” infrastructure that allows wider public involvement in a national PPI infrastructure and a pool of “local voices”. This concept was explored by the Office of Public Management and the Nuffield Trust and a paper was submitted to the Wanless Consultation. The proposals were rejected by the Department of Health.

As the Committee will be aware the Commission will be abolished in 2006 as a result of the review of Department of Health Arms Length Bodies. The Department of Health is currently considering the future role of Forums and how they should be supported. It is important in our view that the Forums retain a remit for addressing issues of public health. Our experience has been that the Department of Health prefer to emphasise the Forums’ role in monitoring and reviewing the NHS.

We would also like to highlight the importance of retaining a strong, independent local, regional and national voice for Forums. It is our view that they will not be effective in making an impact on decision making about public health without a “voice” at a national level. This is part of the role of CPPIH. It appears that the Government has no plans to replace this function.

16. *Skills and Capacity for Community Engagement*

We are pleased to see in the White Paper recognition of the need for workforce skills and capacity development in the sphere of community engagement. However, the scale and pace of the proposed action is a cause of concern given how crucial this is to the success of the strategy overall. In establishing CPPIH and its PPI forums, the Commission found a serious shortage of such skills, and has invested heavily in building capacity across the country in this area. We urge that this capacity is built upon to meet the demands of the emerging public health agenda, and is not discarded in the current reforms.
CONCLUSION

17. CPPHI wishes to highlight to the Committee the following:

— The heavy emphasis on a consumerist model of health in the White Paper and concern that the proposals do not support growth in infrastructure necessary for collective community action, through which significant additional health gain can be achieved, particularly amongst those social groups currently experiencing the poorest health outcomes.

— The need to review cross government action required to promote, support and resource active citizenship and approaches to community governance to underpin the achievement of public health goals.

— The White Paper does not in our view adequately address the impact of disadvantage, and particularly multiple disadvantage on the capacity of individuals to pursue positive health choices. The pursuit of health improvement based on a strategy of individual choice has the potential to widen inequalities.

— The importance of ensuring that there is action to tailor information, advice and healthy lifestyle activities to meet specialist needs of individuals such as the sensory, physically and mentally impaired.

— Neither the core standards nor the developmental standards by which the performance of the NHS in respect of public health will be assessed contain explicit reference to community engagement.

— The importance of strong independent Forums who have a voice in health decision-making at local, regional and national level.

— The unique contribution that Forums could make to action to improve public health and the need to retain their remit to secure engagement in public health issues, as well as service monitoring.

— The need to enhance the scale and pace of proposed action to address workforce skills and capacity development in the sphere of community engagement.

January 2005

Memorandum by Debra Shipley MP (WP 72)

1. Introduction

1.1 I am currently the main parliamentary sponsor of the campaign for the Children’s Food Bill, which seeks to improve children’s diet related health through a range of statutory measures, including banning the promotion of unsuitable food and drink to children and introducing new nutritional standards for school meals. The campaign is coordinated by Sustain and backed by 125 national organisations (including three Royal Colleges of medicine, the BMA, the Women’s Institute, National Consumer Council, NUT and the National Heart Forum) and 248 MPs (signatories of EDM 1256 in the last session). I plan to reintroduce the bill during February 2005.

1.2 In summary, I welcome the Public Health White Paper’s recognition of the need to improve children’s diet-related health by restricting food promotion to children and improving school meals. But I am disappointed by the failure to commit to a statutory approach to the problems that exist. I would argue instead that the Government should adopt the measures contained in the Children’s Food Bill and I urge the Health Select Committee to support such an approach.

2. Whether the proposals will enable the Government to achieve its public health goals?

2.1 Obesity is caused by a mismatch between energy consumed as food or drink and energy expended on physical activity. There is a widespread consensus, which I support, that children’s exercise levels must be increased, primarily through increasing the quantity and quality of PE in schools. However, the issue of what children eat is at least equally as important.

2.2 As well as declining exercise levels, recent decades have seen a sharp rise in the consumption of pre-packaged foods. These foods, usually high in fat, sugar or salt, not only mean that children are often consuming far more calories than they need, they are also likely to suffer increasingly from the health consequences of obesity. FSA research has shown that the vast majority of children consume more saturated fat, added sugar and salt than the Government’s recommended amounts for adults. The Government’s Public Health White Paper represents a potential landmark in the battle to tackle the “epidemic” of childhood obesity as it recognises for the first time the need to restrict the promotion to children of foods

137 See www.sustainweb.org/child_index.asp.
high in fat, sugar and salt. I welcome the Government’s recognition of the scale of the problem and its desire to restrict food promotion in a comprehensive manner, including, for example, sponsorship of sporting events and through school vending machines.

2.3 I welcome the Government’s acceptance of the conclusions of the FSA review of research on the Effects of Food Promotion to Children, which found that the influence of television advertising on children’s food preferences, behaviour and consumption is significant.139 This had previously been resisted by the Department for Culture, Media and Sport and Ofcom, which both refused to implement significant controls on advertising to children prior to the White Paper.

2.4 However, compared to the scale of the problem identified in the White Paper, reliance by Government on a voluntary code for industry is weak and unsatisfactory. The food industry has shown itself to be incapable of responding to numerous past calls from Government for more responsible behaviour. This is shown by the lack of positive responses to previous attempts to change practice, such as the FSA’s attempts in 2000 to negotiate a voluntary code, the Secretary of State for Culture Media and Sport’s public exhortations for more responsible behaviour in 2004, and the Health Select Committee’s recommendation in its inquiry into obesity that industry voluntarily withdraw from television advertising of unsuitable foods to children. Indeed, industry to this day continues to strenuously argue and lobby against any restrictions on its actions in relation to children, rather than arguing for a level playing field where all companies can compete on an equally responsible footing.

2.5 To take one recent example of continuing unsuitable food promotion to children, Kellogg’s continues to use a deal with the Amateur Swimming Association to promote its highly processed high-sugar product, Frosties, to children. The Food Standards Agency states that 10g of sugar and 0.5g of sodium per 100g of food represents “a lot” of sugar or salt (respectively) within a food product. Kellogg’s Frosties are 37g/100g sugar and 0.6g/100g sodium, which exceeds (and sugar drastically so) both of these thresholds. However, Kellogg’s has branded children’s swimming with its character Tony the Tiger, including having large banners at swimming pools, logos on children’s swimming badges and ASA logos on its cereal boxes. This seeks to associate a highly inappropriate food with a healthy activity in a way designed to appeal to small children and mislead their parents. The deal goes against the current FSA guidance on promotion to seek to associate a highly inappropriate food with a healthy activity in a way designed to appeal to small children. Indeed, industry to this day continues to strenuously argue and lobby against any restrictions on its actions in relation to children, rather than arguing for a level playing field where all companies can compete on an equally responsible footing.

2.6 On the related issue of food in schools, I welcome the White Paper’s aim of reducing consumption of fat, salt and sugar and of requiring Ofsted inspectors to look at healthy eating and school meals. It is disappointing, however, that the goal for all schools to achieve healthy school status is 2009—too late for the millions of children now attending these schools.

2.7 The current standard of meals in many schools is abysmal—unsurprising given the small amounts of funding provided for the purpose. I therefore welcome the decision to revise primary and secondary meal standards and the promised consideration of introducing nutrient-based standards. Exacting nutrient-based standards are absolutely vital for ensuring that food is healthy and of high enough quality so that children actually wish to eat school meals. The Government should go further in prioritising school meals and indicate that it will provide LEAs and schools with additional funding to allow high-quality, balanced and nutritious meals to be provided for all children.

3. Whether the proposals are appropriate, will be effective and whether they represent value for money?

3.1 Given the scale of the obesity problem and the refusal of the food industry to make meaningful change to its behaviour, I am deeply concerned that the White Paper gives responsibility for introducing the new regime to Ofcom. Ofcom is a body that is highly sympathetic to the TV and advertising industries and ill-equipped to act decisively against its stakeholders in the interests of public health. Its lack of impartiality was demonstrated following its previous evaluation of the need to more tightly regulate advertising to children, as requested by the Secretary of State for Culture, Media and Sport in December 2003. Ofcom chose to carry out unnecessary and secretive new research on the effects of advertising, in spite of the recent publication of the much more comprehensive and extensively peer-reviewed FSA review. Following the review, Ofcom also issued a misleading media release concerning its research and the conclusions that could be drawn, which resulted in newspapers inaccurately reporting that Ofcom had already decided not to restrict food advertising to children. Ofcom has also, in the past, engaged in differential treatment of industry compared to health and public interest groups.

3.2 Ofcom’s annual plan consultation document for 2005–06 illustrates why it is unsuitable for the task it has been given. Admitting that it operates with a bias against intervention, Ofcom’s operational principles state “Ofcom will intervene where there is a specific statutory duty to work towards a public policy goal markets alone cannot achieve.”140 The Government proposes no such statutory duty in respect of restricting food advertising to children. The Public Health White Paper is not mentioned in Ofcom’s annual plan.

141 Ofcom Ofcom’s Annual Plan 2005/06 Consultation Document, p 5.
consultation document. There is merely a single sentence commitment to take forward a review of the rules on food advertising to children and a promise to continue to work to understand and assess options for protecting children.\footnote{Ofcom Ofcom’s Annual Plan 2005/06 Consultation Document, p.18.} This illustrates the low priority Ofcom attaches to the review it has been asked to undertake. There is also still no recognition from Ofcom that tough restrictions are needed on food promotion to children, and no evidence that the contents of the White Paper have been accepted or have produced a change in the organisation’s policy.

4. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved

4.1 If Ofcom is to fulfil the role it has been given, I would strongly urge the Government to give the FSA joint control of the process and to issue far firmer guidance to Ofcom on how its new review is to be carried out and evaluated. The Government also needs to be clearer on the situation that it is seeking to create by 2007 and provide information on how it will independently monitor whether the voluntary approach has succeeded. A far quicker and more effective method of achieving the Government’s public health goals would simply be to introduce the measures contained in the Children’s Food Bill.

January 2005

Memorandum by British Medical Association (WP 73)

The British Medical Association (BMA) is a voluntary, professional association that represents all doctors from all branches of medicine across the UK. About 80% of practising doctors are members, as are nearly 14,000 medical students and over 3,000 members overseas.

The BMA’s response is based upon a long-term interest in public health\footnote{Recent reports include: Healthcare in a rural setting (2005), Smoking and reproductive life (2004), Adolescent health (2003), Health and ageing (2003), Housing and Health (2003), Towards smoke free public places (2002).} and discussion within the BMA on the strengths and weaknesses of the government’s public health white paper, Choosing Health: Making healthy choices easier.

Aside from its continuing lack of leadership around smoking and alcohol policy, the White Paper contains several welcome initiatives as well as some positive proposals.

The proposed investment to develop sexual health services is excellent but it is important to ensure investment to increase capacity comes early enough to respond to the expected increase in demand.

The BMA welcomes proposals to expand school health services, to incorporate a health impact assessment on policy across government, and supports the creation of an arms-length body that will gather data and report on key indicators, as well as money to support it.

There is little detail behind the proposals and it is less a plan and more an outline of policy ideas that are still to be shaped. Therefore the BMA’s comments focus mainly on implementation issues and the need for a clear strategy and framework to develop these ideas and sustain them in practice.

The proposals outline a medium term agenda and initiatives that need to be driven forward. The extent to which forthcoming reviews are absorbed into policy needs to be monitored.

It is appropriate now to look at the practicalities of the proposals so that they can be developed further. Without careful reflection on how to progress the proposals to achieve public health goals, it will be difficult to take advantage of the current high profile of public health.

1. Will the proposals enable the government to meet its public health goals?

I. The case of smoking illustrates some of the higher-order challenges in translating the political philosophy of the public health white paper into effective action. Proposals have been developed based on politics rather than published scientific evidence and public health has become even more focused on health service delivery.

II. The government’s proposal on smoke-free public places is a really disappointing area in the White Paper. The government has missed the opportunity to demonstrate leadership in public health. Creating comprehensive UK-wide smoke-free public places is the single action that above any other would drastically improve public health and remove a huge burden from the NHS. It makes no sense to allow smoking in some pubs putting the health and lives of employees who work in them at risk. The BMA is also particularly worried about the time-scale. For every year’s delay at least 1,000 lives are lost to second-hand tobacco smoke UK-wide. When lives need saving, doctors act immediately. The government should follow this lead.
III. The Department of Health brought together a range of experts in task groups and undertook local consultation exercises around the country. The government heard consistent messages: a need for a sustained focus on public health, for joined-up policy across government, strong action on smoking and strategies to cut excessive and socially damaging levels of drinking.

IV. A whole range of practical measures were put forward that were widely supported and had evidence to support their introduction. An example is legislating to make all enclosed public places smoke-free. But the government has not taken these fully on board. They have made moves in the right direction, but not acted with full conviction.

V. During the consultation process, more than once, the health secretary made clear his discomfort at the suggestion of an outright ban of smoking in the workplace. It served to limit a wider public political debate about liberties in relation to smoking. The overriding aim of the government seemed to be about not alienating important political constituencies. The subsequent political decision for partial measures with a very long implementation period overruled clear advice from the chief medical officer, expert task groups, scientific evidence, the lobbying of all health organisations, and the majority of the public.

VI. The proposals on smoke-free public places are unworkable, will not achieve the benefits that comprehensive smoke-free legislation would bring and would be extremely difficult and divisive to implement.

VII. While the tone of the white paper is that the proposals reflect a mature balance between the protection of individual and social liberties, the decision to introduce a partial ban on smoking exposes policy that disregards an extensive evidence base that should underpin the public health ethos of the government.

Proposals are too focused on health service delivery

VIII. A further concern with the proposals is that they are too focused on health service delivery.

IX. The need for effective cross-department proposals was a key theme of the responses the government received during the consultation process. It is widely accepted that the health of an individual has a myriad of influences, not all of which are within their control. Income, diet, access to playing fields, quality of housing and family relationships are all key influences. Securing good health for all members of society will mean coordinating policy across different departments to ensure policy in one area does not undermine policy in another. Achieving coordinated working on the ground between health, education, social services and transport policy is a challenge which requires sustained cross-departmental collaboration and development of synergistic policies.

X. The White Paper mainly sees public health from the individual’s perspective in terms of helping to overcome damaging behaviour and developing more tailored services. The emphasis on the individual is positive and has been a missing element of public health. Initiatives like the expert patient programme have great potential. But an exclusively individual focus runs the risk of missing the critical role of factors outside the remit of the health department and concentrating too much on individual behaviour and lifestyle.

XI. Obesity, for example, is not simply a lifestyle problem that can be solved by allocating a personal trainer, though this may help. It is a social issue with complex influences. As the House of Commons Health Committee said in its report on obesity last year, a strategic framework is needed that is multifaceted and clearly targeted.

XII. The more traditional focus of public health still has its merits—the examination of income and unequal opportunities. The level of poverty is not something that can be influenced solely by a reform of health services and has an enormous influence on health status.

XIII. Poor people tend to live in less desirable neighbourhoods where they have more unpleasant and fewer positive environmental experiences. As Dr John Reid indicated during the consultation, poor people are more likely to smoke. Poverty creates stress, which cigarettes are still wrongly perceived to relieve.

XIV. The BMA is aware that income is not the sole issue in combating public health inequalities and that all individuals are variously unequal. However, the importance of income in relation to health status cannot be ignored.

XV. Greater attention is needed on integrating different policies across departments so that they reinforce one another. Poverty diminishes choice and it adds insult to injury if people are blamed for the choices they have not made because they lacked the power to make them. Individuals can only make choices when they are empowered to do so and that this is strongly influenced by the physical, social and legislative environment in which they live.

XVI. The causes of ill-health are complex and there are some limitations in public health policy being located within the Department of Health. The recent white paper suggests to us that the government seeks to take public health ever closer to healthcare and service delivery. In fact, to be effective, public health must be multidimensional and cross departmental boundaries.
2. *Are the proposals appropriate, effective, and do they provide good value for money?*

   I. The majority of proposals are appropriate, but the BMA is concerned at the length of time it is taking to develop action. The timetable is not appropriate: why are there so many built in delays to taking action?

   II. The comments below relate to the appropriateness and effectiveness of different policies on smoking, sexual health services, alcohol, diet and nutrition, exercise and school health services.

**Smoking**

   III. The government have justified their partial ban by linking smoking to eating. There is no logic behind protecting staff who work in a pub where food is prepared and served and not those who work in drinking only pubs. Legislation based on food preparation has important social consequences—in separating pubs between drinking dens in which smoking is permitted and others.

   IV. The proposed system would be unworkable and complex to implement. There is enormous scope for creating loopholes when interpreting the proposals. The proposals create incentives for pubs and breweries to bypass the proposed regulations, for example to close kitchens, move them off-site or pre-package food and meals so they do not contravene the regulations. Another move might see the creation of private “clubs” which would be exempt from the ban.

   V. The BMA supports the private bill in the House of Lords to end smoking in all workplaces in Liverpool but urges the government to follow Scotland’s example and introduce legislation for a simple and comprehensive end to smoking in all public places.

   VI. The BMA was disappointed that further duty increases on tobacco were ruled out. The BMA would also like to have seen an agency created to regulate all tobacco and nicotine products.

   VII. The White Paper announces that the Healthcare Commission will examine what action primary care trusts (PCTs) are taking to reduce smoking by the end of 2005–06. All the reviews announced in the white paper need to be held to task.

**Sexual health**

   VIII. The £300 million to develop sexual health services is very welcome. It is critically important that quick access to genito-urinary medicine (GUM) clinics is restored, action the BMA has consistently called for. Access to clinics is woefully inadequate and services are desperately in need of money.

   IX. The government may see the private sector having an important role in guaranteeing access to sexual health services within 48 hours. While there may be an appropriate role for the private sector in delivering services, offering sexual health services in supermarkets is inappropriate. Sexual health consultations usually involve confidential encounters for people. It is not the same as visiting a pharmacist or opticians in a supermarket. There are also potential conflicts of interest with regard to where the staff will come from to deliver these services.

   X. A key reason for the current crisis is because the capacity for treatment is abysmally inadequate. Workload at GUM clinics has increased by more than 50% over the last three years yet opening times are sometimes limited to 21 hours a week—and many services operate from portakabs. An important question is how the new money to modernise services is going to be spent to rectify the problems.

   XI. Will new money be targeted at the chronic underinvestment in the clinics that diagnose and treat people with STIs? The British Association for Sexual Health and HIV estimate that a third of the money allocated to PCTs is not getting through to clinics and they are spending the money on alternative priorities. Will this money be ring-fenced to ensure that it is spent on sexual health services? How will this be monitored? The aim of improving access to sexual health services should be added to the key performance goals of the NHS.

   XII. Because the proposed new sexual health media campaign will happen significantly earlier than the additional funding for GUM services and a high profile campaign is to follow, demand will increase still further. The funding to enable them to increase their capacity must happen sooner rather than later and before further demand is created and expectations are raised that cannot be met.

**Alcohol**

   XIII. Action on alcohol is easily the weakest part of the White Paper. The strongest measure is a pledge to strengthen the policing of licensed premises to prevent sales to underage drinkers.

   XIV. The strongest initiatives relate to the anti-social aspects of excess consumption in relation to anti-social behaviour. While all the attention is at the extreme end there is little focus on promoting alcohol as a mainstream public health campaign. There is a need to mainstream the alcohol initiatives and not focus only on anti-social behaviour and criminal elements.
XV. As the measures focus on excess consumption, other drinkers may take refuge in a sense that they are not the ones information campaign are speaking to. It is good that moves are being made to label unit consumption on products, but there is also a need to update the measurement of alcoholic units and public understanding of safe drinking. The measurement of units is complicated and cumbersome. A clearer definition of units needs to be developed as part of a mainstream campaign on the effects of excess alcohol consumption. The allocation of units to different types of drinks is based on 1985 data and some drinks are now stronger. A pint of Stella, for example, is three units. Wine is served in larger glass than in the past and it is generally stronger, around 13% as opposed to the assumption of 8.5%.

XVI. The dangers of alcohol and the paucity of measures to tackle its effects mean that radical measures are required. In 2002 the Health Development Agency considered the evidence and concluded that only pricing and tax measures could reduce alcohol intake. The government should be pressed to examine the experience of the Soviet Union, Sweden and other Scandinavian countries where drinks are priced according to alcohol content.

XVII. The white paper promises to work with the drinks-industry funded Portman Group to develop better information on products. Why isn’t the government aiming to work with a variety of bodies? Why solely the industry?

XVIII. The paper sets in place a number of reviews that will inform future strategy after the publication of the implementation plan. There is one on the provision of alcohol services that will be undertaken by the Audit Commission. It is important the government is held to task and incorporates findings into changes in policy.

Diet and nutrition

XIX. The BMA was pleased by the commitment to more clearly label food. The proposed traffic light system is a good starting point on which to build. Action is very welcome. The coding system will help people to understand the differences between products. It may help people to make better choices. The BMA will press to improve the sophistication of the system and the quality of the information it presents.

XX. There is a need to monitor whether the voluntary code that relies on food manufacturers to comply with various government targets—for example on maximum levels of salt—proves to be effective and timely.

XXI. It is important to monitor the Food Standards Agency’s “food and health action plan”.

XXII. There are some in-built time limits to implementation. The White Paper says that if by 2007 the strategy to influence food advertising fails to make an impact, “we will take action”. The industry has been given three years to change. There is no detail on the threats that the producers face or on the framework by which various discussions with the food industry will be shaped.

XXIII. The White Paper discusses pricing as a mechanism to improve the consumption of healthier food. This is a commendable aim. How can it be realised? Can some specific action be taken to aid access to healthier food to the most economically deprived?

Exercise

XXIV. When presenting the white paper to Parliament the Health Secretary said he had taken action to “strengthen the protection for school playing fields”. It is very weak action, which offers guidance to schools that fields should only be sold as a last resort and that proceeds from sales should be invested in activities that will contribute to health.

XXV. In the days after the publication of the White Paper there were press headlines saying that the government would ensure children experienced four hours of PE, sports and exercise in each school week. While this is very welcome, such initiatives tend to slip as another priority is introduced. The BMA will want to monitor its implementation and the extent to which it is sustained.

School health services

XXVI. The BMA would like to see a strengthening of school health services and a more central role for health in the school curriculum and policies.

XXVII. Some measures to strengthen school services seem to lack the backing they will need. The proposal to have one school nurse per cluster of schools by 2010 seems to lack ambition. If a “cluster” covers a PCT and PCTs merge, nurses will cover impossibly large areas. How can one person lead the scale of change required?
XXVIII. It is often difficult for schools to set schemes in place, such as the free fruit scheme, because of bureaucratic obstacles. Headteacher groups should be supported in examining their schools’ public health roles and ways to further develop health in schools.

XXIX. It also important that, with young people being set as a priority group, policy does not ignore the public health needs of other groups.

Value for money

XXX. The Chief Medical Officer has estimated that going smoke-free would lead to a net benefit to the economy of £2.3–£2.7 billion annually, equivalent to treating 1.3–1.5 million patients on waiting lists. The CMO also projects a decline in smoking rates of 4% which would lead to additional savings for the NHS.

XXXI. A strategy that was able to reduce alcohol abuse would also make significant savings. Recent work from the Cabinet Office suggested a culture of binge drinking is costing the country £20 billion a year, with 17 million working days being lost to hangovers and drink-related illnesses. The cost to the NHS is estimated to be in the region of £1.7 billion.

XXXII. Money is crucial to the effective implementation of the plans outlined above. Overall, the white paper “envisages” an investment of £1 billion over the next three years. It is not easy to disentangle this money. Some is new—money for school nurses and to modernise sexual health services—but much of it is already in the system and will require PCTs to spend in new ways.

XXXIII. The BMA worries that PCTs may withdraw some service to support the introduction of others, which could undermine the overall strategy. They might, for example, stop funding intermediate care in favour of initiatives to encourage self-care.

3. Do the necessary public health infrastructure and mechanisms exist to ensure proposals will be implemented and goals achieved?

I. Whether public health goals are met essentially depends upon the infrastructure and mechanisms to translate proposals into effective and sustainable action. The time has come to put in place mechanisms to take forward proposals in a coordinated fashion while monitoring their effectiveness and considering alternative approaches.

National strategies

II. The BMA was very pleased to see the promise of health impact assessments being undertaken on policy proposals across government and by the announcement of investment on research to improve our knowledge of public health, which will help regional authorities to begin to develop population profiles.

III. The acknowledgement that the public trust information from professionals much more than anything that comes from government is welcome as is the formation of an agency—the Health and Information and Intelligence Task Force—to gather public health information, provide data and tackle the weaknesses in data. They will report to the government every six months on key indicators. This approach sounds positive. The BMA will wait to see what the key indicators will be and how they will be gauged.

IV. The BMA also notes that NICE will receive increased funding to expand its remit into public health. An executive director for health improvement will be appointed.

V. How will these organisations work together and their functions be split? Will the Health and Information and Intelligence Task Force be part of NICE?

VI. A sophisticated public health information approach is needed that can match resources with changing social need. An agency is needed to help maintain a wide perspective on public health goals and whether they are being achieved. It would collate information and report to government. It would help support regional centres by developing information systems and coordinating analysis of policy effectiveness.

VII. Most public health interventions are instituted in complex environments with many confounding influences. There is a need to develop research tools for assessment that do not simply transfer the tools used in controlled environments such as drug trials. For example, we need methods to combine qualitative and quantitative data and to develop more rigorous decision and impact analysis. We need to examine the way measures interact instead of trying to isolate them.

VIII. An independent assessment of public health should be carried out and published annually.
IX. It is not only the information strategy that needs attention. There are also major challenges in moving the NHS to a health rather than a sickness service. Better managing the care of those with long-term conditions and preventing costly and needless hospital admission will require close working across health and social services. All the key long-term aims set out in the White Paper depend on effective cross boundary working. In some areas the White Paper suggests professionals should work as groups formed around groups of clients, such as children, and lead to new organisational models. This is interesting but we worry that there are no worked through models of how these will work in practice.

X. An implementation plan is due soon with, presumably, an implementation team. If real progress is to be made on public health, this team should be used as the basis for developing an infrastructure for public health that is independent of the Department of Health.

Developing the workforce

XI. The BMA welcomes the idea to establish a Health Improvement Workforce Steering Group which can stimulate action.

XII. There is a lot to be done. There are four aspects of the workforce that the government need to guide carefully: (a) developing the capacity for public health expertise, (b) supporting occupational health, (c) developing new roles, such as community matrons and personal health trainers and most importantly (d) how they work with primary care teams.

XIII. The White Paper expresses a will to attract more public health trainees but does not outline how. As a matter of urgency the government should increase public health training places and the number of posts for this specialty.

XIV. There is an aim to have 3,000 community matrons by 2008. Public health will become a core part of staff induction. It will become part of the competency framework in Agenda for Change and the Modernising Medical Careers initiative. It will be strengthened in the medical undergraduate curriculum.

XV. Personal trainers are a catch-all new role. They will work under the direction of community matrons and help people to give up smoking, formulate exercise plans, eat healthily and better deal with stress. There are some obvious questions about this new role: how will personal trainers be recruited, trained and deployed? What will be their working relationship with other professionals? Will they be seeking to motivate or inform patients? How will they support them? Where will they be based? How much face to face time will they give to clients? Will poorer patients have financial help to access facilities?

XVI. More thought is needed on how to develop leadership for the development of the public health workforce.

Explore ways to support effective cross-boundary working across government policy

XVII. The BMA is pleased to see proposals to strengthen school health services because of the potential to bring together health promotion, discussion of behaviour, the assessment of individual needs, and to make health a key part of the curriculum. Schools are places where it is possible to bring together different elements of public health in practice. School nurses, dieticians, psychologists and health promotion experts can align their work plans.

XVIII. The BMA is also pleased to see ideas set out for local public health partnerships between local authorities, PCTs and other key bodies.

XIX. The details of how these might develop in practice are very sketchy. Working out the practicalities of this is essential because so much of policy, such as children’s trusts, represent complex organisational ambitions that have yet to be put in place. In the case of school nurses, only one per PCT is promised. They will have a lot of ground to cover. If, as rumoured, PCTs begin to merge then they will have to monitor an even larger area. The BMA is not convinced the staffing levels proposed can achieve the policy proposals set out.

XX. More radical thinking is needed on how health and local government agencies and authorities bring their work together on the ground, around children, the elderly, and drug users. A client-based focus would help them coordinate services. A public health profile of local populations would also provide a tool for agencies to coordinate their work.

XXI. The BMA would like to see public health targets added to the key performance goals of strategic health authorities and local authorities who should work together to discharge joint goals.
Local strategies

XXII. While an overview of public health demands a national approach, it is important that there are strategies at different levels, and that these are joined-up. The BMA is concerned about the strategic capacity for public health at local level and particularly within primary care trusts. There is a great deficit in public health operational capacity. The public health function is split between regional offices, strategic health authorities and primary care trusts. Public health practitioners feel isolated and fragmented, struggling to keep public health on the agenda.

XXIII. The BMA believes that local government can have an important role in all three of the areas critical to effective public health policy: (a) health improvement, (b) health protection, (c) the planning of population based services to improve health. Different localities have different needs.

XXIV. Local partnership boards are a good idea but a lot of thought needs to go into how they are established. The threads holding the two sectors seem fragile. The document says that strategic health authorities with specialist public health skills have the key role in holding the ring between different partners. Regional directors of public health will have new responsibilities for ensuring that performance improvement information on cross-government agendas is acted upon. Local directors of public health will liaise with local authorities.

CONCLUSION

The BMA welcomes the Select Committees inquiry in this area.

The BMA is a passionate supporter of public health initiatives. Over the last few years there has been consistent debate on how best to employ a public health perspective. There is a raft of analysis and we now know what needs to be done. Now is the time for evidence-based action and to reflect upon the initial proposals for a public health strategy and a plan of action. This must happen now when public health is currently high on the political agenda.

February 2005

Memorandum by the NHS Confederation (WP 74)

INTRODUCTION

1. The NHS Confederation welcomes the new public health White Paper “Choosing Health” and, in particular, its emphasis on dealing with the preventable determinants of ill health eg smoking, obesity.

2. The NHS Confederation is a membership body that represents over 93% of all statutory NHS organisations, including Primary Care Trusts (PCTs), across the UK. Our role is to provide a voice for the management of the NHS and represent the interests of NHS organisations. We are independent of the UK Government although we work closely with the Department of Health and the devolved administrations.

3. Our evidence sets out our general views on the Public Health White Paper but then concentrates on the specific questions posed by the Committee.

OVERALL VIEW

4. Health is not purely the province of health care organisations and it is only by facilitating the use of a range of different approaches and the expertise of all stakeholders that the public health agenda can be delivered.

5. The Confederation believes that it is important to stress that the key delivery vehicle for health improvement is local partnership; both strategic in terms of the planning and delivery of services by the wider health and social care community; and personal between health and other professionals and the individual or local community.

6. The NHS Confederation endorses a model which encourages policy and planning around public health to be joined up at all levels including between government departments (for example referencing the impact of changes to licensing laws as part of the overall alcohol strategy) in order to gain maximum benefit from the work done in local partnerships.

7. The NHS Confederation believes that the worsening trends in health inequalities have been as a result of long term health differentials and will require long term solutions delivered in a stable environment where developments are part of a consistent programme of action. To this end, it would strongly urge a cross party approach to public health, enabling the delivery of this agenda to continue in line with the available evidence and good practice models irrespective of party political changes.

8. The NHS Confederation also advocates a balanced approach to the twin health improvement vehicles that is to say; of technological advance in healthcare; and the building of health capacity and personal responsibility for health through health promotional advice, empowerment and support for self care. It
believes that there are sometimes false perceptions of the relative impacts of each element, whereas, in reality, each is required in different proportions at different stages in the individual’s health journey, delivered using pathways of care which join the two together across NHS and other organisational boundaries.

9. Whilst all NHS organisations have a responsibility to promote health, PCTs were developed specifically with a remit to lead health improvement within local communities. This responsibility is of equal importance to other areas of work eg their commissioning responsibilities and was re-iterated in “Shifting the Balance of Power” (2001) and strengthened through the development of public health structures with Board level accountabilities within each PCT nationally.

10. PCTs are alone amongst NHS organisations in their responsibilities with regard to health equity auditing and assessing the health impact of local industrial and other developments. These responsibilities require a significant depth of knowledge about the local communities served and their differential health status and aspirations.

11. The NHS Confederation believes, therefore, that these requirements mitigate against the enlarging or merging of PCTs without the development of strong underpinning locality structures which enable responsiveness to and intelligence of local issues to be maintained.

**IN RESPONSE TO THE COMMITTEE’S QUESTIONS**

**Question 1—** Whether the proposals will enable the government to achieve its public health goals?

12. The NHS Confederation remains committed to an absolute ban on smoking in public places. However, it believes that this will need to be through a staged approach with continued support from smoking cessation services. In a recent poll of Chief Executives, smoking was spontaneously raised as one of their top three overall concerns. We believe that the implementation of an outright ban would be very challenging in the short term. The Confederation, therefore, supports the proposals on smoking outlined in the White Paper, with the proviso that this is a first step towards a total ban in public places.

13. There is evidence that access to work and educational attainment are major health determinants and any proposals which encourage getting individuals into or back into work are to be welcomed. The Confederation, therefore, supports the emphasis on work related health, both in general and in the NHS in particular, and believes that, with occupational health support as outlined in the White Paper, this is essential to ensuring healthy futures.

14. The NHS Confederation believes that there is a genuine problem with the levels of sexual health services available across the country for all age ranges. We would urge a more radical approach to the existing under-capacity including the use of Alternative Personal Medical Services (APMS) and independent sector procurement where appropriate. We believe that the proposed 48 hour waiting target for specialist Genito-Urinary Medicine services (GUM) is a step forward and that, if the rapid increase in sexually transmitted disease is to be halted, there must be a full review of service to improve access in appropriate settings and to improve the speed of diagnosis and treatment.

15. The NHS Confederation also supports the work which will build on the National Alcohol Harm Reduction Strategy (2004), particularly around auditing access to treatment services, the programme for improvement for treatment services and approaches to targeted screening and brief intervention in primary care.

16. The Confederation supports the use of Local Strategic Partnerships as vehicles for building community capacity for health through the development of Local Public Service Agreement (LPSA) targets which relate to local health inequalities. By drawing down pooled resources, the partnership can then allocate these to cross agency, joined up and community based projects. The proposal for the development of accredited Health Trainers, drawn from local deprived communities, is similarly welcomed as a way of building empowered and informed local communities, aware of the health choices available to them.

17. There is a need to build on models which focus positively on health, rather than perceiving it as an absence of illness. Whilst welcoming proactive health checks, we believe that there is a need to ensure that these do not encourage a continued focus on ill health. We would therefore suggest that the content of such checks uses a “wellbeing model” rather than one which stresses the need to screen for potential ill health.

18. However, these initiatives will not overcome distortions in community perceptions of risk and the consequences of risk taking behaviours, particularly in the young. For example, parents seeking to protect their children by driving them to school but failing to recognise the risk of low exercise levels. Developments based on the Canadian SmartRisk model are therefore also supported by the Confederation as a method of developing informed personal health choices.
Question 2—Whether the proposals are appropriate, will be effective and whether they represent value for money?

19. The NHS Confederation believes that the White Paper proposals are, in the main, appropriate and will form an effective basis for the achievement of the Public Service Agreement (PSA) targets to which they relate.

20. Existing evidence shows that the highest savings in terms of quality of life are achieved where cheap, positive health advice and support can be used to effect and/or support change.

21. We therefore particularly welcome the tobacco control initiatives outlined in the White Paper as representing long term value for money.

22. Similarly, the use of Pedometers and the encouragement of young people to exercise through walking buses and sports initiatives in schools are examples of cost effective and wholly appropriate proposals.

23. Personal Health guides will also represent value for money but only when linked to other patient held records and to the development of the National Care Record and Healthspace through the National Programme for Information Technology (NPfIT).

24. It is to be hoped that the Health Direct support line will be part of existing systems (eg NHS Direct) and will not represent another call centre based service with a separate infrastructure as has been the case with local GP referral centres etc.

Question 3—Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

25. The delivery of the White Paper principles and the related PSA targets will require the commitment of the whole workforce and not just the specialist public health teams in PCTs, Strategic Health Authorities, Government Offices and Local Authorities.

26. There has been a rapid expansion of specialist public health roles, particularly into primary care over the past three years but it is important to place these in the context of the changes in the traditional roles of the wider non-specialist workforce and to consider the fitness of the existing vocational programmes to train public health consultants towards the wider remit of Directors of Public Health.

27. The NHS Confederation does not believe that increases in overall staffing will be necessary to deliver the public health agenda. However, there is a need to improve public health skills across a range of professionals through multi-professional education programmes so that health improvement takes its place as core business across the NHS and other statutory partners.

28. Whilst recognising the shortfalls in specialist public health professionals outlined in the White Paper, the NHS Confederation also would emphasise the need for strengthening the effectiveness of public health management programmes. This will need to be embedded in such a way as to ensure that the skills of both existing and new specialists, both medical and non-medical, are fit to support the necessary changes which the White Paper will bring.

29. It is essential that work continues through the National Institute of Health and Clinical Excellence (NIHCE) to ensure that effective and consistent measures of improvement are available for those initiatives highlighted in the White Paper. This will enable continuous audit of progress against nationally agreed standards so that health improvements can be objectively assessed.

In summary, the NHS Confederation believes that the White Paper forms a firm basis from which to tackle, through partnerships and improved education and support arrangements, the existing inequalities in health.

Memorandum by SmokeFree Cities and Communities Network (WP 75)

INTRODUCING THE SMOKEFREE CITIES AND COMMUNITIES NETWORK

The SmokeFree Cities and Communities Network brings together local authority and health professionals from across England who are currently involved in the process of achieving smoke freedom for their cities, towns and communities.

The SmokeFree Cities and Communities Network welcomes the Health Select Committee’s Inquiry into the Government’s White Paper on Public Health and values the opportunity to submit written evidence.

Will the proposals enable the Government to achieve its public health goals?

1. Firstly we would like to offer our congratulations on the tobacco control proposals contained in the White Paper. The White Paper proposes to end smoking in the great majority of workplaces and public places. This will inevitably cut the toll of illness and premature deaths caused by secondhand smoke. It will also, of course, encourage many smokers to quit.
Smoking is the major cause of preventable death in many of our cities and is responsible for shocking health inequalities in our most deprived communities. We are deeply concerned by the serious health and safety risks other people’s smoke poses to employees and the general public, particularly but not exclusively, in the hospitality trades. The White Paper offers an important opportunity to provide protection to non-smokers and to achieve a sharp cut in smoking prevalence rates.

2. However, we believe that the Government has missed an opportunity to save lives by not imposing a complete ban in all workplaces, including pubs and private clubs. The SmokeFree Cities and Communities Network does not believe that it can be acceptable for a worker in a non-food pub or private members club to suffer the damaging effects of second hand tobacco smoke. We believe the evidence on the harmful effects of second hand smoke is clear and unequivocal and we note the comments of the Chief Medical Officer to this effect. We also note that the report of the Scientific Committee on Tobacco and Health, whose report you published with the White Paper, identified bar workers as the occupational group at most risk from other people’s smoke. In many cities and communities people frequently do not have a choice about where they work and employees in exempted premises would therefore be exposed against their will and continue to suffer the same health inequalities.

3. There is growing evidence that most pubs in England, which may be covered by the proposed exemptions, will be in poorer communities. These communities will have higher than average smoking prevalence rates and largely as a result will be at the wrong end of sharp health inequalities. We believe that these exemptions, which cannot be justified on health and safety grounds, would significantly undermine the purpose of the legislation, and in particular would sharply reduce the contribution of the legislation to achieving the Government’s public health goals as listed below:

- Substantially reduce mortality rates by 2010:
  - from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
  - from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

- Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

- Tackle the underlying determinants of ill health and health inequalities by:
  - reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.

Are the proposals appropriate, effective and do they represent value for money?

4. The Government has failed to act on the conclusions of the report it commissioned from the Scientific Committee on Tobacco & Health (SCOTH), which was published at the same time as the White Paper, these are:

- “Knowledge of the hazardous nature of secondhand smoke (SHS) has consolidated over the last five years, and this evidence strengthens earlier estimates of the size of the health risks.”
- “This is a controllable and preventable form of indoor air pollution.”
- “It is evident that no infant, child or adult should be exposed to SHS”.
- “This update confirms that SHS represent a substantial public health hazard.”

5. Paragraphs 8 and 9 of the Regulatory Impact Assessment, published with the White Paper, estimate that ending smoking in all workplaces and enclosed public places would reduce overall smoking prevalence rates by 1.7%.<sup>0.7</sup> of this effect is estimated to result from the direct effect of ending smoking in employees’ own place of work, and 1% from more places outside smokers’ own place of work going smoke free. There is no indication of the estimated drop in smoking prevalence that a partial ban would bring. A complete ban would be by far the simplest and most cost effective step the Government could take to achieve its public health targets in relation to smoking. Without it, these targets will not be achieved.

6. The proposal to prohibit smoking in the “bar area” of exempted pubs cannot provide adequate protection for employees or members of the public. Smoke cannot be confined to one area of a pub. Ventilation systems are expensive and at best only partly effective. We believe it would cause significant economic damage in cities and towns across England if hospitality venues were required to install expensive and inefficient systems of this kind. The proposed exemptions would add unnecessarily to the regulatory burden on business. A comprehensive end to smoking in all workplaces and enclosed public places would be simpler, cheaper and more effective.

7. There is growing evidence that most pubs in England, which may be covered by the proposed exemptions, will be in poorer communities. These communities will have higher than average smoking prevalence rates and largely as a result will be at the wrong end of sharp health inequalities. We believe that these exemptions, which cannot be justified on health and safety grounds, would significantly undermine
the purpose of the legislation. In particular, they would sharply reduce the contribution of the legislation to achieving the Government’s public health goals to reduce the inequalities gaps in the areas of heart disease and cancer, life expectancy and smoking prevalence.

8. We also believe that the Government’s proposed timescale—around 18 months longer than is proposed in Scotland—is too long and arises mainly from the excessive complexity of the proposed legislation. A simple piece of legislation ending smoking in all workplaces would be easier and quicker to introduce, as well as being subsequently easier to publicise and enforce.

Does the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

9. The proposals in the White Paper give no clear definition for “pubs that serve food”, would be extremely difficult to enforce and leave many opportunities for loopholes to be found. Chapter 4, paragraph 76 of the White Paper states that: “we propose to regulate, with legislation where necessary, in order to ensure that:

All enclosed public places and workplaces (other than licensed premises) will be smoke free;

Licensed premises will be treated as follows:
— all restaurants will be smoke free;
— all pubs and bars preparing and serving food will be smoke-free;
— other pubs and bars will be free to choose whether to allow smoking or to be smoke-free;
— in membership clubs the members will be free to choose whether to allow smoking or to be smoke-free; and
— smoking in the bar area will be prohibited everywhere.

This proposal is poorly drafted, confused, probably unworkable and certainly undesirable. It is poorly drafted because the words “regulate, with legislation where necessary” leaves open the possibility of a return to the failed “voluntary approach” in respect of smoking in pubs and bars. It is confused because there is no useful line to be drawn between pubs that “prepare and serve food” and those which do not. From their public statements, Ministers appear to have only the vaguest idea how many pubs do not serve prepared food and no idea at all where such pubs are concentrated. It is also evident that no clear definition of prepared food was arrived at before the White Paper was produced. Indeed the Chartered Institute of Environmental Health has described the Government’s proposals for the licensed sector as unworkable.

10. The goal of reducing health inequalities cannot be achieved unless the proposals are amended to include legislation to make all workplaces smoke-free including all pubs and clubs.

Recommendations for action

11. At a meeting held in Manchester on 26 January it was agreed that the SmokeFree Cities and Communities Network would provide an official response to the White Paper and urge the Government to think again on this important issue. The Network also wished to make known its support of the pioneering work of the Liverpool and London local authorities, which are currently pursuing Private Bills on this issue. We believe you should consider adopting comprehensive legislation along the lines of the Liverpool and ALG Bills so that employees and the public across England can enjoy the same protection from the public health hazard of second hand tobacco smoke as those in Scotland and Wales. Other cities and towns are currently considering the moving forward with local legislation, however, we would all prefer to see comprehensive legislation for England.

12. We ask the Committee to urge the Government to include a commitment to legislate to prohibit smoking in all enclosed workplaces in the United Kingdom in its first legislative programme after the General Election.

January 2005

Memorandum by Faculty of Public Health of the Royal Colleges of Physicians of the United Kingdom (WP 76)

The Faculty of Public Health (FPH) sets and maintains professional standards for public health specialists. The Faculty works to improve the public’s health through its three key areas of activity: professional affairs, education and standards, and advocacy and policy contribution. For further information visit our website www.fph.org.uk.
In this paper, the Faculty presents its evidence in response to the three questions raised by the Health Committee’s Inquiry into the Government’s Public Health White Paper. In submitting evidence, the Faculty will concentrate on capacity and workforce issues for specialist public health. The President of the Faculty of Public Health, Professor Rod Griffiths CBE, is available on the day of the hearing to present additional oral evidence if required.

**Will the proposals enable the Government to achieve its public health goals?**

The Faculty of Public Health welcomes the Department of Health’s commitment to a new approach to delivering public health which is set out in its White Paper: *Choosing Health: Making Health Choices Easier* (November, 2004). The Faculty is impressed by the broad scope of the paper which embraces a joined-up approach to the delivery of public health. It focuses on empowering and enabling people to take responsibility for their own health, and on the development of a public health workforce to implement its recommendations.

No English government has ever given such a high priority to public health and the proposals contained in *Choosing Health* should support the Government in working towards its public health goals. *Choosing Health* addresses the key issues for health improvement—obesity, tobacco, sexual health, alcohol and mental health, and, if implemented, should improve population health.

The Faculty of Public Health sees public health as three key areas of practice: health improvement, health protection and health services. It is concerned that the *Choosing Health* has focused on health improvement to the neglect of health protection and health services and that this will affect the overall delivery of public health (see enclosed a factsheet on the Faculty and its definition of public health for more information).

*Choosing Health* goes some way to addressing the recommendations set out by Derek Wanless in his final report, *Securing Good Health for the Whole Population* (February 2004). However, in order for public health goals to be met we need to see:

- an effective delivery plan which is tightly managed and reviewed;
- a long-term programme of investment in and prioritisation of public health by government; and
- a workforce strategy.

**Are the proposals appropriate, will they be effective and are they value for money?**

The proposals contained in Choosing Health are an appropriate response to the public health needs of the population and have largely taken into account the recommendations contained in recent Government and Parliamentary reports on aspects of public health. However, to answer this question fully we need to ensure that delivery, evaluation and data collection are embedded within public health programmes. This will require not only a sea change in mainstream attitudes but an investment in research capacity—an issue covered by Securing Health which highlighted the under-investment in public health research.

The Faculty of Public Health welcomes the Government’s pledged investment in public health research and the announcement of the development of a comprehensive public health information and intelligence strategy. We also need to see sustained investment in academic careers and money made available for evaluative research in order to monitor the effectiveness of public health programmes.

The Faculty of Public Health welcomes the focus on competency development in the public health workforce and the concept of the skills escalator to encourage lifelong learning and engagement with NHS staff.

However, it has specific concerns about the following health improvement programmes:

**Tobacco**

Whilst the Faculty welcomes the Government’s recognition that second-hand smoke is a major public health threat, there are inconsistencies in its approach to tackling this issue, such as allowing exceptions for licensed premises that do not sell food. If we are to protect and improve people’s health—including those who work in these licensed premises—there can be no exceptions.

**Sexual Health**

The Government sets out its action plan to tackle the growing sexual health crisis—which the Faculty welcomes. However, there is contradiction between this acceptance of the problem and the timeliness of the solution. The Government recognises that delay in access to treatment has a major impact on future health and fertility. How, then, can it justify a four year wait to implement its goal of 48 hours for a GUM appointment—a recommendation which was first made by the Health Select Committee in June 2003. The Faculty believes that serious infectious diseases such as Chlamydia and HIV should be treated as emergencies and access to GUM services should be made available within four hours—in line with other accident and emergency cases.
Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

The Faculty of Public Health’s survey *The Specialist Public Health Workforce in the UK* (March 2004) concluded that a 40% increase in the current public health specialist workforce is urgently needed if a safe and effective public health service is to be delivered. The Faculty made recommendations to the Choosing Health consultation which have been reflected in the final White Paper. However, the Faculty seeks assurance that the extra resources promised for developing the specialist workforce will be delivered. It is particularly concerned about the following:

- the potential impact of Multi Professional Education and Training (MPET) budget cuts on public health;
- effective inclusion of public health into the NHS National Programme for IT (NPfIT) is needed;
- the use of General Medical Services (GMS) and Personal Medical Services (PMS) contracts to achieve maximum public health effect in primary care should be promoted;
- local authorities need to be resourced/commit resources (eg for public health training) to ensure they maximise their public health role locally;
- that opportunities offered by the Modernising Medical Careers initiative are used to ensure that public health is taught in foundation years;
- that effective use is made of the NHS Careers framework from the Modernisation Agency to map out careers in public health;
- assurance is needed that Workforce Development Directorates will rise to the challenge of developing public health as part of mainstream delivery;
- the Health Protection Agency needs to have the resource to provide safe front-line services and these are at risk with the current Arms Length Body review cuts; and
- co-terminosity be considered in any restructuring of the NHS/local government.

Overall, the Faculty of Public Health is impressed with Choosing Health and welcomes the opportunity to work with the Department of Health to support the design and implementation of the delivery plan.

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**Memorandum by the Football Foundation (WP 77)**

**INTRODUCTION**

A unique partnership funded by the FA Premier League, The FA and the Government, the Football Foundation is the UK’s largest sports charity. Our mission is to improve facilities, create opportunities and build communities. We are:

- Putting in place a new generation of modern facilities in parks, local leagues and schools.
- Providing capital/revenue support to increase participation in grass roots football.
- Strengthening the links between football and the community, harnessing potential as a force for good in society, promoting health, education and social inclusion.

In particular, football can play an important role in promoting improved health outcomes by:

- Encouraging participation in physical activity—helping people meet the Chief Medical Officer’s “At least five a week” message.
- Engaging people who the NHS finds hard to reach—enabling communication and interaction with excluded groups on health issues.
- Promoting positive attitudes to health and well-being—encouraging people to look after themselves and seek help when they need it.

The Football Foundation supports the objectives and broad themes of the Public Health White Paper and we welcome this opportunity to contribute to its scrutiny.

**Will the proposals enable the Government to achieve its public health goals?**

The Football Foundation welcomes the explicit recognition in “At least five a week” that regular participation in physical activity has major health benefits, including leading to a lower risk of coronary heart disease, stroke, type 2 diabetes and certain types of cancer.

We also welcome the recognition in the White Paper that: “Football and other sports have a huge reach and engagement, and a strong community base.” (Choosing Health: making healthier choices easier, page 90, paragraph 51). We consider that the Public Health White Paper does contain initiatives, which will help meet the objective of increasing participation in physical activity. Encouraging initiatives include:

- The establishment of a Physical Activity Promotion Fund to roll out evidence-based physical activity interventions, building on the LEAP Programme.
Regional Physical Activity Co-ordinators to manage delivery of activity interventions.

A commitment to build on the successful partnerships already established between health services and football clubs, including a pledge to publish a guide for PCTs and sports clubs to encourage good practice and foster links on health improvement work.

*Are the proposals appropriate, will they be effective, do they represent value for money?*

The proposals in the White Paper relating to football and physical activity do have the potential to deliver significant improvements to the health of the nation and therefore are appropriate. The Football Foundation is involved in a number of existing initiatives, which demonstrate that real benefits can be delivered by linking health and football. Some examples of the 1,140 projects funded to date are:

- **Kidderminster Harriers Football in the Community scheme**—the Foundation has provided a grant of £72,396 to establish a healthy lifestyle football project for local children. Working in association with the Worcestershire Health Authority, County Council, Local Education Authority and the British Heart Foundation, Kidderminster Harriers coaches visit schools and provide football-coaching sessions, passing on the benefits of regular exercise, healthy living and good diets, involving up to 6,000 local children.

- **Fit Through Football**—the Foundation provided a grant of £148,920 to help the Middlesbrough FC Football in the Community Programme to deliver a comprehensive healthy lifestyle programme, embracing positive lifestyle messages, drug awareness information, citizenship classes, physical activities, literacy and numeracy education as well as after-school coaching clubs. By providing positive messages, alongside regular football sessions, the club hope to promote health, as well as encourage and stimulate future football participation. The scheme will offer additional community benefits by addressing such issues as crime reduction and anti-social behaviour.

- **Dads Against Drugs (DADs)**—the Foundation provided a grant of £95,000 to a Hull group to fund a project co-ordinator over the next five years to continue their expanding work, which includes running regular annual football and drugs education events. DADs has proved particularly effective in targeting youngsters at risk, using innovative approaches to combating drug abuse, such as primary school five-a-side tournaments and drug awareness project and sponsoring a comic to tour primary schools talking to children aged 7–11 to increase drug awareness.

- **Northumberland Primary Care Trust**—the Foundation provided a grant of £3,080 for the PCT to undertake a football project aimed at promoting healthy lifestyles, increasing participation in sports and improving the levels of understanding about the dangers of smoking amongst young people and encourage them to quit. The project is linked to initiatives such as Positive Futures and the Government’s Teenage Pregnancy Strategy.

The White Paper recognises the potential of projects such as these and offers the opportunity to extend and embed them in England’s public health system. However to do so will require additional investment and a willingness on the part of Primary Care Trusts to engage with the football community. The decision in the Spending Review of 2004 to extend Government Funding of the Football Foundation is a welcome start and the White Paper makes clear that the Department of Health recognises the potential of football to make a difference.

This recognition now needs to be turned into action and we await the Implementation Plan with interest. For our part we are committed to developing further relationships with local NHS bodies and we hope to work closely with the Spearhead PCTs to ensure that the contribution that football can make is maximised. In return we urge the Government and the NHS to prioritise the funding of public health projects involving sport, harnessing the power of football to help promote better health for the nation.

*Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?*

Traditionally the NHS has not interacted with other organisations with a stake in improving public health as well as it could have. For example, links with local football clubs have not in the past been optimised. There are indications that this is changing (see examples above) and the Football Foundation is committed to playing a part in facilitating this. We are also hopeful that some of the initiatives announced in the White Paper will help to develop structures, which enhance the interaction between sport and traditional health providers.

*January 2003*
Memorandum by the British Dental Association (WP 78)

BRITISH DENTAL ASSOCIATION (BDA)

1. The British Dental Association is the trade union and professional association for dentists and represents over 20,000 dentists in the UK. Our mission statement includes promoting the oral health of the nation giving us clear mandate for commenting on improving health.

Whether the proposals will enable the Government to achieve its public health goals?

2. The proposals will certainly not enable the Government to achieve the dental public health goals as there has been a failure to include dental public health in this report.

3. Dental decay and gum disease are the two biggest dental problems in the UK—and both are preventable. Despite this, the recently published Child Dental Health Survey of 2003 shows that the targets for dental decay for five-year-olds have been missed again.

4. Dental decay is very prevalent in children. It is five times more common than asthma, seven times more common than hay fever. Dental decay can cause considerable pain and discomfort and may result in children as young as two or three having antibiotics or even teeth removed. It is the leading cause of general anaesthesia in children, and there is increasing evidence that dental disease affects growth in children.

5. Recent evidence given to the Health Select Committee on the scientific aspects of ageing outlined the role of sugars in dental decay throughout childhood and on into older age. The amount of sugar and fluoride to which one is exposed will affect the amount of dental decay one has. Decreasing the intake of sugar and increasing exposure to fluoride would have a positive impact on oral health.

6. Dental decay shares common risk factors with obesity. It also affects well being and quality of life in both children and adults. It fulfils all the criteria for a “public health problem” yet has been ignored in the report.

7. There are 30,000 dentists and as many dental nurses, hygienists and therapists that have regular contact with half of the population. This workforce could provide people with information on diet, oral hygiene and smoking cessation.

Whether the proposals are appropriate, will be effective and whether they represent value for money?

8. There are three main ways that people can improve their oral health. Brushing twice a day with fluoride toothpaste, appropriate use of fluoride (toothpaste or water fluoridation) and visiting the dentist regularly.

9. The BDA’s submission to the consultation highlighted the cost efficiency and effectiveness of targeted water fluoridation, a well-recognised mechanism to improve dental health in the UK. Five-year-old children in unfluoridated Manchester have three times the level of decay of those in Birmingham where the water is fluoridated. Oral health inequalities mirror health inequalities in all parts of the country except in areas where the water has been fluoridated.

10. Smoking and other tobacco use has a significant impact on oral health and may result in serious conditions like mouth cancer. Dentists and the dental team therefore have both a vested interest and an important role in smoking cessation initiatives. Evidence suggests that this is both effective and cost effective.

Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

11. There is a whole network of dentists that are able to provide dental and public health advice on a range of subjects including diet and smoking cessation. Often a person’s most frequent contact with the NHS is via the dentist. Multidisciplinary working with schools, health visitors, Sure Start and other such bodies could all lead to better oral health, and an understanding thereof, especially among children.

RECOMMENDATIONS FOR ACTION

12. The Department of Health must recognise the importance of good dental public health and reflect this by including actions to improve dental public health in the list of goals.

January 2005
Memorandum by The British Psychological Society (WP 79)

SUMMARY
1. The British Psychological Society welcomes the opportunity of providing written evidence to the House of Commons Health Select Committee regarding the Government’s Public Health White Paper.
2. Applied psychologists are currently active within the spheres of service delivery as envisioned in the White Paper. Given the prominence of psychological factors in terms of primary prevention of ill-health and secondary prevention and rehabilitation following the development of long term conditions, we use this opportunity to strongly support the strategic shift in the delivery of public health and offer additional recommendations to assist this change in emphasis.

INTRODUCTION
3. The British Psychological Society is the learned and professional body, incorporated by Royal Charter, for psychologists in the United Kingdom. The Society has a total membership of over 40,000 and is a registered charity. The key Charter objective of the Society is “to promote the advancement and diffusion of the knowledge of pure and applied psychology and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge”. As acknowledged in the White Paper, applied psychological science has a central contribution to make to the successful implementation of the objectives set out in this strategy.

Will the proposals enable the Government to achieve its public health goals?
4. The British Psychological Society welcomes the strategic shift in emphasis from the treatment of ill-health to the prevention of disease and active promotion of health choices. The theoretical underpinnings of the strategy appear well considered. We strongly support the understanding and therefore, the core requirement to consider psychological factors in advancing the framework for public health as described in the White Paper.
5. The six key priorities for action are well rehearsed. The methods that are conceptualised to enable change at the various levels of individual, social network, community and from the national level, but matrixed through collaboration across agency are welcomed. The structural configuration to facilitate delivery appears to be synergistic, but is dependent upon developing a shared view of the strategic vision and its implementation at a national level.
6. Primary prevention parameters appear to have been well considered in the White Paper and reflected in the requirement to develop the roles of the public health workforce to deliver these objectives seem highly relevant. The British Psychological Society supports the development of health trainers skilled in behavioural change principles to work to prevent ill-health. Whilst we are supportive of this community role, we would wish to strengthen the psychological skill base within public health overall. We would therefore suggest that further consideration be made to developing an applied psychology workforce within public health so as to close the gap that we consider emergent in the proposals.
7. Although strong secondary prevention and rehabilitation services exist within the current NHS configuration, these are variable in portfolio across the UK. Given the significant impact (across domain) of long-term conditions, we are uncertain about the role that NHS Trusts will have in developing the public health objectives (although we acknowledge that the White Paper will address this issue in the delivery plan). However, we would suggest that further consideration be made to developing and extending, at a national level, the role of multi-disciplinary chronic disease management programmes that incorporate a psychological care dimension and contain a significant therapeutic focus on secondary prevention parameters (as envisioned in the various National Service Frameworks). We also consider that these structures should develop strategic linkage to the Expert Patients Programme.
8. The British Psychological Society would welcome the opportunity to develop further partnerships, as a professional organisation, to support the implementation of the core objectives of the White Paper.

Are the proposals appropriate, will they be effective and will they represent value for money?
9. The British Psychological Society considers the proposals to be wide-ranging and complex in organisation form, but highly appropriate to the health of the nation. If the objectives can be fully implemented, then there will be a significant enhancement of health parameters across the nation. However, the proposals are focussed on those people who are ready to make the necessary positive health changes. We consider it important that the evidence-base for psychological interventions designed to modify people’s motivational status to behaviour change (for example, from a contemplative position to being ready to make choices) be further considered. Public health practitioners should have, or should develop, competencies to implement interventions designed to achieve motivational parameter changes. We would encourage further psychological change skills training, delivered by an applied psychologist with the necessary competencies.
10. The White Paper requires a matrix of interventions, but which are co-ordinated and integrated across agencies. In terms of effectiveness, interventions that are individually tailored result in greater behaviour change. We would, therefore, support the further development of the public health workforce in psychological change work. However, to provide psychological interventions, at the levels specified, would appear to require significant training within applied psychology (practitioners within applied psychology require doctoral level or equivalent qualifications). Psychological interventions can be time consuming to implement because of the complex nature of the cognitive computational tasks required to be undertaken, both to create psychological change and then to maintain these same changes. We therefore recommend that consideration be made to these factors when mapping training competencies.

11. The White Paper requires complex organisational collaboration and will require the mobilisation of various workforces, towards the shared vision. This, in turn, will require strong leadership to implement across the national frame. It will also necessitate additional resources to develop the public health team beyond the current configuration.

12. In terms of primary prevention, we support the developments of health trainers as supporters of people who wish to make health choices. We also support the role for community matrons in leading the deployment of the new public health objectives. We support the development of further psychological knowledge and skills in the current public health practitioner workforce. However, the British Psychological Society would consider there to be a gap in the White Paper, in terms of its capacity to deliver core psychological services to support the strategic objectives (both direct and indirect services). We would therefore recommend that consideration be made to the development of an applied psychology workforce with the necessary competencies, to be integrated into each public health team configuration.

13. In secondary prevention/rehabilitation, service delivery has begun to enable people with long-term conditions to consider health choices. Although these services are delivered through multi-professional teams, the evidence-base highlights a central role for an integrated psychological care dimension. Applied psychologists are currently active within this service domain, but deployment is variable across the UK. We are of the view that it is of fundamental importance to the success of the White Paper that further consideration be made to developing these teams. This would require both re-deployment and workforce development. We would also consider the benefits of structural linkage between secondary prevention services and to other policy drivers such as the Expert Patients Programme.

14. By implementing our applied psychology workforce planning recommendations, both the public health teams and the services providing secondary prevention would have on-line direct access to psychological resources. This position has been well understood in terms of current guidance (in terms of National Service Frameworks and National Institute of Clinical Excellence guidelines) and we would therefore strongly urge consideration of the added benefits that incorporation of an applied psychology dimension would have to the delivery of this strategy.

15. The British Psychological Society strongly supports the policy shift, as described in the White Paper, for improving the health of the nation. Significant benefits will accrue at individual, vocational and community levels, should the objectives be achieved. Given the proportion of resource that will be made available to this strategy against the entire NHS budget and the potential benefits that will emerge, then these proposals do indeed represent value. We are of the view that the additional applied psychology workforce developments described above would add further value to the proposals (and this position is supported from the evidence-base for psychological skills development within other healthcare professionals from an integrated psychological care stream, as reflected in the national clinical guidelines).

Will the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

16. The British Psychological Society would consider that the infrastructure will require additional development from that specified, if the objectives laid out in the White Paper are to be achieved. We have suggested that the further development of public health teams and secondary prevention services would be required. We have described the benefits that these services would gain from primary investment into an integrated applied psychology workforce, both in primary and secondary prevention services, to develop overall, the matrix of psychological skills that will be required within the entire organisational frame to ensure implementation.

17. We are concerned that the new public health workforce configurations, as detailed in the White Paper, will not have sufficient access to services offered by applied psychologists with the appropriate competencies, for onward referral or assistance with psychological issues. This may well lead to potential difficulties in service quality and reaching the necessary performance standards. We therefore recommend that further consideration be made to developing the applied psychology workforce within the structures identified to achieve full implementation of the proposals.

18. We highlight the benefits that would accrue from developing the roles that NHS Trusts could have in delivering the service structures required for successful implementation of the White Paper (although we acknowledge that the White Paper will address this issue in the delivery plan).
19. The British Psychological Society strongly supports the leadership and governance (including regulation) structures that will be configured within the delivery plan. We also support the central role that will be undertaken by the “change” agencies. We would welcome the opportunity to work within these frameworks to support workforce skills development and improving performance, but also in consideration of our earlier recommendations for the additional applied psychology deployment required.

20. The British Psychological Society supports the objectives considered for enhancing public health research and also in the development of the National Institute for Health and Clinical Excellence. We would welcome further opportunities to enhance our partnership with NICE to support the objectives as specified in the White Paper.

RECOMMENDATIONS

21. To summarise our recommendations:

— The British Psychological Society strongly supports this shift in public health policy. We would welcome the opportunity to develop further partnerships, as a professional organisation to support the implementation of the core objectives of the White Paper.

— The British Psychological Society recommends that added value would emerge through developing an applied psychology workforce, with the necessary competencies, to be integrated into each public health team configuration and through deployment into secondary prevention teams. By implementing our applied psychology workforce planning recommendations, both the public health teams and the services providing secondary prevention would have on-line direct access to psychological resources.

— We recommend that public health practitioners should have or should develop further competencies in implementing psychological change interventions.

— We suggest that significant benefits would emerge from strategic linkage of various strands of self-management healthcare policy (Expert Patients Programme).

— The British Psychological Society would highlight the need to consider “hard-to-reach” groups within the population and suggest development of public health interventions to reach these groups.

— The British Psychological Society would welcome further opportunities to enhance our partnership with NICE to support the research and effectiveness objectives as specified in the White Paper.

January 2005

Joint memorandum by ITV plc, Channel 4 Television Corporation, Channel 5 Broadcasting Ltd (Five), GMTV, Nickelodeon UK, Turner Broadcasting Systems (Europe), Jetix and Disney Channel (WP 80)

This memorandum summarises the response of the companies listed below to the Government’s Public Health White Paper. Our common interest is as broadcasters (and in many cases producers) of high quality children’s programming in the UK, funded by advertising revenue.

We understand the widespread concern among health professionals, Government and society as a whole over obesity and unhealthy lifestyles. We recognise that Government is committed to taking action in this area, particularly in respect of children and young people. The White Paper sets out a range of far-reaching proposals designed to encourage more people to make healthier lifestyle choices. We thoroughly support this multi-faceted approach.

The White Paper rightly acknowledges that television can play a positive role in assisting the Government’s health objectives. Because it plays an important role in people’s lives, TV can help convey information about healthier lifestyles—whether through specific initiatives like ITV’s Britain on the Move or the BBC’s Fat Nation, storylines in soaps, dramas and documentaries, or more straightforward public awareness campaigns.

Nevertheless we are concerned that proposals in the White Paper may lead to action being taken to restrict the advertising of food and drink products on television, the effects of which would be disproportionate to the hoped-for benefits. We support the need for tight advertising codes, with particular protection for children. However, banning or restricting categories of advertising would be likely to have a major impact on us as primarily advertiser-funded television companies and, therefore, on our ability to invest in original programming and, in particular, continue to deliver a range of well-funded, high-quality children’s programming. We also believe such measures would not be effective in tackling public health issues in relation to diet.

Our comments below therefore concentrate on the proposals and recommendations in the White Paper that relate to advertising and promotions (Chapter 2, “Health in the Consumer Society”).
1. **Will the proposals enable the Government to achieve its public health goals?**

The White Paper recognises that the need to address both nutrition and exercise (“calories in” and “calories out”) necessitates a co-ordinated and multi-dimensional approach and this is reflected in the Government’s wide-ranging conclusions and recommendations, the vast majority of which we would support.

Specifically, we welcome the fact that Government—in line with the recent Health Select Committee Report on obesity—believes that the food and advertising industry can play a helpful role in tackling obesity. In our view, the most effective contribution broadcasters can make is to convey positive messages about diet and lifestyle to their viewers through programming or promotion. In many cases, this is already happening, for example:

— **ITV’s Britain On The Move** is a UK-wide initiative encouraging everyone to improve their health and quality of life by walking a little further each day. It was a great success in 2004, with over 1.2 million people participating in ITV’s National Day of Walking on 19 September right across the country, and will be developed further in 2005. It also included 60 hours of dedicated programming across the ITV regions and a storyline in Coronation Street—the nation’s favourite soap—was watched by an average 12 million people across its two episodes.

— **Channel 4’s educational output supports various areas related to the school curriculum and covers both food technology, diet and health. Programmes like Citizen Power, Planet.Com and Consumer Power include information about organic food production, sustainability and the media. Channel 4’s “FitFarm” also include messages on diet and healthy lifestyles whilst “You Are What You Eat” and a forthcoming series looking at how school meals can be changed for the better both address important issues of diet.

— In 2004 Nickelodeon ran a six-week summer holiday campaign encouraging kids to adopt a healthy lifestyle. The scope of the campaign ranged from pre-schoolers through to teenagers who make up the 3.5 million kids the Nickelodeon channels reach on a monthly basis, and the positive messaging was executed with Nickelodeon’s unique, humorous and non-preachy slant to engage the audience in an effective way. Summer schedules were also devoted to programming which focused on active lifestyles and healthy eating. Examples included “Fit Facts”—an educational animation series covering fat, nutrition, exercise, and fast food; “Get the Skinny”—a regular news magazine programme on healthy eating; and “Wiggles”—song and dance routines aimed at pre-schoolers. The campaign was backed up by our annual six-week summer road show, “Nick on the Road”, which had a “Let’s Play” active lifestyle theme in 2004.

We also support the White Paper’s emphasis on the need for “positive health campaigns” that would aim to raise awareness of the need to make healthier choices and target behavioural change. We have already offered to work with Government on this (as have the food and advertising industries), and believe that we have much to contribute, particularly in terms of creative expertise.

2. **Are the proposals appropriate, will they be effective and do they represent value for money?**

Paragraph 54 of Chapter 2 of the White Paper outlines three particular areas in which it expects Ofcom to consider amending the rules governing food and drink advertising and promotion:

(i) “when, where and how frequently certain advertisements and promotions appear—for example, an option would be to consider different restrictions during children’s television (pre 6 pm), during peak times (6 pm–9 pm) and after the 9 pm watershed;

(ii) the use of cartoon characters, role models, celebrities and glamorisation of foods that children should only eat seldom or in moderation as part of a balanced diet; and

(iii) the inclusion of clear nutritional information—perhaps based on a signposting system—and/or balancing messages in advertisements to counteract the influence of high fat, salt and sugar food advertisements.”

We would like to stress that we have always supported the need for appropriate advertising controls, and acknowledge that children need particular protection. It is vital that advertising rules evolve to reflect public concerns and we will be co-operating fully with Ofcom as it undertakes a review of the Advertising Code over the coming months. Like Ofcom, we believe any tightening of the Code in respect of food advertising to children must be proportionate and evidence-based.

**However, we do not believe that proposals to restrict the volume of advertising of certain food and drink products would be “appropriate, effective or represent value for money”**. In short, we consider that this would constitute a disproportionate response given its potentially severe impact on broadcasting revenues, a view shared by Ofcom when it published its extensive research on food advertising to children in July 2004.

The partial regulatory impact assessment published in tandem with the White Paper seriously underestimates the implications of advertising volume restrictions for commercial broadcasters’ revenues, as well as the knock-on effects on investment in children’s programmes, employment in the UK, inward investment, the health of the independent production sector, and the ability of viewers to enjoy a wide range of programmes from a variety of broadcasters.
In 2003 £522 million was spent by advertisers promoting food, soft drinks and chain restaurants on television. This represents 14% of total television advertising revenue—and 30% of the revenue of dedicated children’s channels. To ban or seriously restrict the advertising of these products would leave a massive hole in the revenues of all advertiser-funded television. This would have a negative impact on the value of terrestrial broadcasting licences (the terms for which are currently being discussed with Ofcom) and could also lead some channels to reconsider their business model or even go out of business.

The White Paper suggests that consideration be given to introducing advertising restrictions both during children’s television and at other times when children watch television. This would still have a considerable impact: a ban on advertising food and drinks products between 6 am and 6 pm would have meant a fall in revenue to all broadcasters of £144 million in 2003; a ban between 6 am and 9 pm would have meant a revenue loss of £344 million.

There is a direct correlation between advertising revenue and programme investment: any reduction in advertising revenue would have a direct impact on programme commissioning. In 2003, the commercial public service broadcasters (ITV1, GMTV, Channel 4 and Five) invested nearly £72 million in children’s programmes across different genres (drama, education, information and entertainment), of which the vast majority was commissioned for the UK audience, thus generating a significant number of jobs in this country. Specialist children’s channels, whose whole output is aimed at children, would suffer an even greater impact across all their airtime, which would lead to job cuts and the end of programme contracts.

Independent production companies would also be affected. The independent sector produces a higher than average proportion of programmes for children’s television. Some independent producers are very small and losing one output deal with a major broadcaster would put them out of business.

The children’s TV market in the UK is extremely competitive, and the BBC, with children’s programmes on BBC1, BBC2 and its two digital children’s channels, is growing its viewing share (now 34% of all children’s viewing). An advertising ban would de-stabilise the commercial broadcasters and threaten the competitiveness of the children’s TV sector as a whole—this could leave the BBC the monopoly provider of children’s programming in the UK.

The White Paper goes on to state at paragraph 58 that “The Government is committed to ensuring that measures to protect children’s health are rigorously implemented and soundly based on evidence of impact. We will therefore monitor the success of these measures in relation to the balance of food and drink advertising and promotion to children, and children’s food preferences to assess their impact. If, by early 2007, they have failed to produce change in the nature and balance of food promotion, we will take action through existing powers or new legislation to implement a clearly defined framework for regulating the promotion of food to children”.

Legislation is a far blunter tool than regulatory codes, which are able to adapt to changing environments far more quickly. We therefore welcome the White Paper’s intention to resort to legislation only as a last resort. However, Government must be clear how it will judge success or failure of the advertising industry in 2007. Whilst it is legitimate to assess the need for further action by reference to the degree of change in the “nature and balance of food promotion” by 2007, there must be no suggestion that the advertising industry will face further restrictions if it has failed to secure a shift in “children’s food preferences”. This is not within the direct control of the advertising industry but will depend on the whole range of factors identified in the White Paper.

We will be seeking clarity from Government on how it will measure in 2007 whether the nature and balance of food promotion has changed sufficiently. The impact of changes to the Advertising Code implemented by Ofcom will clearly be one measure. However, it is also important that Government factors in the extent to which the market has self-regulated, eg by individual companies changing the way in which they advertise their products or actually diverting spend away from advertising. As an illustration of this last point, advertising spend on television by food, chain restaurants and soft drink manufacturers has actually declined by 22% between 1999 and 2003 (Source: Ofcom, Page 122, paragraph 3.5.2) and this trend has continued in 2004, as advertisers have responded to public concern and regulatory uncertainty.

3. Does the necessary infrastructure exist to ensure that proposals will be implemented and goals achieved?

The necessary infrastructure certainly exists to implement changes to the regulation of both broadcast and non-broadcast advertising. Broadcast advertising is subject to statutory regulation, while non-broadcast advertising is subject to self-regulation.

In broadcasting, the Advertising Code which for many years was drawn up and policed by the ITC has recently been transferred to the new co-regulatory system for broadcast advertising under the auspices of the ASA. This new regulatory framework was approved by Parliament last year and adherence is a condition of broadcast licences. All advertisements go through a rigorous pre-clearance exercise prior to transmission (performed in most cases on behalf of broadcasters by the Broadcast Advertising Clearance Centre) to ensure that they comply with both the spirit and the letter of the Code. The ASA then adjudicates on all complaints and where complaints are upheld can demand immediate amendment or withdrawal of an
advertisement. If necessary, the ASA can refer a broadcaster that continues to carry non-compliant advertising to Ofcom, which has the full range of regulatory sanctions at its disposal, including fines and withdrawal of the licence to broadcast.

We note and support the White Paper’s view that television advertising should not be the sole focus of regulatory intention. Clearly to be effective, any new measures must embrace both broadcast and non-broadcast advertising. Failure to adopt a consistent approach to the advertising sector as a whole would also risk disproportionately impacting the broadcast advertising market as advertising spend would be diverted to the less heavily regulated non-broadcast sector (eg print, Internet). Indeed the current year-on-year decline in television food advertising spend that has been precipitated by the current regulatory uncertainty suggests that this is already happening.

February 2005

Memorandum by the Advertising Standards Authority (WP 81)

1. INTRODUCTION

1.1 The Advertising Standards Authority (ASA) welcomes the opportunity to submit written evidence to this inquiry. The ASA is responsible for supervising the self-regulatory system for advertising standards in both broadcast and non-broadcast media. The ASA assumed responsibility for TV and radio advertising standards on 1 November 2004.

1.2 This submission aims to address two main points:

1.2.1 Food and Drink Advertising

This paper aims to give an overview of the ASA’s initial response to the White Paper.

1.2.2 The role of the ASA

We hope that this short explanation will clarify the role of the ASA following the Committee’s report on Obesity, which confused the responsibilities of the ASA and the ITC. The ITC merged into Ofcom on 29 December 2003. On 1 November 2004, the ASA assumed a broader remit of policing the broadcast advertising codes.

2. FOOD ADVERTISING

2.1 The Government’s White Paper raises a number of concerns and suggestions about the advertising of food, particularly to children. We recognize that the self-regulatory system must respond to the White Paper appropriately.

2.2 Ofcom is currently reviewing the requirements for food advertising laid down in the broadcast advertising codes. Although responsibility for regulating broadcast advertising and the Codes now lies with the self-regulatory system in partnership with Ofcom, it made sense for Ofcom to retain lead responsibility for this area of work because of the significant amount of work it had already completed on this issue. Furthermore, the Secretary of State had specifically charged Ofcom with this work prior to the co-regulatory agreement with ASA.

2.3 ASA is, however, closely involved with Ofcom’s review, which is expected to go out for consultation later this year. If, following this review, significant changes are made to the broadcast Code, the ASA would anticipate that the CAP Code (ie non-broadcast) would be reviewed in the light of this.

2.4 ASA is also taking a strong and active interest in the Food Standards Agency’s (FSA) work on nutritional profiling and signposting of food. In particular, the FSA’s work on nutritional profiling will inform the ongoing review of the broadcast Code.

2.5 The ASA welcomes the fact that Government has recommended a multi-faceted approach towards tackling obesity and nutritional ill-health amongst the population, especially in the light of the findings in Ofcom’s report that food advertising has a “… modest effect on children’s food choices. While indirect effects are likely to be larger, there is insufficient evidence to determine the relative size of the effects of TV advertising on children’s food choices by comparison with other factors”. Ofcom’s research clearly states that media is one of a number of factors that impact upon food choices, alongside psychosocial factors, behavioural factors, family, friends, schools, commercial sites and consumerism.

2.6 For this reason, the ASA is keen that the uncertainty of the potential impacts of the advertising are acknowledged when assessing progress against the White Paper. Section 58 of “Choosing Health” states, “We will therefore monitor the success of these measures in relation to the balance of food and drink advertising and promotion to children, and children’s food preferences to assess their impact.” The Government expects to see these changes by 2007.
2.7 Although the Government should expect to see changes with respect to the first half of this statement by 2007, we would caution against potential Government action based on progress against the second half of this statement, namely children’s food preferences. Bringing about a cultural change in eating habits cannot happen overnight.

2.8 By 2007, any formal changes to the advertising code will have been in place for less than a year. This is, of course, owing to the requirement for proper consultation on any proposed changes. Until the Food Standards Agency has completed its consultation on nutritional profiling, Ofcom is unable to complete its review of the broadcast Code. Likewise the self-regulatory system is unable to review its Code before Ofcom has finished its consultation. We understand that the Department of Health is not planning to produce a delivery plan on food advertising before these consultations have taken place, so we are unlikely to see anything further from Government until the fourth quarter of 2005 at the earliest.

2.9 We feel that it would be unfair to impose strong penalties after a relatively short time, when the Government’s own document acknowledges that changes in food habits are reliant on a number of different factors, often in combination.

2.10 We believe that self-regulation in non-broadcast advertising has worked efficiently and effectively for more than 40 years and the ASA will continue to uphold high standards in advertising, as stated in the Codes. We caution against any action that would undermine what has been a very successful system and which might lead to a less responsive complaints and regulatory system for the consumer.

2.11 Finally, a note of explanation about the alcohol television advertising rules that were mentioned in the White Paper. Although the new rules take effect from 1 January 2005, there is a period of transition until 30 September 2005. This is because television advertisements are generally made some time in advance of being aired. Although, some changes may be noticeable immediately, the revised Code will not be fully enforceable until 1 October 2005. The Broadcast Committee of Advertising Practice (BCAP) will be consulting on the revised explanatory guidance shortly.

3. About the ASA and Self-regulation

3.1 The ASA has been the self-regulatory body responsible for policing the non-broadcast advertising codes for more than 40 years. However, on 1 November 2004, under contract from the communications regulator Ofcom, the ASA assumed responsibility for standards in respect of TV and radio advertising standards.

3.2 This new co-regulatory arrangement with Ofcom recognises the success of advertising self-regulation in the UK and the work of the ASA. It is also an easier system for consumers to understand. Now that there is a “one-stop shop” for advertising regulation, consumers no longer have to juggle with several different regulators in order to get action on misleading, offensive or harmful advertising.

3.3 The ASA administers the rules by which the marketing industry controls the content of marketing communications. We investigate complaints from both the public and industry about non-broadcast marketing communications that are alleged to break the British Code of Advertising, Sales Promotion and Direct Marketing (the CAP Code).

3.4 Since commercial TV began in 1955, broadcast advertisements have been subject to statutory standards codes. Under the new co-regulatory system, day-to-day responsibility for the TV and radio advertising codes rests with BCAP, an industry body also known as CAP (Broadcast). Ofcom’s licensees, the commercial TV channels and radio stations, must continue to observe the codes, but, if advertisements mislead or cause harm or distress, the matter will be dealt with first by the ASA, and not Ofcom.

3.5 The Advertising Advisory Committee (AAC) has recently been appointed to act as a sounding board for BCAP as it updates the TV and radio advertising codes. Its members, most of whom hold existing positions on consumer panels, have been appointed to ensure that the concerns of viewers and listeners are at the heart of broadcast advertising regulation. The AAC is chaired by Elizabeth Filkin, the former Commissioner for Parliamentary Standards.

3.6 Although BCAP has day-to-day responsibility for the broadcast Codes, ultimate responsibility rests with Ofcom. No changes can be made to the Codes without Ofcom’s consent. Furthermore, the Secretary of State for Culture, Media and Sport can require changes to be made to the broadcast Codes.

3.7 The system works because of the commitment of the advertising industry to make self-and co-regulation effective. The current system means that regulation and the codes can keep pace with one of the fastest moving industries in the world. We are best placed to respond quickly and decisively to new technologies, changes in societal attitudes and progression in advertising. Ultimately, consumers are better protected because they do not have to wait for lengthy and expensive judicial proceedings or legislation in order to receive the protection that they expect and deserve.

3.8 Finally there is no charge for making a complaint. All of the ASA’s costs are met by a levy paid by advertisers.

3.9 Further information about the ASA and its work can be found at www.asa.org.uk.
I do hope that the Committee will take into account the ongoing work of the ASA in the course of this inquiry. The ASA takes its role as a regulator very seriously and is committed to upholding a workable regulatory system which meets the high expectations of all stakeholders, including the Government, consumers and the advertising industry.

If you have any further queries about the ASA and the work that we do, please do not hesitate to contact me. In particular, if the Committee expects to deal with the work of the ASA when writing its report, I do hope that we will be given the opportunity of giving oral evidence before the Committee to answer any questions that you might have.

February 2005

Memorandum by Shelter (WP 82)

Shelter is the UK’s largest provider of independent housing advice, helping over 100,000 homeless or badly housed people every year.

INTRODUCTION

Shelter welcomes the Government’s White Paper Choosing Health and the commitment it makes to helping people make healthier choices for themselves. We particularly welcome the continuing commitment it sets out to tackling health inequalities and the recognition that the Government needs to ensure that people living in disadvantaged areas have the opportunity to live healthier lives.

Florence Nightingale once said: “The connections between the health of the nation and the dwellings of the population is one of the most important that exists.” Well over 100 years later, the British Medical Association stated that “Multiple housing deprivation appears to pose a health risk that is of the same magnitude as smoking and, on average, greater than that posed by excessive alcohol consumption.”

In 1999, the Government’s White Paper Saving Lives: Our Healthier Nation suggested that at least 70% of determinants of health are outside the health sector and recognised that bad housing and homelessness are among the most important of these. There is a wealth of evidence linking bad housing, and in particular overcrowding, to ill health. For example, research has shown that children living in poor housing experience disturbed sleep, poor diet, hyperactivity, bedwetting and soiling, aggression and higher rates of accidents and infectious disease. We therefore believe that decent homes are central to improving Britain’s public health.

This evidence focuses on the particular impact on health of living in temporary accommodation and is based on specific research we have recently carried out into this issue.

BACKGROUND

The number of homeless households living in temporary accommodation has increased by 140% since 1997 and now stands at a record high of 100,810. 66,120 of these households are families with dependent children or households which include expectant mothers. This includes over 116,000 children.

Although not literally on the streets, people living in temporary accommodation are homeless in every sense of the word—they have lost their home, often in very traumatic circumstances; have been “officially” recognised as homeless by their local authority; and are forced to live in insecure and often inappropriate housing until a settled home can be found. The average length of time spent in temporary accommodation has almost trebled since 1997 to 267 days and in some areas, stays of two or three years are not uncommon. During this time, they may be moved several times, causing severe disruption in terms of changing schools, access to the labour market and the loss of social and support networks. The insecurity and uncertainty this causes compounds the impact of homelessness to make living in temporary accommodation such a damaging experience.

Research has consistently shown that homeless people are more likely to suffer from poor physical, mental and emotional health than the rest of the population. Homeless families in temporary accommodation report high incidences of infectious respiratory and gastrointestinal diseases, are at greater risk of being malnourished and having babies with a low birth weight and are more likely to suffer from poor diet and nutrition.

144 Housing and health: Building for the future; BMA 2003.
Sick and Tired

In 2004, Shelter produced two reports which examined the effects on homeless households of living in temporary accommodation. *Living in limbo* was based on a survey of more than 400 homeless households in this situation. It provided strong evidence of the negative impact this has on people’s health:

- Overall, 78% of households reported at least one specific health problem.
- 49% of respondents said that their health or their family’s health had suffered as a result of living in temporary accommodation.
- 38% of households reported more frequent visits to their doctor or hospital.

These findings were explored further in our report *Sick and tired* which was based on more detailed work on a sample of 194 families from the original survey with specific health problems. The report provides further evidence of the damaging impact on health of living in temporary accommodation:

- The number of households reporting that their health had suffered as a result of living in temporary accommodation increased to 58% in this sample.
- Almost all of the households felt that their children’s health had suffered through living in temporary accommodation.
- 63% of people suffering from depression said this had become worse since they had moved into temporary accommodation.
- 40% of those with asthma or other chest and breathing problems said their condition had deteriorated.

Delivery

The White Paper gives strong recognition to the links between bad housing and health. For example, page 87 of the report notes that “…poor-quality housing has been clearly shown to have detrimental health impacts.” Page 82 states “Poor health is often compounded by other problems such as poor housing, poor quality street environments and inadequate transport and leisure provision. Living in a safer environment extends opportunities for people to be physically active and develop social networks… We will publish revised guidance on health and neighbourhood renewal, early in 2005, to support local action to address health inequalities and deliver neighbourhood renewal.”

The Government’s cross-cutting review of health inequalities in 2002 identified homeless people as a key group to target to improve health outcomes. In July 2003, the Department of Health published *Tackling health inequalities: A programme for action* which set out the Government’s strategy for tackling the wider causes of health inequalities including poor housing and homelessness. It included the number of homeless families with children in temporary accommodation as one of the 12 key national headline indicators for monitoring progress in addressing health inequalities. This was followed by a joint ODPM/Department of Health good practice guidance note *Achieving positive outcomes in health and homelessness*.

There is evidence that these initiatives are encouraging joint working at a local level. In Camden, for example, health check ups are being piloted for homeless children and all children under the age of six in temporary accommodation are put in contact with a health visitor. However, independent research published recently by ODPM found that joint working between local housing authorities and primary care trusts is still patchy and that the majority of local homelessness strategies paid little attention to the health of homeless people.

The ODPM’s Five Year Plan includes a target to halve the number of homeless households of living in temporary accommodation by 2010. This is very welcome. However, it is important to note that achieving this target would still leave more households in this situation—approximately 50,000—than in 1997. For those who are, and will continue live in temporary accommodation, it is vital that their health needs are addressed. This is also essential if the Government is to deliver on its health inequalities and public health agendas. Joint working between housing and health bodies at the local level must therefore improve.

The White Paper proposes to deliver many of its objectives via schools and schemes such as Sure Start. However, Living in limbo found that only 20% of households with eligible children were accessing Sure Start and that children had missed an average of 55 school days due to the disruption of moves into and between temporary accommodation. We are therefore concerned about the extent to which these delivery

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145 *Living in limbo*: Mitchell, F; Neuburger, J; Radebe, D and Rayne, A; Shelter; June 2004.
146 *Sick and tired*: Credland, S and Lewis, H; Shelter; December 2004.
148 ODPM; Housing, Planning, Local Government and the Regions Committee; *Homelessness*; Third report of session 2004–05; HC 61-I.
149 *Sustainable communities: Homes for all*; ODPM; January 2005.
mechanisms will be successful in reaching homeless households. Plans to extend health provision via community based initiatives, such as children’s centres and school nurses also risk not reaching homeless people in temporary accommodation.

RECOMMENDATIONS

— Primary Care Trusts, Health Trusts and other strategic health bodies should work more closely with local housing authorities to develop a more effective approach to addressing the health needs of homeless people at the local level.
— As key agents in delivering the public health agenda, Sure Start services and the new children’s centres should be more accessible for homeless families in temporary accommodation.
— Tenancy support teams and other services working with homeless households should work closely with health professionals to ensure that their health needs are addressed.
— Departments across Whitehall should work together with ODPM as it develops its strategy for meeting its 2010 target to halve the number of households in temporary accommodation to develop a comprehensive package of support for meeting the health and other support needs of homeless households in temporary accommodation.
— The forthcoming five year Supporting People strategies must be co-ordinated with local homelessness strategies and give priority to services providing support to households living in temporary accommodation.

February 2005

Memorandum by the National Children’s Bureau (WP 83)

1. The National Children’s Bureau (NCB) promotes the voices, interests and well-being of all children and young people across every aspect of their lives.

1.1 As an umbrella body for the children’s sector in England and Northern Ireland, we provide essential information on policy, research and best practice for our members and other partners.

1.2 NCB has been heavily involved in the development of the Public Health White Paper, with our Chief Executive chairing the taskgroup charged with developing Chapter 3 “children and young people, starting on the right path”. We were also key partners in the development of the National Service Framework (NSF) for Children, Young People and Maternity Services (Department of Health, 2004), and continue to work on the implementation of that framework. Furthermore, NCB runs a National Network of Primary Care Trusts (PCTs), with over 50 PCTs in membership the network which gives us a unique opportunity to consult with and listen to children’s leads from across the country.

2. GENERAL

2.1 NCB welcomes the Public Health White Paper with its particular focus on children and we very much welcome the range of measures set out to improve children’s health. However we believe the government needs to be more prescriptive in its actions, building on previous public health policy and evidence. We would have preferred more immediate action rather than further deliberation in some areas, for example food advertising to children.

2.2 We would welcome the opportunity to be consulted on the development of a comprehensive and integrated prevention framework for the NSF for children, young people and maternity services as described in Chapter 6.

3. Will the proposals enable government to achieve its public health goals?

3.1 Although we welcome many of the new proposals to help reach the public health goals, we are still concerned that there are key areas that need to be addressed. These include marketing of food to children, marketing and consistency of health information, mental health promotion, and the role of parenting.
3.2 The white paper acknowledges the need to influence market provision as one way of changing consumer demand. NCB is signed up to Sustain’s Food Campaign (Sustain, 2004), which demonstrates that a voluntary ban on the advertising of unhealthy food to children will not produce the desired effects and reduce levels of childhood obesity; the government needs to impose a compulsory ban in order to fulfil its duty to protect children and improve their well-being.

3.3 There is plenty of health related information available to children, and—although NCB agrees that messages need to be consistent, in line with the proposals in Chapter 2—it is important that this information is better marketed. There are two key points here. First, NCB is concerned that government attempts to generate consistent, evidence based messages will be undermined by the food industry as has happened in the past. It must also be recognised that the public often don’t trust information from the government. The body charged with producing consistent messages need to be independent from the government. Second, NCB is seeking clarification as to how the new body charged with implementing the health promotion strategy (paragraph 13) will work. It is essential that children’s views are taken onboard in the design and implementation of such a strategy to ensure its effectiveness in getting health messages across to children and to ensure it operates in line with Article 12 of the United Nations Convention on the Rights of the Child.

3.4 Although there is a Summary of Intelligence on Mental Health included in the Choosing Health pack, there is a distinct lack of information as to how the Government will ensure local organisations support children in the promotion of their mental health. NCB would like to see more, and clearer, suggestions as to how children’s mental health will be promoted, in line with the 3-levelled model described in paragraph 38—strengthening individuals, strengthening communities and reducing structural barriers.

3.5 Parental relationships, particularly in infancy and the early years, is critical and a key influence on the nature and quality of the other relationships children will form in their future lives (S Stewart-Brown, 2004). Although this white paper proposes to provide additional information and support to parents, NCB is seeking further clarity on what this information and support will entail. The first chapter of Every Child Matters (DfES, 2004) focuses on supporting parents and families which shows the government’s willingness to take action in this area (not just in relation to public health), though specific recommendations as to how this will happen have not been made.

4. Are the proposals appropriate, will they be effective and do they represent value for money?

4.1 We are pleased to see a range of measures to recruit new staff to improve the nation’s health, however we are seeking further clarification as to how Health Trainers (Chapter 5) will integrate with sexual health email experts and School Nurses (Chapter 3) and with Health Direct Staff (Chapter 2). With the current recruitment crisis in the public services, and the limited pool of staff available, we are concerned that these new roles will be filled by staff who already fill crucial roles. The government must demonstrate that it values existing staff working with children (for example school nurses), and focus attention on offering training and incentives for such staff, rather than creating new posts.

5. Do the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

5.1 We welcome the recognition of School Nurses as essential in the promotion of health and support of learning about health choices, however are aware that it is estimated that there are currently 2,500 school nurses serving almost 26,000 secondary and primary schools (Chief Nursing Officers Review, 2004). NCB’s own research with around 3,000 pupils across the country shows that school nurses play an increasingly important role in health promotion, but that the service is over-stretched. This was echoed by the Royal College of Nurses in 2004. To set a target for a school nurse in every school cluster by 2010 is a good step towards addressing this, however NCB would like to see more immediate action to better recruit and value school nurses. One way of achieving this would be through Extended Schools. School Nurses should be an integral part of this new programme, and the DfES guidance on extended schools should reflect that. In addition, we would welcome clarification on what definition of school clusters is being used in this paper.

5.2 Article 12 of the UNCRC states that children have the right to be involved in decisions affecting them. A key component of the NSF is the participation of children in their own care and in service design (in particular laid out in Chapter 3). The infrastructure for involving children in the work of public health agencies doesn’t yet exist, except through one-off pieces of work. Patient and Public Involvement (PPI) Forums could be one of the vehicles through which children are involved in the shaping of local public health services, however anecdotally we know they are currently failing to engage children and their parents. It should be a requirement of PPI Forums to engage with children and their parents, particularly given that Joint Area Reviews (Children Act 2004) are likely to inspect organisations in relation to how far they are achieving this.

5.3 We are pleased to see targets set in relation to Healthy Schools—that by 2009 every school will have healthy school status. However with the status of Personal, Social, and Health Education being non statutory, and not being delivered consistently across the country, we question the strength of these proposals. We are aware that Ofsted’s Framework for Inspection of Schools (DfES, 2005) will include benchmarking against the Children Act (2004) five outcomes, of which one is “being healthy”, however we
believe the government needs to create additional incentives to ensure every school becomes healthy. Furthermore, the Health Scrutiny Committee (Local Government Act 2000) and children’s service planning groups (as laid out in the Children Act 2004) should have a key role in ensuring Schools are working to the partnership agenda, and meeting their communities’ health needs.

5.4 We welcome the proposal to offer a sexual health email service (chapter 3), however this must only be part of the package to improve sexual health. We are concerned at the quality of advice on offer through this service, and how confidential it will be for those using it. We are therefore seeking clarity as to the skills and training staff delivering this service will have, whether it will be delivered nationally, or locally, and in what ways children with no private PC can gain access to this kind of valuable, anonymous advice.

5.5 NCB is extremely pleased that under the Children Act 2004, Children’s Services Authorities are charged with developing a single Children and Young People’s Plan. This is to be the overarching plan for all children, and to bring together all other plans, such as the Youth Justice Plan, and the Early Years Development and Childcare Plan. The Public Health Observatories’ investigations into health patterns and trends (the first of which reports are due from every observatory in 2006 as specified in Chapter 4) will be crucial in informing priorities for children’s services as a whole, and monitoring local need. NCB is seeking assurance that the government will require Public Health Observatories and Local Authorities to work together to make the best use of this information in developing strategy and ensuring the accurate forecast of children’s future health needs.

February 2005

Memorandum by Ms Jane Sunter, Public Health Development Manager—Tobacco Control, North, South and Central Manchester Primary Care Trust (WP 84)

I work within the Manchester Public Health Development Service, managing the tobacco control remit on behalf of North, South and Central Manchester Primary Care Trust (PCT). This includes the coordination and management of the Manchester Stop Smoking Service.

1. The national current estimate of smoking prevalence taken from the General Household Survey (2002) is 26%. Smoking prevalence varies considerably between geographical and socio-economic areas, with the North West currently holding the highest overall prevalence (28%) of all-English regions.

1.1 In Manchester the estimated prevalence of smoking is considerably higher than even North West totals, with 40% of the population smoking in North Manchester PCT, 37% in South Manchester PCT and 35% in Central Manchester.

1.2 In order for us to hit the ambitious target advocated to reduce the smoking prevalence to 11% by 2022, cities like Manchester need to take brave and drastic action to start to turn the tide of the high mortality and morbidity rates in its population. This action would also have an impact in helping to contribute to the steep quit targets set through the Local Delivery Plan process.

1.3 Whilst the Manchester Stop Smoking Service welcomes the spirit of the White Paper in promoting choice in the individual and personalizing health care, we feel that the White Paper has not gone far enough in recommending that smoking should be banned in all enclosed public places and work places. We had hoped that the Government would use the White Paper to spearhead the campaign, enabling our cities to become Smoke Free, following the highly positive outcomes of the Irish experience.

2. The White Paper states that between 10–30% of pubs would fall in to the “not serving food” category and would, therefore, be exempt from any smoking ban. In Manchester, we know however, that this figure may rise up to 80–90% of pubs being exempt, reflecting the high levels of social inequalities present in some Manchester wards. The recommendations of the White Paper, as they are currently proposed, would actually widen the gap in health inequalities experienced by many socially deprived groups within the city.

2.1 The Manchester Stop Smoking Service is currently undertaking a survey in conjunction with Smoke Free North West, University of Manchester and John Moores University to assess the current provision of food serving in the pubs of Manchester. This will provide us with base line information to enable us to monitor changes in attitude to smoke free work places and reduction or expansion of the serving of food in licensed premises.

2.2 The publication of the White Paper was an opportune time for the Government to become a trail-blazer in applying its own recommendations for “new action” and “fresh thinking” around Smoke Free status for cities and communities, but the document’s lack of leadership has led to disappointment and confusion in how cities now take this agenda forward on behalf of their communities.

3. On a Greater Manchester level, many of the Local Authorities are now working with the NHS to move their cities and communities to Smoke Free status. Licensees have, however, expresses concern that as Smoke Free status is achieved at different rates in each area, and many pubs will be exempt from becoming Smoke Free and an un-level playing field will be created. This could mean that individuals unable to smoke
and drink in Manchester may travel to Stockport for a night out, creating an impact on the local economy. A blanket ban would have removed any discrepancies and create a fair and equitable market across the Greater Manchester conurbation.

3.1 As a service, we are now more than equipped to be able to deal with the growing demand of people requesting support to quit. As the campaign to move Manchester to Smoke Free status by 2006 continues, the White paper has been instrumental in increasing the debate around the concept of what it means to be Smoke Free. The White Paper has not, however, taken the opportunity the lead the way in tackling the greatest threat to public health within this century.

Memorandum by Cholesterol UK (WP 85)

SUMMARY

1. Cholesterol UK welcomes the Government’s White Paper on Public Health. There is a great need for improvements in the health of our nation, and it is right that the Government should take a lead in driving, encouraging, and supporting the changes that organisations as well as individuals need to make.

2. Coronary heart disease (CHD) is the nation’s biggest killer. In turn, raised cholesterol is the single greatest risk factor for CHD. Importantly most people can help lower and manage their cholesterol through changes to their diet and lifestyle. Cholesterol has been undervalued as a focus of attention in public health and has not been given clear priority alongside other heart health risk factors in this White Paper.

3. Cholesterol UK calls for a greater focus on adults, who will be new heart patients in the short and medium term. We also call for clearer targets and systems of accountability than are presently set out in order to ensure the public health strategies are given adequate funding and priority at a local level.

4. Cholesterol UK calls for three specific actions to be included in the Government’s strategy. Increased awareness of the dangers of unhealthy levels of cholesterol; greater access to heart health check-ups, including cholesterol tests to motivate individuals to improve heart health; and the development of practical guidelines for healthcare professionals to help individuals adopt a healthier diet and lifestyle, drawing on the latest Joint British Societies’ Guidelines 2 on Prevention of Coronary Heart Disease in Clinical Practice.

EVIDENCE BASE FOR CHOLESTEROL

5. Every year in the UK 125,000 people die from CHD. It is the nation’s biggest killer. Of the risk factors linked to CHD, cholesterol is its single greatest risk factor. Statistics show that raised blood cholesterol is a factor in nearly half of all CHD cases (47%)\(^\text{150}\), greater than smoking, blood pressure, or lack of exercise. Studies show that the relationship between CHD and cholesterol is continuous, and that as levels of cholesterol decrease, heart health risk continuously decreases alongside it\(^\text{151, 152}\). Despite the declining number of deaths from heart attacks, the number known to be living with CHD is increasing as a proportion of the population every year—it now stands at 12%, up from 7% only 15 years ago\(^\text{153}\).

6. Raised cholesterol is also a major risk factor in the 110,000 strokes suffered every year in the UK. Diabetes and obesity also significantly increase the risk of CHD and stroke.

7. Most people can help lower and manage their cholesterol through changes to their diet and lifestyle. Studies have shown that a 10% reduction in cholesterol (achievable by changes in diet and lifestyle) in a 40-year-old male would lead to a 54% reduction in CHD\(^\text{154}\). The Health Development Agency recently published a report stating that “reducing cholesterol levels by even a small amount would prevent approximately 25,000 fewer deaths each year. This is quite possible”.\(^\text{155}\) Even those individuals with a family history of high cholesterol levels can improve their health outcomes through diet and lifestyle changes.

8. Against the existing guidelines recommendation of a healthy level of cholesterol (less than 5mmol/l) 70% of UK adults over 35 have raised cholesterol\(^\text{156}\). This statistic will become much worse because the Joint British Societies’ Guidelines will be updated in 2005 with a new lower recommended level of healthy cholesterol of less than 4mmol/l. Yet only 5% of the population and, even more worryingly, only 4% of GPs recognise cholesterol to be the major risk factor for CHD\(^\text{157}\). Most think that smoking is the greatest risk factor.

\(^{154}\) Law MR et al By how much and how quickly does reduction in serum cholesterol concentration lower the risk of ischaemic heart disease? BMJ 308, 363–6.
\(^{156}\) Coronary Heart Disease Statistics. British Heart Foundation Statistics Database 2003.
\(^{157}\) Cholesterol UK surveys conducted by Communicate Research and ICM published in 2004—available on request.
9. CHD costs the UK economy over £7 billion every year. Heart disease and cholesterol levels are also highest in the lower socio-economic groups—tackling CHD and cholesterol is part of addressing health inequalities.

**GENERAL COMMENT ON GOVERNMENT WHITE PAPER**

10. Through the National Service Framework for CHD, the Government has placed great emphasis on lowering cholesterol as part of secondary prevention strategies for those with a high risk of CHD or those who have already had a coronary event. It has also often trumpeted the benefits of this through lives saved. However, a focus on lowering cholesterol in the wider population through diet and lifestyle change as part of primary prevention has been undervalued to date—the focus has been on reducing smoking, salt intake and increasing fruit and vegetable consumption. All of these are very welcome, but Cholesterol UK is disappointed that the White Paper has not been taken as an opportunity to prioritise cholesterol alongside other major risk factors for CHD and stroke.

11. Cholesterol UK believes that the White Paper prioritises action on children at the expense of adults. We believe this is short-sighted. Children are, of course, enormously important. However, the current adult population are the patients of tomorrow, next year and next decade. They are the people that must be reached if the current increases in heart disease are to be stemmed and if the financially crippling Wanless scenario is to be avoided.

12. Cholesterol UK has concerns over the ability of the Government to ensure implementation of the many good actions in the White Paper. The Paper states that the Government will issue a “technical note” to the NHS reinforcing the priorities of this White Paper. This is not enough. If there is no clear accountability structure for implementation of the White Paper then we fear it will not receive the local funding and the priority it needs. The expected Delivery Plan for the White Paper must set clear targets for healthcare organisations and others to ensure action.

13. The White Paper also states that the new contract for primary medical care “offers enormous potential,” (pp 126). GPs and their team are vital to successful public health strategies, and a clearer commitment to drive action through this new contract must be given.

**SPECIFIC ACTIONS**

14. The White Paper makes many unspecific commitments which require further detail. Cholesterol UK wishes to see three specific actions developed from these commitments. These concern awareness campaigns, greater access to testing, and more information for health professionals.

15. These three have been selected because they fit into a complementary whole of knowledge, empowerment and support. An awareness of risk factors and what can be done to reduce them (awareness campaigns), linked to an understanding of personal risk levels (testing) and the motivation for action it provides, together with better information for health professionals to support the individual in making and continuing the right changes to diet and lifestyle for their needs.

**Awareness Campaigns**

16. Cholesterol UK agrees with the White Paper which states that people need information in order to make informed choices. In Chapter Two it pledges to fund specific campaigns through third party organisations. The Government has already funded large scale campaigns against smoking and on the dangers of too much salt in the diet. Cholesterol UK calls for a consumer awareness campaign to highlight the dangers of a high saturated fat diet, its link to cholesterol and heart health, and ways to lower cholesterol through diet and lifestyle. A Cholesterol UK survey in 2004 showed that only 5% of the population know that cholesterol is the major risk factor for CHD, and also showed a clear lack of understanding of a healthy diet. Recent industry focus group research[^158] has shown the need to clarify for the population that a diet high in saturated fat not only makes it likely that you will put on weight but that it also clogs arteries.

17. Such a campaign has already received wide support. An Early Day Motion supported by Cholesterol UK and the Stroke Association calling for such a campaign was one of the more popular EDMs of the 2003–04 session. It was supported by 163 MPs of all parties including several current and previous members of the Health Committee: Doug Naysmith, Paul Burstow, Patsy Calton, John Austin, Keith Bradley, David Amess, Simon Burns and Siobhan McDonagh.

18. The White Paper makes no commitment on the subject of forthcoming campaigns. A commitment for a campaign against the single greatest risk factor for heart disease is needed. Cholesterol UK suggests that such a campaign could be led by a charity or by the Food Standards Agency.

Greater Access to Testing

19. An understanding of personal risk is a strong motivator for action. In the absence of knowledge, too often we like to think that “we’re all right”. In particular, people with high cholesterol may experience no outward symptoms or signs. A study amongst people with family history of high cholesterol shows that understanding of their condition resulted in significant heart healthy choices in diet and lifestyle. Through managing their cholesterol levels with diet and lifestyle changes and increased physical activity, the patients substantially reduced their risk of death from gastro-intestinal cancers159.

20. It is currently difficult to obtain a heart health check-up on the NHS. One can easily obtain such a service privately, either through a health insurance plan or by purchasing tests at pharmacies. But such payments exacerbate health inequalities. Cholesterol UK calls for easy access to heart health check-ups including testing of cholesterol, blood pressure, blood sugar, and body mass index or waist circumference measurement. These tests should be free (or only a nominal cost). They should not be established as an added responsibility for GPs. Pharmacies could be a venue, but to provide full access and to motivate hard-to-reach groups who would benefit from testing, innovative community outreach schemes run through PCTs and partnerships should also be rolled out.

21. The White Paper discusses screening on page 127 but makes no commitment to an extension of screening. Cholesterol UK is interested to see what the “health stock take” offered by health trainers will become, and also awaits further information on the “personal health guides”. However, both of these schemes will only be available in deprived areas to begin with. Cholesterol UK believes there should be a commitment to offer health check-ups for all those who wish to use them. The Government is rightly concerned to avoid the extension of health inequalities in uptake of screening. However, this is not a reason to deny access to all. The experience of Boots the Chemists, whose free cholesterol tests have been vastly oversubscribed, shows the massive unmet demand for information by the public. (It is worth noting that the Boots test is a test for “total cholesterol” rather than a breakdown of “good” and “bad” cholesterol. The detailed breakdown test is preferred as it gives a more comprehensive picture of an individual’s heart health).

22. Both the Conservative Party and the Liberal Democrats have pledged to give greater access to testing (including cholesterol) as part of their public health plans.

More Information for Primary Care Health Professionals

23. Cholesterol UK welcomes the many measures to provide greater training for health professionals in public health. In particular we are concerned to see that primary care health professionals (including GPs, practice nurses and pharmacists) are equipped to fully advise patients on diet and lifestyle choices. Many have made the effort to train and equip themselves. But many have not. This change would be incentivised through inclusion in the relevant contracts. In addition, appropriate evidence based information is key.

24. In particular, there is a range of guidelines, but little consensus amongst primary care health professionals on which guidelines to use. Many are secondary care focused, due to the nature of their compilation, rather than appropriate for primary prevention for the majority of individuals presenting in primary care. In addition, many require a level of detailed nutritional understanding uncommon amongst primary care professionals. As the public and non-high risk individuals increasingly seek advice from general practitioners, practice nurses, occupational and community based nurses, pharmacists, as well as dietitians and nutritionists, it is important to have guidelines and information for healthcare professionals which provide consistently simple, practical, and user friendly advice.

25. The new Joint British Societies Guidelines on Prevention of Coronary Heart Disease in Clinical Practice and the current British Hypertension Society’s Guidelines for the Management of Hypertension (2004) provide an opportunity for a simple condensed version of the primary prevention sections to be developed and circulated to relevant primary care professionals, providing the latest evidence based information in accessible form. This could be developed independently with Government funding and distributed through NHS organisations.

Conclusion

26. Cholesterol UK recommends the following three actions in order to provide the necessary knowledge, empowerment and support to improving public health through:

(a) Awareness campaigns, including a public awareness campaign on saturated fat and heart health—to provide improved understanding of cholesterol and risk factors for ill health and what can be done to reduce them.

(b) Accessible health check-ups, including cholesterol tests, at a national and local level—will provide greater understanding of personal risk and the motivation for positive action.

(c) Improved practical information for healthcare professionals—will support the individual in making and continuing to make the right changes to diet and lifestyle for their needs.

27. These recommendations should not work in isolation but be part of an integrated approach to implementing the many positive steps outlined in the Public Health White Paper.

**CHOLESTEROL UK**

28. Cholesterol UK is an active advocacy coalition of two leading heart patient support charities: **H·E·A·R·T UK** and the British Cardiac Patients Association. It was established in 2002 and campaigns for policy change to achieve a greater focus on high cholesterol as a dangerous risk of heart disease and stroke in the wider population, and greater awareness of ways to decrease and manage cholesterol levels through diet and lifestyle changes.

*February 2005*

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**Memorandum by the Association of Directors of Social Services (WP 86)**

The Association of Directors of Social Services (ADSS) has pleasure in submitting comments on the White Paper as requested. In this submission we address the Paper according to the requested Terms of Reference but looking at each chapter in turn.

**CHAPTER 1—THE TIME FOR ACTION ON HEALTH AND HEALTH INEQUALITIES**

*Do the proposals enable the Government to achieve its public health goals?*

The concept of choice should not rely on a consumerist model where it is assumed that rational processes take place. Damaged and disadvantaged individuals need more support to enable them to make healthier choices.

*Are the proposals appropriate, effective and value for money?*

Strengthening local and sub-regional partnerships may require access to financial incentives from central and regional government.

*Are the right public health mechanisms and infrastructure in place?*

Very little attention is paid to the potential of social care specialists in delivering the public health agenda.

Public health trained monitors may be needed to ensure compliance with voluntary agreements; the role of national voluntary organisations, professional bodies (eg ADSS), consumer associations, and trade unions might help here.

**CHAPTER 2—HEALTH IN THE CONSUMER SOCIETY**

*Do the proposals enable the Government to achieve its public health goals?*

There is some evidence of the effectiveness of nationally run public health campaigns, especially where they are linked to local action (eg the AIDS campaign in 1980s linked to specific grants for NHS and social services).

*Are the proposals, appropriate, effective and value for money?*

Surveys may be needed to collect reliable health information at a small area level or for specific population subset. Better value for money might be achieved if this work was undertaken regionally or by groups of local authorities with similar characteristics.
CHAPTER 3—CHILDREN AND YOUNG PEOPLE—STARTING ON THE RIGHT PATH

Do the proposals enable the Government to achieve its public health goals?

For Councils to be effective in tackling underage tobacco sales they may require additional resources for environmental health, trading standards, licensing and youth services.

Healthy schools initiative should be linked to similar initiatives targeting looked after children.

The emphasis on the role of school nurses is not balanced by consideration of the potential of social care specialists working with disadvantaged children and families to better promote health.

Are the proposals appropriate, effective and value for money?

More radical approaches to universal healthy approaches to universal healthy school meals provision may achieve better results than investment at the margins; breakfast clubs should be available in all primary schools and early years centres in the 10% most deprived neighbourhoods.

Are the right public health mechanisms and infrastructure in place?

There is a need to develop public health skills and understanding of key social care staff, not excluding social work professionals and students.

CHAPTER 4—LOCAL COMMUNITIES LEADING FOR HEALTH

Do the proposals enable the Government to achieve its public health goals?

Should there be an explicit requirement to include local PCT targets in Council’s annual performance plans following consultation with local health OSCs?

Are the proposals appropriate, effective and value for money?

More emphasis should be placed by LEAP initiatives in addressing the potential for preventing falls amongst older persons.

More financial incentives are needed to encourage healthy neighbourhood renewals especially in those areas not eligible for NRF funding.

Should there be a requirement for NHS local accessibility plans to be consulted on with LSPs and Health OSCs?

How can the significant levels of investment in NHS patient transport services and community transport schemes operated by local authorities be better harnessed to (a) offer better value for money and (b) encourage healthier alternatives?

Are the right public health mechanisms and infrastructure in place?

Guidance is needed on the role of local government and voluntary sector health “champions” (and how they will be supported locally, regionally and nationally). For example should this role be aligned with the role of the elected executive or non executive?

Should the role of public health observatories integrate more with regional social care information networks?

Local authorities need to be properly resourced to implement legislation on smoking through additional investment in licensing, enforcement and monitoring systems.

CHAPTER 5—HEALTH AS A WAY OF LIFE

Do the proposals enable the Government to achieve its public health goals?

Insufficient attention is paid to the role of social care staff and other local government personnel in delivering health training and developing personal health guides—especially for vulnerable people.

There is little mention here about the capacity of elected members of health OSC Committees or members of the public on Patient Forums, Expert Patients Programme, and Social Services User and Carer Groups.

Are the proposals appropriate, effective and value for money?

It may be most cost effective for the NHS to develop the skills and capacity of community and voluntary sector organisation to deliver personal health advice.
Are the right public health mechanisms and infrastructure in place?

A public health contribution to promoting health as a way of life needs to adopt more of a community development focus rather than rely on a bio-medical model of health education.

CHAPTER 6—HEALTH PROMOTING NHS

Do the proposals enable the Government to achieve its public health goals?

In some areas local NSFs (and similar initiatives) are being co-ordinated by social care services managers (eg in respect of older persons, mental health, learning disabilities, children and young people) but little consideration has been given to how they can contribute to better delivery of the prevention standards without dedicated resources.

The welcome focus on mental health might be better achieved by engaging local authority staff and the voluntary sector seeking to overcome barriers to employment and strengthen individuals and communities.

Is there a role for health OSCs in assessing local health and wellbeing?

Are the proposals appropriate, effective and value for money?

Is there scope to develop the role of the social care practitioner to enable them to acquire the necessary top up skills and training to achieve community matron status or equivalent?

Resources will also be needed to develop alcohol harm reduction initiatives at local level.

Are the right public health mechanisms and infrastructure in place?

How can social care practitioners and specialist be encouraged to develop the public health skills and expertise?

CHAPTER 7—WORK AND HEALTH

Do the proposals enable the Government to achieve its public health goals?

Do local government employees fit the definition of Government Department staff for the purposes of this section?

Are the proposals appropriate, effective and value for money?

Should social care staff employed by local government expect similar levels of support to that proposed for NHS staff?

Are the right public health mechanisms and infrastructure in place?

More encouragement is needed for local government to focus on new settings for promoting health improvement: including social care settings, young people’s services outside of school and leisure.

CHAPTER 8—MAKING IT HAPPEN: NATIONAL AND LOCAL DELIVERY

Do the proposals enable the Government to achieve its public health goals?

Health Impact Assessment tools need to be developed at regional and local level and ensure appropriate input from appropriate local government leads (including social care staff).

Are the proposals appropriate, effective and value for money?

Best value for money might be achieved by linking new investment to other funding programmes at regional and local level (eg NRF, Lottery bids, LPSA, LAA, specific grants for social care, education standards funds).

Consideration should be given to the role of voluntary/community organisations (including social enterprises and self help groups) in delivering objectives attracting new investment.
Are the right public health mechanisms and infrastructure in place?

Health Impact Assessment training is needed for local government Members and staff involved in decision making and scrutiny processes impacting on health and well-being.

February 2005

Memorandum by Alcohol Concern (WP 87)

About Alcohol Concern

Alcohol Concern is the national voluntary agency on alcohol misuse. Established in 1984 we seek to reduce the harm caused by alcohol on individuals, families and society. Our work spans the breadth of public policy impacted on by alcohol; we run projects targeted at specific areas of policy and practice, such as mental health and children and families and also provide the most comprehensive information service in the country on alcohol-related issues.

Alcohol and Public Health

Tackling alcohol misuse remains a key challenge for any coherent and proactive public health strategy. Alcohol has been identified by the World Health Organisation160 as posing the third highest risk to health in developed countries; For example, excessive alcohol consumption is a lifestyle risk for coronary heart disease and stroke, whilst an estimated one-third of psychiatric patients with serious mental illness have a substance misuse problem. People with alcohol misuse problems tend to experience poor health, present to a range of NHS services and costs at least £1.7 billion in health spend each year; yet in the vast majority of cases, the NHS fails to diagnose alcohol misuse and fails to provide adequate treatment.

Alcohol contributes to such a wide range of physical and psychological harms, that even modest improvements in identification and treatment will help in meeting NHS targets. For example National Service Framework targets on key issues such as Coronary Heart Disease, Older People, Mental Health and Diabetes are all related to alcohol misuse.

Over 8 million people in this country drink at levels that put them at increased risk of harm but are not chronic drinkers or alcohol dependent. These people are so numerous that behaviour change in this group is even more essential to public health targets than the much smaller number of people who are alcohol dependent.

The publication of the Alcohol Harm Reduction Strategy for England in March 2004 was an important first step in tackling alcohol related harm in an holistic way. It was not however underpinned by a strong public health perspective. Choosing Health presented an ideal opportunity to build on the Alcohol Harm Reduction Strategy, and we would endorse the comments by the CMO in his annual report that it was “an excellent opportunity to transform the alcohol strategy from a framework for action into an action plan, broadened and enhanced by other measures, to address what is a very deep-seated problem with complex causes”.

The central question of this submission from Alcohol Concern is whether Choosing Health has fulfilled these aspirations.

A public health approach to alcohol?

The World Health Organisation identifies three main types of approaches to reducing alcohol related harm:

(a) Population-based policies that can shape drinking behaviour across the whole population, eg taxation, availability restrictions, minimum drinking age.

(b) Policies targeted at particular problems, such as drink-driving or offences like sales to minors.

(c) Policies to help individual drinkers, such as brief interventions or rehabilitation programmes.

A public health approach to alcohol should embrace initiatives of known effectiveness from all of the above categories and weave these into a coherent and strategic response.

When average alcohol consumption increases, the number of people drinking at different degrees of severity tends to increase proportionately. Put another way, if we see a continued rise in average consumption, there is no evidence-based and tested set of policies that will succeed in reducing hazardous and harmful drinking. The most effective and cost effective approach is therefore to decrease the overall level of alcohol consumption in society through supply side controls such as taxation and licensing, as described in the type “a” approaches. Unfortunately many of these measures are politically unpalatable or (as in the case of licensing) beset by complex political tradeoffs.

Alcohol Concern views it as a problematic that the Government has failed to reflect the solid evidence base of whole population approaches in its response to alcohol, but recognises that many other excellent policies are being pursued.

*Choosing Health* could include many more measures within the type “b” category, targeted at particular problems. For example, reducing underage sales should help reduce the number of young people developing alcohol problems. Reducing the legal drink drive alcohol level would also save many lives each year.

As well as trying to reduce overall levels of consumption, it is important to respond to those who currently drink at risky levels. This requires us to identify these individuals, and provide an intervention for which there is an evidence base of effectiveness; these are known in the research literature as “brief interventions”. We therefore welcome the inclusion in *Choosing Health* of considerable interest in improving identification and treatment and the range of type “c” measures.

A public health approach to alcohol should include a co-ordinated range of measures covering supply side controls, initiatives to target specific behaviours and the identification and treatment of individuals who drink excessively. The combination of measures should bring about a shift in cultural norms (the assumptions and expectations around drinking including when and how much is drunk) and downward pressure on the overall level of alcohol consumption as well as a reduction in risk behaviour.

**Visibility of Alcohol within Choosing Health**

Our first concern was whether alcohol would be given a level of attention within the document that reflects its importance as a determinant of ill health. On balance we are pleased with the level of inclusion, and commend the Government for their apparent shift in thinking in the last two years (all too often, alcohol is underplayed to the point of invisibility). This visibility is vital to encourage local planners, clinicians and commissioners to take alcohol seriously and develop innovative and local solutions. We would argue that the overall level of attention to alcohol should be increased, but it is important to acknowledge the progress made.

**Recommendation**

— It is essential that *Choosing Health* maintains or increases the visibility of alcohol as a determinant of ill health alongside smoking and obesity.

**Role of the Alcohol Industry**

Alcohol Concern has always advocated a partnership approach to tackling alcohol misuse, and that this should include the Alcohol Industry. We are however profoundly concerned about the role of an industry funded lobby organisation “The Portman Group” proposed in *Choosing Health*.

The alcohol industry is in the business of selling alcohol and has legal responsibilities to maximise shareholder value. This will in general be achieved by selling more alcohol. This legitimate business activity brings harm as well as benefit to society, and therefore represents a clear conflict of interest in running campaigns to reduce consumption of alcohol (an inevitable corollary of trying to reduce alcohol misuse).

The Portman Group has a part to play in tackling alcohol misuse, as industry representatives they should be instrumental in bringing the alcohol industry into line with their social and legal obligations; the high proportion of licensed premises that promote irresponsible drinking and continue to sell alcohol to children, suggests there is much work to be done.

We urge the Government to work on public education with experts from across the medical, alcohol policy and research community. The industry should be included, but as a partner not a leader. Such work should be evidence based and free from (or at very least counter balance) the competing interests of the alcohol industry. The Royal Colleges, Alcohol Concern and other bodies are keen to work in such a collaborative fashion and have no difficulty of sharing the table with industry.

We urge the Government to abandon any bilateral approach to Public Health with industry, and adopt a more inclusive approach.

**Recommendation**

— That the Government establish an advisory panel including the Royal Colleges, Alcohol Concern, researchers and representatives from the alcohol industry, to lead on or oversee campaigns aimed to reduce alcohol misuse.

— Industry representatives should include on trade and off trade as well as producers.
SUPPORT FOR SPECIALIST TREATMENT

The funding and coordination of alcohol treatment services in this country is in a parlous state. They receive one tenth the funding of drugs services despite five times as many people dying from alcohol than drugs, in many areas no individual has responsibility for commissioning these services and there is no national system of performance management, monitoring or planning.

We warmly welcome many of the proposals in Choosing Health that support the role of treatment services. Although there is much repetition from the alcohol strategy, this is not in itself a bad thing and in some areas offers stronger (or at least clarified) commitment to turning proposals into an actual programme of improvement.

One section of Choosing Health refers to additional funding provided through pooled treatment budgets. We have clarified with the DoH that the funds are not intended (nor of sufficient size) to invest in provision of treatment per se, and will instead go toward improving commissioning. This section needs clarification as it raises false hope for new funding. A better approach still would be for the Government to make a reasonable and realistic investment in alcohol treatment services and indicate in how the “planned programme of improvement” will be resourced.

The National Treatment Agency for Substance Misuse has been tasked with developing a Models of Care framework for alcohol, along the lines of the existing framework for drugs. The drugs document is described as “having the status of a national service framework” and has played a major role in the strategic development of drug treatment services. It did however focus largely on the specialist treatment services.

Models of Care for Alcohol must have a wider remit than the drugs document, and set out the nature and structure of interventions across non-specialist as well as specialist services. It should, for example cover interventions in A&E and Primary Care.

Whilst Choosing Health reiterates commitment to the delivery of Models of Care for Alcohol, this would be more effective if it was clearer how the document sat within the NHS Plan and National Service Frameworks. It recommends that “... alcohol services—benefit fully from the same drive for modernisation and improvement that exists across the rest of the NHS”. This will only be achieved if Models of Care reflects that standards based approach used across the National Service Frameworks.

One benefit of NTA involvement in alcohol would be that the existing investment in the drugs infrastructure (workforce planning, information management and commissioning structures) could be quickly extended to support the alcohol sector. New money for alcohol services should therefore result in a relatively quick impact on the ground, with relatively small amounts needing to be diverted to building infrastructure.

Choosing Health explicitly mentions the role of the voluntary sector in the delivery of alcohol treatment. This is to be welcomed. A key challenge facing this sector is the slow implementation of the recommendations of the Treasury review of the role of the voluntary sector in delivery of public services, in particular full cost recovery.

The prison alcohol strategy is referenced in the white paper, and has now been published. It remains aspirational and to be delivered “within existing resources”, which means on the ground that nothing changes.

Recommendations

— The Models of Care for Alcohol Misusers should have the status of a National Service Framework and include standards linked to the NHS plan.
— Investment in commissioning through pooled treatment budgets needs clarification.
— Significant new investment is needed in alcohol treatment services, and Choosing Health should commit to such spending.
— Choosing Health should reference the Treasury review of the role of the voluntary sector and recommend the implementation of its findings.
— The prison alcohol strategy could be referenced with recommendations that it is adequately resourced.

BUILDING LINKS TO OTHER POLICY AREAS

A key plank in improving public health is to ensure that there are links between the public health and other policy agendas and this is of particular importance if we are genuinely to shift the culture of drinking in the UK.

A key gap in the public health white paper was the lack of proposals to push the identification of alcohol problems into settings other than health. The identification/brief intervention initiatives proposed for the NHS would have equal effectiveness in other settings across social care and criminal justice. The task is to identify places where hazardous and harmful drinkers come into contact with professionals. These can be
described as “capture points”, and exist way beyond healthcare settings (for example criminal justice, education and social care). An example of this activity is to skill up custody officers to identify people who may have alcohol misuse problems and refer them for brief interventions at local alcohol treatment services.

These other policy areas need workforce-planning strategies to ensure that staff are trained in identification, minimal intervention and referral of people with alcohol problems. This could be achieved by a commitment to include basic Drug and Alcohol National Occupational Standards competencies into the emerging national occupational standards for these fields.

There are other areas of alcohol policy that would yield marked public health gains yet are not mentioned in the strategy. Some of these are covered in these recommendations:

**Recommendations**

— Increased reference to the role of other social care, criminal justice and housing sectors in delivery of public health goals around alcohol.

— Specifically, to state that the DANOS competencies for the identification, brief interventions and referral on will be included in the occupational standards for these sectors.

— For the legal drink drive limit to be reduced to the European consensus of 50mg/ml.

— For effective enforcement of underage sales policy (a key supply side control).

**IMPACTING THE OVERALL CONSUMPTION OF ALCOHOL**

Over the last 50 years, the per capita consumption in the UK has risen by a little over 100%. This is seen as the result of increased accessibility including affordability (price in real terms), the proliferation of bars, clubs, pubs and off licensed premises and the relaxation of licensing laws.

The evidence base overwhelmingly links increased per capita consumption with increases in diseases linked to long term heavy drinking, accidents as a result of being drunk, crime, violence and suicide. The recent publication from the Academy of Medical Sciences\(^ {161}\) cites numerous examples of research from Europe, Canada and the UK to conclude that per capita consumption stands out as a crucial determinant of how many people will drink heavily and as an indicator of alcohol related harm more broadly. Yet both the Alcohol Strategy 2004 and the Public Health White Paper avoided this approach as a basis for formulating policy.

Instead the Government’s current approach is focussed on changing the behaviour of specific groups of problem drinkers. Whilst many of the policies that are proposed are excellent, they are an inadequate response to the steadily increasing problem of excessive alcohol consumption. In addition to a targeted approach there is a need to policies related to reducing the overall level of national drinking if we are to see a sustainable improvement to public health in the long term.

We would particularly highlight a failure of joined up government, the development of the Licensing Act without significant regard for public health. The licensing regime in this country is one of the prime means available for the Government to control the availability of alcohol, yet the opportunity to coordinate these reforms with the alcohol strategy was missed. Many of the reforms proposed in the Act are positive (such as increased democratic accountability of licensing decisions) so we would not argue for the whole act to be scrapped, but in its present form may worsen public health.

**Recommendations**

— If alcohol consumption or alcohol misuse continues to rise, moderate increases in the price of alcohol should be considered. This is a valuable tool that is recommended by the World Health Organisation as effective.

— The Licensing Act and guidance that supports implementation urgently needs review. The Act should have at its heart a consideration for public health.

— Moderation of average alcohol consumption should be an accepted and acceptable target for government, and reflected in a range of policy initiatives.

— We welcome the revision of Ofcom guidelines on the broadcast advertising of alcohol and are pleased that this was seen as relevant for inclusion.

— We support the calls from the RCP for an end to broadcast advertising of alcohol before 9 pm.

\(^ {161}\) Academy of medical science: Calling Time—The nations drinking as a major health issue (2004).
BUILDING CULTURE CHANGE IN THE NHS

The NHS is one of the largest employers in the country and does not have a coherent workplace alcohol policy. If we are interested in changing the culture of the NHS in its approach to alcohol, a good place to start would be to look at the drinking culture of the NHS. NHS physicians would find the necessary shift in role legitimacy easier to navigate if their own places of work had less conflicted approaches to drinking. It should for example be unacceptable for medical school bars to offer subsidised alcohol and run drink promotions that the rest of the alcohol industry is under pressure to stop.

One of the problems identified with the alcohol strategy was the lack of clear teeth or commitments to bring about culture shift within the NHS. The white paper builds usefully on the alcohol strategy, for example promising: “guidance and training to ensure all health professionals are able to identify alcohol problems early”. There is a broad commitment for the NHS to have conversations “linking health improvement advice to clinical care”. If we succeed in getting health professionals trained in screening and minimal/brief intervention, there are real opportunities to help the millions of hazardous drinkers who present to the NHS but do not need referral to specialist services.

The white paper is however a little weak on the specifics of implementation. We look forward, for example to seeing greater detail on how the training is to be delivered.

Primary care is the ideal setting for identification, brief intervention and referral of alcohol misusers. Models of Care for Alcohol Misusers is considering how this activity might be structured, but there is not yet an appropriate set of levers to ensure this gets implemented across primary care. Screening needs to take place in every surgery, not just a handful, and the nGMS contract represented was a missed opportunity to create an incentive structure (similar to smoking cessation) to get GPs involved in early identification work.

Recommendations

— There should be an NHS wide workplace alcohol strategy, and review of how as an employer the NHS can set the standard by example on how to move away from a culture of heavy drinking.
— A more concrete delivery plan is provided for alcohol in primary care.
— A more concrete delivery plan for the training of NHS staff is needed.
— The review of the nGMS contract and Quality in Outcomes Framework should consider how screening and brief interventions can be encouraged in primary care.

CONCLUSIONS

Alcohol Concern welcomed the inclusion of Alcohol in the public health white paper, and recognises that the level of inclusion on alcohol is an important step forwards. There are however a number of shortcomings that should be addressed as a matter of urgency; in other areas there are comparatively minor revisions that would ensure that Choosing Health has a greater impact to the reduction of alcohol related harm in this country.

January 2005

Memorandum by the Central Council of Physical Recreation (WP 88)

The Central Council of Physical Recreation (CCPR) is the umbrella body for 270 national organisations for sport and recreation, representing and promoting the interests of voluntary sector sport and recreation. CCPR believes that voluntary sector sport and recreation has a positive role to play in improving the health of the nation, and welcomes the opportunity to submit a memorandum to the Committee.

CCPR strongly believes that the promotion of physical activity should be central to any government strategy aimed at improving public health. Physical activity provides positive messages, whereas many other public health campaigns are necessarily centred on negative messages: “don’t eat too much, don’t drink too much alcohol, smoke, take drugs”, etc. Whilst these messages are essential, physical activity has the benefit of being a “yes” factor.

RESPONSE TO KEY QUESTIONS

In responding to specific questions, the CCPR has concentrated on evaluating the effectiveness of the Government’s physical activity goals, as this is where our expertise lies, and where CCPR member organisations are best placed to deliver.
1. **Whether the proposals will enable the Government to achieve its public health goals?**

   — The Government has set out in the White Paper what it plans to do with regard to meeting its physical activity targets. The CCPR broadly supports the stated measures, although it is difficult to tell if they will enable the Government to achieve all of its goals in this area, as much of the detail is still to be laid out.

   — CCPR supports the Government’s commitment to “work with the sports and recreational activity sectors to deliver positive, innovative messages about healthy lifestyles including physical activity”. However, CCPR urges that the Government commits to a high level, national and sustained campaign to promote physical activity in order that the desired results are achieved. Evidence from comparator European nations suggests that only sustained campaigns of considerable longevity can achieve significant increases in participation. For example, government backed sustained anti-drink driving and seat belt campaigns of this nature have yielded significant results. CCPR also urges that public health messages to promote physical activity be simple and positive: ANY ACTIVITY IS BETTER THAN NONE AND THE MORE ACTIVITY THE BETTER. CCPR believes that specific messages about intensity, frequency and duration can be counter-productive.

   — Similarly, CCPR supports the Government’s desire to resource local communities so that they can “lead for health”. CCPR feels it is particularly important that community sport and recreation organisations, and their governing bodies, are resourced and able to build capacity in order that they can deliver in local settings.

   — CCPR feels it is crucial that assistance is offered for sport and recreation organisations to forge links with local health networks and PCTs. If this is achieved, sporting organisations’ experience and coaching expertise can be utilised to meet local health needs. This kind of partnership is also vital for achieving value for money in public health policy. Many of the organisations in CCPR’s membership offer activity opportunities which reap significant health benefits. These organisations also offer inclusive settings in which to be active, successfully target traditionally “hard to reach” populations (for example young girls and older women engaging in movement and dance activities) in neighbourhood locations and have excellent retention rates. These organisations are well governed, offer an established structure and system for participation and have well trained and qualified coaches/trainers. Sport and recreation organisations thus have much to offer in the development of public health activity solutions. They are excellent value for money because they are already well established. CCPR urges that the national governing bodies of sport and recreation are resourced to join up with health services at local and regional levels, so that they can increase their ability to deliver in health settings. CCPR believes that this strategy would offer a “good buy” and value for money in public health terms.

   — The Government has stated that the Activity Coordination Team (ACT) will publish a Delivery Strategy for the public health White Paper early in 2005. The CCPR has been disappointed to date with the progress of ACT in achieving the “joined-up action on physical activity” that it was established to deliver. ACT was originally charged with publishing a Delivery Strategy in April 2004. This was delayed as a result of the Choosing Health Consultation and the Team appears to have achieved few concrete outcomes. Therefore, CCPR urges that the work of ACT be monitored closely on value and effectiveness.

2. **Whether the proposals are appropriate, will be effective and whether they represent value for money?**

   — CCPR broadly believes that the Government’s proposals are appropriate and that is it necessary to pursue a multi-faceted public health approach to combating the problems of overweight and obesity. It is important that activity is recognised as a crucial part of the solution and activity organisations are resourced to this end. CCPR encourages the Government to implement its stated proposals with urgency in order that they are effective in the short to medium term. The severity of the obesity “epidemic”, particularly amongst children and young people, requires a rapid response.

   — There is clear evidence that those who have a good experience of physical education from an early age are more likely to remain active in later life. We believe that ensuring all young people have an enjoyable experience of physical education represents value for money in public health terms, because engendering an appreciation for physical education and physical activity from a young age contributes to the long term health of individuals. CCPR is supportive of the investment into the school sport system and feels this will make a positive difference to young people’s experiences of physical education. CCPR also supports the recent announcement to increase school pupils’ entitlement to two hours physical education within the school curriculum by 2010, plus a further two to three hours beyond curriculum time. A commitment to physical education within the curriculum is key because it is the ONLY way of ensuring that every pupil receives their physical education entitlement.
CCPR believes more can be done in this area so that the Government more effectively reaches its public health goals and maximises value for money. CCPR believes the Government should require a minimum of 30 hours’ initial training in physical education for all primary school teachers. This would equip primary school teachers with the confidence and skills to teach high quality programmes covering the breadth of the physical education national curriculum.

CCPR also feels that positive physical activity experiences should be guaranteed to those of pre-school age. CCPR supports the Children Act’s requirement for local authorities to make provision for children’s recreation. The Children Act makes provision for children’s centres in every community and for universal childcare in a range of settings. CCPR feels this is an excellent opportunity to instil physical activity habits early, and thus that an adequate understanding of movement and physical activity should be part of the core training of the childcare workforce. CCPR also advocates inspection of provision for physical activity within childcare settings.

CCPR, in collaboration with the professional physical education organisations, has recently published a Physical Education Declaration, following the National Summit on Physical Education held on 24 January 2005. The Declaration makes further recommendations with regard to the provision of high quality physical education and a copy of the Declaration is attached to this memorandum.162

The CCPR supports the Child Growth Foundation’s view that the BMI of young people should be regularly monitored. Whilst agreeing with many medical professionals and public health specialists that BMI is an imperfect means of measurement, CCPR feels that at a time of sharply rising rates of overweight and obesity, regular monitoring of young people would be a useful intervention. This intervention should be linked to and result in the development of suitable activity and educational programmes and the provision of dietary advice, provided to children and parents.

CCPR recommends that the Government focuses on the provision of activity opportunities and infrastructure in further and higher education, as well as in school settings, in order to influence the large percentage of the 16–19 and 18–21 age ranges in these institutions.

It is worth noting that the single biggest influence in activity participation figures in recent years, that of an increasing number of young women remaining active for longer, is linked to the increased number of females engaged in higher education. It is therefore appropriate to invest in facilities and programmes of activity in both further and higher education as a way of capturing more young people and encouraging them to become, and to remain, active.

CCPR is disappointed at the lack of focus on getting older people active, reflected in the White Paper. Current population demographics highlight the need to target older people as well as the young in activity programmes and initiatives. CCPR is working in collaboration with several other agencies to promote activity within older populations and to raise the profile of older people in public health policy debate. A formal coalition of organisations promoting Active Aging is due to be launched shortly.

3. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

CCPR believes that at present, there is a chronic lack of investment in infrastructure at local and regional level to facilitate sport and recreation organisations to link up with health networks. Some organisations in CCPR membership are already carrying out excellent work with local health partners to provide activity and sporting opportunities for local people. Much of this good practice happens because of the hard work of talented and committed sports workers, paid and unpaid, but exists in isolation and is vulnerable to personnel and funding alterations. We are concerned that much of this work will not be sustainable, nor will it be possible to mainstream many of the programmes, without infrastructure and capacity building. Similarly, those involving health promotion through physical activity require a communication and support network to help them consult with each other and share good practice.

The CCPR believes that the Government should prioritise the provision of resources to aid the development of this infrastructure.

January 2005

162 Not printed.
Memorandum by the Design Council (WP 89)

INTRODUCTION

The Design Council, a Non Departmental Public Body funded principally by DTI grant, works to enhance prosperity and well-being in the UK by demonstrating and promoting the vital role of design in a modern economy.

Through a series of three year Design Campaigns we encourage the more effective use of design expertise at a strategic level within the public sector and private organisations to enable innovation in their products, processes and services.

In addition, the Design Council’s RED unit uses a design-based approach to challenge accepted thinking on central social and economic problems. RED is currently examining health issues, and in particular how design processes might be applied to the prevention and management of chronic conditions.

Further information about the work of the Design Council and RED is available at www.designcouncil.org.uk and www.designcouncil.org.uk/red respectively.

SUMMARY OF POSITION

The nature of the health problem has changed from tackling infection and acute illness to the management of chronic conditions. The Government’s Public Health White Paper recognises this and sets out proposals for addressing it through a shift away from traditional models of health service delivery.

The Design Council strongly supports the agenda set out in the White Paper. In the work of the RED unit we are prototyping methods of delivering this agenda through the ‘co-creation’ of services—the active involvement of patients, healthcare professionals, community organisations and others in the design of new models of health management through the study of user needs.

SPECIFIC REMARKS

Wanless argued that the future of health care in an era of chronic disease, would turn on the “full engagement” of people in their own health care: “there are potentially large gains to be made by refocusing the health service towards the promotion of good health and the prevention of illness.”

The key issue he identified was the need to engage people in the responsible, collaborative maintenance of their own health and the recognition of this need informs the three underpinning principles of the White Paper’s new approach to public health—“informed choice”, “personalisation” and “working together”.

The Design Council has been approaching these issues in terms of a co-creation approach as set out in the RED Publication, Health: Co-creating Services (appendix A). Pilot projects are underway in Kent and Bolton.

This work suggests that adequate solutions to preventing the emergence of chronic conditions or managing them post emergence will have four key characteristics. They will need to mobilise resources, know-how, effort and expertise distributed across communities and households, rather than turning solely to professional expertise located within institutions. Distributed resources will be most effective when they can be used collaboratively to share ideas, provide mutual support and give voice to user needs.

Services will be co-created to address the particular needs and circumstances of individuals and communities. This requires interaction, participation and joint problem solving between users and professionals. Distributed, collaborative and co-created services will require radical organisational innovation on a scale that goes beyond current models of public service reform.

Co-created service models demand new types of interaction to take place between users, professionals, technology and infrastructure. Developing such responses will require social creativity, activating knowledge networks, resources and imagination across society not just within the public service professions and institutions. This, we argue, can be achieved by the effective use of design and the design process, and which we are prototyping in Kent and Bolton.

CONCLUSION

Effective responses to our public health problems must encourage new norms of behaviour within society, developing approaches in which those who use services become involved in their design and delivery.

Developing co-created services will necessarily be dependent on a set of key processes that support and enable the distribution of resources and knowledge, collaborative approaches and new interfaces between users and professionals across disciplines.

Communities of the kind we envisage are well developed in software and over the last decade the principles behind this highly collaborative approach have increasingly been applied to other fields including professional associations, knowledge networks and manufacturing. These open source style communities offer a promising organisational model for “communities of co-creation”.

The decentralised, networked responses we envisage will not emerge on their own accord. They will only come about through concerted reforms to create more distributed capacity, to provide spaces in which people can collaborate and devise co-created solutions.

We should be pleased to explore these themes further with the Committee.

January 2005

Memorandum by the National Obesity Forum (WP 90)

INTRODUCTION

The National Obesity Forum (NOF) is delighted and encouraged by recent activity and reports including the Health Select Committee report and the Public Health White Paper, surrounding the issue of obesity. The NOF believes that these documents are practical, well-directed and hard-hitting, and noted particularly that treatment of obesity, which we see as vital alongside preventative measures, is given full acknowledgement. However we believe that the reports will stand or fall based on the action which is now taken to implement them. The NOF is embarking on an ambitious initiative to set up a Nationwide network of Regional Obesity Groups to engage with and support PCTs and Primary Care in order to actively improve the management of obesity and its related disorders in the UK. In this brief submission the NOF would like to outline this scheme, and provide further details of current NOF activity. The NOF put a proposal to the Department of Health for funding of its Regional Obesity Group scheme six months ago, was promised a meeting, but has yet to be granted one. However the scheme presented below fulfills a large part of Recommendations 38, 39, 40, 41 and 42 of the Government Response to the Health Select Committee’s Report on Obesity.

REGIONAL OBESITY GROUPS

— During 2005, NOF will create a series of 18 Regional Obesity Groups to cover England, Scotland and Wales. This is intended to be in collaboration with Pharmacy groups, DOM-UK, Foundations, Move4Health, Nursing groups and others, and is currently in discussions with commercial slimming clinics with a view to possible partnership. Pilot groups have been created and are now running in the West Midlands and South-East England. In addition to acting as a focal point for information, education and advice on obesity, and being a first-contact point for Primary Care Professionals, PCT’s and media. The work of the groups is summarized by a five point plan:
  — The formation of Regional Obesity Groups comprising local motivated inspirational individuals, mirroring the NOF Executive Board—GP, nurse, pharmacist, dietitian, PCT lead, Secondary Care consultant.
  — A “scope-ing” exercise to map a provision of obesity management in each area. This is work in progress and includes elements such as current weight management clinics, individual examples of Best Practice in Primary Care, successful action against obesity at PCT and SHA level, specifically PCT strategies as well as commercial slimming clubs, exercise and activity schemes, availability of Dietitian services and other nutrition-based schemes eg supermarket store tours, school education schemes. The formation of a database of PCT and SHA activity around obesity.
  — Identifying and assessing gaps in the provision of obesity care; PCTs with no workable strategy or who need assistance in formulating one; GPs and nurses who are motivated but lack the skills to provide effective care or set up weight management clinics. There may be a large ethnic population in a particular area with no provision of care or awareness of the increased risk; or there may be inadequate provision of support for Breast-Feeding in a region.
  — To look within other parts of the region and within the network as a whole to find the solution of information required. This is likely to be that a PCT needs an effective strategy for obesity-management but does not have one, whereas a PCT in a different area would be willing to share information. A PCT may have a good strategy for obesity management but not have an adequate model of obesity management to suit its needs in a particular field. Help may be required to set up a weight management clinic in a practice or to supply a course to educate GPs and nurses on the effective care of obese patients.
  — To act to correct the deficiency in provision of care by supplying the necessary skills, resources or toolkit material to fulfill the needs identified above. To help PCTs formulate obesity management strategies or provide evidence based models of obesity management to them; to provide educational materials or courses; to make effective use of models already in existence, and to encourage collaboration between pharmacies, GPs and commercial clinics. We are in the final stages of creating a “toolkit” or template for PCTs for formulating an effective and
apprehensive, workable local obesity strategy, which will also include summaries of recent
Government reports, and the relevant sections of NSF’s, NICE appraisals, algorithms of
treatment, and a glossary/dictionary of Obesity for GP’s and patients to help them understand
different diets, food labeling etc.

— This five point plan fits within the range of additional NOF ambitions, which include the
establishment of an accredited Obesity Management course in association with DOM-UK, regular
Regional Obesity Conferences and involvement in the foundation of an “Obesity Institute” to act
as an over-arching body comprising all the major stakeholders in the fight against the current
obesity epidemic.

— Since its foundation four years ago, the National Obesity Forum (NOF) has aimed to increase
awareness of obesity as a medical condition, improve its management and highlight obesity as an
underlying factor in conditions such as Type II Diabetes and Coronary Heart Disease. The NOF
has had a significant effect on the management and prevention of obesity in the UK by providing
education, guidelines and support to Primary and Secondary Care in many and varied forms as
well as raising the profile of obesity and related conditions to Government, opinion-formers,
media and the general public.

— The NOF is delighted to read that the GMS contract is likely to include obesity to a greater extent
after its first re-draft. We are currently in consultation with the architects of the contract, as we feel
our input as full-time primary care professionals with expertise in obesity and related conditions is
essential to this process.

— The NOF is well-placed to take positive, rapid and effective action to influence the medical
profession and general public by improving the provision of care within Primary and Secondary
Care.

— The NOF is already undertaking specific projects to improve individual health. Examples include
the “Men’s Weight Project” in collaboration with the Men’s Health Forum to assess and manage
weight and subsequent health problems by intervention in the workplace; and with Foundations
Charity to improve nutrition and lifestyle education in schools to prevent both obesity and eating
disorders.

NOF VIEWS

— NOF considers there are two equally important aspects of obesity management—prevention and
treatment. If preventative measures to tackle obesity are successful, within 10 years we will still see
an epidemic of Type II diabetes. Within another four years this will be followed by an epidemic
of heart disease as co-morbidities become clinically evident in chronically obese people; followed
by early death.

— This is why the NOF believes that the treatment of obesity should be supported by the Department
of Health, and why the NOF is in a position to act as a vehicle with collaboration from other
organisations, to take immediate action.

January 2005

Memorandum by the Disability Rights Commission (WP 91)

1. BACKGROUND

1.1 The Disability Rights Commission was created by the Disability Rights Commission Act 1999
(DRCA). Section II of the DRCA imposes the following duties on the Commission:

— To work towards the elimination of discrimination against disabled persons;
— To promote the equalisation of opportunities for disabled persons;
— To take such steps as is considered appropriate with a view to encouraging good practice in the
treatment of disabled persons;
— To keep under review the workings of the Disability Discrimination Act (DDA) 1995 and this Act.

1.2 The Commission’s goal is a society in which all disabled people can participate fully as equal citizens.

2. RESPONSE

Summary

2.1 The DRC welcomes the Government’s commitment to tackling health inequalities and the focus set
out in the White Paper Choosing Health on removing the barriers to effective health care choice and access
for all.
2.2 We urge the Government to build on its current programme and make reducing the inequality gaps in health access and increasing healthy living options for disabled people one of the centrepieces of future health policy and part of a joined-up strategy across all Government departments.

2.3 Providing high quality health services to disabled people can also play a crucial role in supporting them in other areas of their lives, like helping them to stay in work and participate in family life and other activities. It is important to relate to the person in the context of their whole life and to enable them to participate in society—not to focus on treatment alone.

2.4 For our part the DRC has made the achievement of greater equality in health outcomes and choice one of our four strategic priorities for 2004–07. We aim to achieve this by promoting and implementing new rights under the DDA effectively, by using our enforcement powers as a catalyst for change, by strengthening the rights framework in health where evidence suggests policy gaps or weaknesses and by building major partnerships with the NHS and its regulatory bodies.

3. Whether the proposals will enable the Government to achieve its public health goals?

3.1 The DRC welcomes the government’s broad commitment to tackling health inequalities. We also welcome that the white paper acknowledges there is a need to “step up action” on tackling the causes of ill health and health inequalities.

3.2. However we remain concerned that opportunities for good health are not shared equally by all people. Evidence points to the fact that disabled people have higher mortality rates (ie die earlier) than the overall population—not always for reasons related to their impairment. Some deaths are preventable illnesses. Disabled people have unequal access to health screening, treatment and assessment and—as a result—are more likely to die young from preventable “killer” diseases like coronary heart disease.

3.3 For example, one piece of research has shown that people with learning disabilities risk of dying before the age of 50 is 58 times greater than the general UK average. Another found that people who are psychiatric outpatients are nearly twice as likely to die as the general population.

3.4 Disabled people—people with physical, sensory, learning or psychiatric impairments or other long-term health conditions—make up about 22% of all adults and a far higher proportion of primary care service users. Therefore making disability equality central to the health service is essential to meeting national priorities. It is not possible to improve the overall quality of care and support, to deliver on patient choice or to meet service standards without meeting the needs of disabled people. Disabled people are a “target group” on which local action needs to be focused in order to make progress against targets to reduce health inequalities.

4. Whether the proposals are appropriate, will be effective and whether they represent value for money?

Appropriateness

4.1 The DRC welcomes the Government’s outline proposals laid out in the white paper Choosing Health to support people in disadvantaged groups to make informed and healthy choices and take control of better access to healthier choices.

4.2 Offering disabled people access to a health check and support on making healthier choices from a health trainer is a positive step in the right direction but further concerted action is required to close the gap in health outcomes between disabled and non-disabled people.

4.3 We look forward to seeing more detailed proposals on the government’s plans to equip people with the skills to look after their own health and provide individuals with appropriate local support and services to do this.

Effectiveness

4.4 For the DRC, the provision of health and social care are not ends in themselves. They should be seen as a means of enabling disabled people to enjoy the same opportunities for participation as any other citizen could reasonably expect. If we want disabled people to be full and equal citizens this requires individuals ultimately to carry the same responsibilities and rights as others. However this has to be accompanied by the right to whatever support or additional requirements needed to enable such responsibilities to be met.

163 For more evidence on inequalities in health outcomes for disabled people see the Background evidence paper for the DRC’s formal investigation into health inequalities experience by people with learning disabilities or mental health problems, available online at http://www.drc.org.uk/newsroom/healthinvestigation.asp, accessed January 2005.


165 Harris EC, Barracough B. “Excess Mortality of Mental Disorder”. British Journal of Psychiatry 1998; 173; 11–53.
4.5 It is important that debates about extending choice, rights and responsibilities are not defined in ways that disadvantage disabled people, but rather that disabled people are enabled to secure their rights and take on responsibilities as active citizens. Ensuring disabled people have “equal opportunity” to exercise choice and access health services or health promotional activities requires change at national, community and individual levels.

4.6 Health and health promotional services and activities need to be accessible to all, including people with mobility, sensory or mental health impairments. Service providers need to ensure that disabled people have fair access to services and that disabled people are consulted when services are being developed.

4.7 People cannot take a more active role in maintaining their own health unless they have access to information and other resources they need to make informed choices. Access to information is essential to enabling disabled people to exercise choice about their health. Equally important are how information is communicated and processed and—where applicable—the availability of advocacy to enable self-directed decision making.

Wider benefits of participation

4.8 There is a link between poverty and poorer health outcomes, and disabled people make up a disproportionate percentage of those who live on Social Security benefits. Providing high quality healthcare services to disabled people is crucial in supporting them in other areas of their lives, like helping them to stay in work and participate in family life and other activities. This in turn helps to support a healthier and fitter population.

4.9 In reality, disabled people are customers, workers, students, parents, taxpayers and voters, and community members. The purpose of any form of support should, therefore, be to enable people to overcome the practical barriers they face to participating in all of these roles and activities. By meeting the health and social care needs of disabled people appropriately, and gearing services to their rights to choice, independence and inclusion, disabled people can have improved opportunities to participate in employment, public life and service delivery. Increased participation not only benefits disabled people themselves but also produces economic benefits to governments, businesses and communities.

4.10 Improving services for disabled people can also bring about improvements in services for all service users. Disabled users may have impairments which can make it particularly difficult for them to exercise choice and access appropriate services—and if services can be responsive to their needs and wishes, then they will also be responsive to people who face less significant obstacles. For example, providing information in ways that are accessible to people with learning disabilities may also help people whose first language is not English; and improving physical access for wheelchair users can help parents with pushchairs,

Wider benefits of participation

5. Whether the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

5.1 We remain concerned that despite compelling evidence of inequalities in health outcomes between disabled and non disabled people, government policy to date has concentrated on health inequalities due to geographic area, deprivation level and ethnicity.

5.2 The DRC believes specific measures are required to address health inequalities experienced by disabled people. Differences in how disabled people access and experience health services need to be fully understood and systematic action taken to close the gap in health outcomes between disabled and non-disabled people.

5.3 On our part the DRC has decided to use its powers of formal investigation to instigate a comprehensive inquiry into physical health inequalities experienced by people with long term mental health problems and people with learning difficulties. Launched in December 2004 the formal investigation will run for 18 months. The investigation will look at both health inequalities and potential solutions with the aim of proposing practical solutions to tackle inequality that can be taken forward at primary care level. The work will include recommendations for national policy and implementation.

5.4 The DRC is committed to working in partnership with the Government to ensure that Disabled people are able to routinely access the full range of health and health promotion services with the same ease as anyone else. Over the past 12 months the partnership framework between the Commission and the Department of Health has started to deliver a number of tangible products that will help raise awareness about disability equality among staff in the health service and equip them to make real changes on the ground.

5.5 The new Public Sector Duty (PSD) to promote equality for disabled people offers a real opportunity for local authorities to provide a strong lead on disability equality and to help drive forward a culture change across the public sector. The PSD will require all public bodies to produce action plans to tackle discrimination and improve outcomes and to monitor the impact on the lives of disabled people.

For more information on making health services accessible for disabled people see the DRC/DH You can make a difference leaflets Available online at http://www.dh.gov.uk/assetRoot/04/08/92/84/04089284.pdf
5.6 Mainstreaming disability equality and anti-discriminatory practice into national standards for health and social services is a key means of transforming services. The DRC looks forward to working with partner organisations the Healthcare Commission and the Commission for Social care Inspection to develop a framework of standards that better support and promote participation and independent living.

6. CONCLUSION AND RECOMMENDATIONS

6.1 While we welcome proposals to offer disabled people support to make healthier choices we urge the Government to:

— Develop demonstrable leadership on the issue of disability equality.
— Develop PSA (Public Services Agreements) targets to reduce health inequalities experienced by disabled, as compared to non-disabled, people.

6.2 The agreed compact between the DRC and the Department of Health and planned partnerships with inspection and health promotion agencies offer major opportunities for strategic change in key areas such as promoting inclusion and equality, tackling access and communication barriers for disabled people and through greater representation of disabled people in NHS employment changing attitudes and approaches on the ground.

6.3 Disabled people being able to routinely access the full range of health services with the same ease as anyone else isn’t just a matter of equity. It makes a real difference to people’s chances of living happy and healthy lives and, in many cases, to how long they will live.

February 2005

Memorandum by UK Vaccine Industry Group (WP 92)

Vaccines and their use in national immunisation programmes continue to rank among the most important contributions to public health in the UK. Indeed the World Health Organisation has commented recently that vaccination is as good at delivering benefits in public health as providing clean drinking water. The previously immense burden of morbidity and mortality associated with “common” childhood diseases such as diphtheria and pertussis is now rare. Further opportunity to reduce the impact of infectious diseases through prevention is still present. Taking preventative measures when managing public health has benefits for the individual, the population as a whole, and for the NHS through efficient use of health care resources.

With reference through the White Paper to the health promoting NHS, local communities leading on health, and health as a way of life it is disappointing to read little or no reference to vaccines and vaccination policy. Further more, given the emphasis on “Choosing Health” it seems peculiar to overlook an area where individual can choose to prevent ill health by vaccination.

The UK Vaccine Industry Group (UVIG) believes that by extending the use of existing vaccines, planning thoroughly for the introduction of new vaccines, targeting previously unmanageable infectious diseases (such as meningitis B, Human Papilloma virus and rotavirus), and undertaking effective dialogue with stakeholders, more can be achieved as part of an overall programme to fight infectious disease.

If vaccination policy with clear plans should be in place to maximise the benefits of vaccination to decrease the health burden as a direct result of infectious diseases.

Immediate opportunities to bring about further improvements in public health via vaccines and vaccination policy present themselves by lowering the age to 55s and over for flu; offering flu vaccine for children; investing to improve uptake of vaccines such as hepatitis B in at risk groups; and preparing the way for the introduction of new vaccines such as those against the human papilloma virus which is known to be linked to cervical cancer.

The development and implementation of vaccination policies and the resultant success, is driven by a number of important factors—surveillance of disease, monitoring of uptake of vaccines, targeting of vaccines to specific population groups, structures and processes in the NHS to deliver policy and the support of individuals and communities.

Effective implementation of all vaccination policy should be promoted at a local level, including those policy recommendations that are supported nationally such as childhood and influenza vaccination. This should include policy recommendations targeted to the population included clinical risk groups.

Despite the introduction of disease registers the NHS struggles to target effectively groups by criteria other than age. Reports from the Department of Health on the 2004 influenza programme have indicated as much and evidence is available in other areas such as hepatitis B and pneumococcal. Whilst, it has now become a cliché, people at risk from certain infectious diseases are subject to a postcode lottery.

Other factors add to the challenge faced by local health care providers—competition with other health priorities for health resources at a national and local level. Parents and people have a greater access to information through the internet and the media as a rule report negatively in vaccination the Government
should be providing health care professionals, who are responsible for delivering policy, with continuing education about vaccines and vaccination. This would equip them to implement policy, to promote vaccination as a safe and effective means to prevent ill health, and to answer questions posed by patients on all aspects of vaccination.

Vaccines are niched within public health with little recognition as part of the wider health agenda. Vaccines and implementation of vaccination policy do not enjoy the priority that their benefits to public health would otherwise suggest. Clinical and NHS structural priorities focus on disease management in the main, with prevention being targeted at heart disease, cancer and obesity rather than infectious disease. Greater recognition of the benefits of vaccines is needed raising awareness, restoring public confidence and supporting public health.

There was the opportunity with the White Paper to send a clear signal to the public and the NHS of the benefits of vaccination and underline the critical role vaccines have as part of the wider public health agenda.

Timely to this enquiry is the recent announcement by the WHO that a pandemic influenza episode is likely to be sooner than perhaps originally thought. On average pandemics occur every 25 years, and although Europe has not seen a pandemic year in over 30 years (1968) experts believe that a future pandemic is inevitable and may be imminent.

In a usual non-pandemic year, death rates from influenza infection or its complication average 3,000–4,000. In epidemic years such as 1993 the death rate reached 13,000 and in 1989–90 some 29,000 deaths were attributed to influenza infection. The death rate in an individual pandemic year is hard to predict, but it will be significantly greater than in inter-pandemic years. Of critical importance, however, is that without adequate preparation and timely access to large volumes of an effective vaccine, the effect of pandemic will be significant. The UK and fellow European member states must be ready to implement a programme of prevention and treatments that will limit the inevitable death toll. This planning must include investment to ensure adequate supply of vaccine, but most also prepare the NHS and associated bodies to be able to deliver a mass vaccination programme on a grand scale. The use of influenza vaccination as part of a national policy is proven to be a cost effective intervention for either a targeted or a more mass vaccination approach.

The UK has enjoyed a reputation of having one of the most effective vaccination programmes to manage infectious disease—high coverage rates with low incidence of diseases and associated morbidity such as congenital rubella syndrome being a distant memory. If new policies fail to address issues of implementation, investment in new vaccines, greater use of licensed vaccines and communication, the UK may lose its status as a leader in public health. The challenge for the Government is to take vaccination strategy as part of public health on to the next level. Working with stakeholders, including companies that research, develop and manufacture vaccines, to develop a comprehensive plan with clear goals, responsibilities and timelines for delivery.

UVIG would welcome more dialogue on these matters and is prepared to work openly and transparently with Government, the Department of Health and other public health agencies.

About UVIG

UVIG, working within the Association of the British Pharmaceutical Industry (ABPI), represents the six pharmaceutical companies that research, manufacture and supply vaccines to the UK—Baxter Healthcare, Chiron Evans Vaccines, GlaxoSmithKline, Sanofi Pasteur MSD, Solvay Healthcare and Wyeth Vaccines. UVIG aims to promote the positive benefits of vaccination as a key element in public health, and to represent the UK vaccine industry to all interested parties.

February 2005

Memorandum by the Infant and Dietetic Foods Association (WP 93)

1. The Infant and Dietetic Foods Association (IDFA) solely represents manufacturers of infant and dietetic foods. These specialist nutrition products are different from normal foods because of their composition or method of manufacture. They include infant foods (baby milks and weaning foods) for normal healthy babies, as well as foods for adults and infants who have special dietary needs, such as medical foods, slimming foods and sports foods.

2. This submission examines the specific issue of infant nutrition, the manner in which it appears within the Government White Paper, and seeks to address the subject in line with the terms of the Committee’s inquiry.

3. There are a number of issues we choose to address and will seek to assess whether they each achieve their goal; are appropriate and effective; represent value for money and whether the infrastructure and mechanisms are there to ensure their delivery. We focus on the overall theme of choice and specifically its
application in the area of infant nutrition; the introduction of the Healthy Start scheme; and the prospect of further restrictions on our members' ability to inform the public and healthcare professionals regarding their products.

4. The Government’s White Paper “Choosing Health” (p 6) states that the Government intends to make it easier for all to make healthier choices in our lives. The Government correctly seeks to protect infants and young children from poor choices by better education of their parents or guardians.

5. IDFA believes that reliable communication which results in clear education and generates easily retained information is clearly the best way forward. All would agree that infants, amongst the most vulnerable in all societies, need special protection and that this is best provided by well-informed adults. These adults need to be secure in the knowledge that they have made the right choices supported by sound, up-to-date, appropriate scientific advice.

6. IDFA shares the Government view that breastfeeding is the best form of infant nutrition.

7. However, we need to equally support both those mothers who choose to breastfeed and also those who cannot or choose not to breastfeed. It is important to support all mothers equally feeding infants in society. Good, sound, factual information should be given to enable safe practices to develop and good health sustained. Unbalanced and negative portrayal of the only safe and healthy alternative choice is harmful to mothers resulting in feelings of marginalisation.

8. The Government seeks to inform pregnant women and new mothers and protect the most vulnerable infants through the introduction of the “Healthy Start” scheme, which will replace the Welfare Food Scheme later this year (p 53 Choosing Health).

9. IDFA wholeheartedly welcomes this advance and hopes that the benefits of the old scheme will not be lost whilst the additional benefits of the new scheme are pursued. By this we mean protecting the good nutritional state of both the infant and mother.

10. For example, the Government has concentrated on the laudable benefit of pregnant women and new mothers getting fresh fruit and vegetables in addition to the provision of fresh milk or infant formula. We believe this to be a very important step in educating pregnant women and new mothers regarding healthy eating, but we would draw the Committee’s attention to the ultimate goal being the improvement in infant health through the appropriate use of breast milk, infant formula and follow on formula.

11. Appropriate, reliable information for pregnant women and new mothers is necessary if we are to delay the introduction of cow’s milk into infant diets until 12 months of age. Inappropriate use of cow’s milk as a main milk drink for nine month-old infants has declined, from 88% in 1985, 76% in 1990, 61% in 1995 and dropped to 54% in 2000, since follow-on formulas were introduced; showing that these formulas have actually educated mothers not to introduce cow’s milk too early. It is essential that this trend continues if infants are to receive appropriate nutrition.

12. The Government has already done a great deal to make parenting easier with its welcome change to maternity leave and the Sure Start service. It needs to be sure that the Healthy Start scheme will enhance these achievements and it is to be hoped that the delays in bringing this scheme into operation have given the Department of Health time to think about the difficulties of implementing the new scheme and re-educating a vulnerable community, given the time pressures already facing midwives and health visitors in particular.

13. The IDFA remains willing to give time, expertise and resources to bring about a smooth and effective transition from the Welfare Food Scheme into Healthy Start. We firmly believe that working with officials, charities and, most importantly, health care professionals, is the best way to bring about sustainable change. We hope that externally monitored piloting of the scheme will ensure that any doubts about it’s efficacy are laid to rest. We cannot comment on its value for money as the only comment made by Government on this matter has been that it will cost the same as its predecessor. At this stage it is probably still too early to determine that.

14. In terms of infrastructure and mechanisms, we believe there is still some way to go towards delivering the new Healthy Start Scheme and would like see more effort expended in bringing about cost-effective change involving all stakeholders. For the scheme to be truly effective it has to be fully supported and properly understood and we hope for co-operation with the Department as it seeks to deliver these aims.

15. The Government states that “Infant formula will no longer be available from healthcare premises, which will reduce its promotion in the NHS” (p 53 Choosing Health). We believe that this should cause all interested parties to consider very carefully what advice, information and education is available in these new circumstances and how this will improve choice. We would argue that this reinforces the case for appropriate information to be provided to the public and to health care professionals about infant and follow-on formula.

16. However, Government concludes that it is seeking “to further restrict the advertisement of infant formula” (p 53 Choosing Health). The infant formula industry does not advertise infant formula direct to the consumers abiding by the 1995 Infant and Follow on Formula Regulations. We believe that further
restriction would not serve to achieve any Government goal, would not serve better to inform any section of society, would be detrimental to the overall desire to deliver informed choice and would be unfair to our members as they seek responsibly to inform parents.

17. A better means of ensuring clear, informed choice would be for Government and industry to work together to ensure that advertising of follow-on formula reinforces the messages which the Government is also trying to promote. This would achieve the goal of a better informed population and represent better value for money delivered through existing mechanisms.

18. In addition the 1995 Regulations allow the infant formula industry to communicate factual, scientific information regarding their products to healthcare professionals. If this facility to communicate were lost it would be difficult to keep healthcare professionals abreast of new advances in this rapidly advancing area.

19. This ultimate goal, of a population better informed about the health choices we make for ourselves and for others, is one we can all support. However, our experience suggest that true “joined-up” thinking in Government is necessary if real benefits are to be built upon rather than lost in the search for new ideas.

20. We have attempted to keep our views concise and self-contained as requested but are naturally available to expand upon them should the Committee require any further information.

Memorandum by the Academy of Medical Sciences (WP 94)

The Academy of Medical Sciences welcomes the opportunity to respond to the House of Commons Health Committee inquiry into the Government’s Public Health White Paper.

INTRODUCTION

The “Choosing Health” White Paper is an important step forward as it draws attention to the significance of public health and the prevention and treatment of disease. The Academy strongly supports the Government’s action in making the promotion of public health a national priority.

CHOICE

At the heart of the White Paper lies a philosophical tension about the balance that should be struck between state intervention and individual freedom. Such confusing messages are likely to undermine the implementation of a long-awaited UK public health strategy.

Despite its opaque philosophical foundations, informed choice is one of the core principles underpinning the new public health strategy. The White Paper proposes that Government should provide information to the public so that individuals will choose healthy practices such as taking regular exercise or avoiding smoking. However, whilst “choice” is ultimately down to personal decisions, these decisions are very much affected by the environments in which people live and work. Knowledge and commitment are needed to adopt a lifestyle that differs from most of the rest of the population. For example, people in the UK have little or no control over three quarters of their salt intake as it is added during food manufacture. To avoid salt, people would have to prepare their own meals and snacks from raw ingredients. This is inconvenient and time consuming. It tends to be the richer minority who more readily make such changes but this, in turn, only serves to widen health inequalities.

Where matters of infectious disease are concerned, an issue the White Paper considers primarily in terms of sexual health, individuals often are less able than governments to make choices.

The Academy is concerned that the White Paper moves the burden of responsibility too much toward individuals who may wish to adopt healthier lifestyles but cannot easily do so.

COLLECTIVE CHOICE

More can often be achieved through collective action than at an individual level. This should be a foundation of UK public health policy. Indeed most public health action is “hidden” in the sense that members of the public are often unaware of its existence: for example, legislation covering clean air, water, safety of buildings, transport, electrical appliances.

Many of the issues raised in the second Wanless Report, such as fragmented public health structures and the need to assess rigorously the effectiveness of public health initiatives, are not fully addressed in the White Paper. Wanless recommends a more coherent approach, recognizing the constraints on individual behaviour and suggests that more can be achieved through collective action than at an individual level. The Academy of Medical Sciences report “Calling Time” provides an example, in the case of alcohol, of how collective choice could control alcohol consumption and thus minimise alcohol-related harm.

Governments are vulnerable to the accusation that population level policy measures will promote a “nanny state”, with individual responsibility removed. This unfounded criticism obscures the all-important need for comprehensive public health programmes. The Academy believes that it is perfectly possible to implement a public health programme that reflects a “caring” state while preserving legitimate individual choices and freedoms. In most cases there is no tension between the interests of the community and the individual.

EVIDENCE-BASED PUBLIC HEALTH POLICY

Public health policy should be evidence-based. The relative gain, probability of success, and cost-effectiveness of public health policies need to be considered before implementation. For example, persuasive local initiatives like SureStart tend to be expensive and have not been properly evaluated. On the other hand the value and safety of fortifying flour with folic acid to prevent the serious birth defect spina bifida has been demonstrated. Sufficient political will is now required to implement this public health measure, as has been done in the USA, Canada and in over 30 other countries.

Academic institutions and researchers are currently under-utilised by policy makers and the contribution made by experts is not always valued. Despite the UK’s status as a world leader in public health research, there is an acute shortfall of clinical academics specialising in public health. It is important to develop academic capacity in public health so that research can be better converted into policy and practice. Additionally, the Research Assessment Exercise should value appropriately the work of researchers who focus on topics relevant to health policy. The gaps between researchers, service providers and policy-makers also need to be bridged.

Despite pressure for “quick fix” solutions, public health policy should be based upon rigorous research. Some of the examples of initiatives given in the White Paper are of unproven effectiveness and there are good reasons to believe that many will have little impact on health because they do not address the underlying constraints to healthy behaviour. For example, giving out pedometers may have little impact on exercise patterns if people do not feel safe walking or cycling or the weather is cold and wet. These proposed actions require rigorous evaluation before they can be endorsed.

JOINED-UP PUBLIC HEALTH

The various public health policies set out in the White Paper do not fit together to form a comprehensive strategy. Instead they provide piecemeal solutions of unproven cost-effectiveness.

Given the appointment of a Minister for Public Health and the public health issues raised in the Chief Medical Officer’s annual reports, it is surprising that the White Paper does not mention new structural developments within the Department of Health to augment its public health work or set out structures/mechanisms for interaction with other public health stakeholders. Since many of the determinants of health such as education, housing and transport are beyond the traditional remit of the Department of Health, or the Primary Care Trusts that have new public health responsibilities, it is clear that any public health strategy needs to cut across Government.

Public health has many facets, creating a complexity that can lead to lack of focus and inactivity. However, the main determinants of disease, diet, smoking and infection can be, and have been, examined in detail quantitatively. These provide compelling evidence that can, and should, drive public health policy. No one could argue that the prevention of BSE is a matter of individual choice. It requires decisive and effective central action. Similarly the prevention of lung cancer, stroke, cardiovascular disease, diabetes, all of which depend to some degree upon personal choice, also require central action so that the requisite facilities and services are available to address them.

174 For further details link to: http://www.surestart.gov.uk/
177 For further details link to: http://www.dh.gov.uk/AboutUs/HeadsOfProfession/ChiefMedicalOfficer/fs/en
CONCLUSION

The Academy would like to emphasise that clinical medicine and public health are complementary not competitive, representing different points along a continuum from individual-centred interventions to population-wide strategies.

The Academy welcomes the contribution the White Paper makes in highlighting the importance of public health but is concerned that its emphasis on individual choice is misplaced. Over the coming months the Academy will develop a detailed vision of public health from a medical academic perspective based upon the issues raised in this response.

February 2005

Memorandum by Asthma UK (WP 95)

Asthma UK is the charity dedicated to improving the health and well-being of the 5.2 million people in the UK who have asthma. To achieve this we work with people with asthma, healthcare professionals and researchers to develop and share expertise to help people to increase their understanding and reduce the effect of asthma on their lives. Our work includes the funding of demonstration projects, research programmes, fellowships and professorships and the provision of services including a nurse specialist Adviceline and our PEAK holidays for children with asthma.

Will the proposals enable the Government to achieve its Public Health goals?

1. Asthma UK welcome the public health White Paper, in particular, we are pleased that the Government published a document that is wide ranging. The action outlined to protect against obesity is also a welcome development for asthma—obesity and poor asthma control reinforce each other. The poorer a child’s control of their asthma the poorer their access to exercise. The less they exercise the harder it becomes to achieve good asthma control—there are 1.1 million children with asthma in the UK. The Government states in the White Paper that halting the growth in childhood obesity is their prime objective and have rightly identified the need for children to exercise regularly and have set a target of 75% of children spending at least two hours every week on sports and exercise either inside or outside the curriculum.

2. In order for the Government to be able to meet its targets on public health we strongly believe that it should consider the impact that asthma has on the ability of our children to be physically active. Asthma is the most common long-term condition in children, with approximately one child in 10 currently being treated for doctor-diagnosed asthma. Consequently, the impact asthma has in schools forms a large part of our work and we have produced our own “schools asthma pack” that gives information for schools, on how to best deal with asthma issues in schools, including physical exercise.

3. The strengthening of school nursing services is also welcome—it would make sense to strengthen the role of the school nurse beyond the proposals for diet and sexual health proposed to encompass training in the management of long-term conditions in schools. Although asthma is by some way the most common of these conditions, research we conducted on behalf of the Department of Health in 2003 leads us to believe such work would be welcomed by the parents of children with a wide range of long-term conditions.

4. There is some evidence that smoking prevalence among people with asthma may be higher than among the population and that is the subject of great concern. Our own data, as yet unpublished, identifies a significant link between smoking and poor asthma outcomes. The British Guideline on the Management of Asthma observes that “no studies were identified that directly related to the question of whether smoking affects asthma severity” yet goes on to recommend “Smoking cessation should be encouraged as it is good for general health and may decrease asthma severity”. Research funded by Asthma UK and carried out by Glasgow University found that smoking interacts with corticosteroids (one of the most effective anti-inflammatory therapies for chronic asthma) to undermine the effectiveness of the drug.

5. Smoking does not only worsen the symptoms of asthma and undermine the effectiveness of asthma medication; there is growing evidence that smoking is a primary cause of asthma in adults and young people. Additionally, of course, there is strong evidence that exposure to second-hand smoke at work and at home also causes asthma.

178 British guideline on the management of asthma, Thorax 2003;58; Supp 1.
6. Asthma UK is concerned that the White Paper was unable to give more attention to the impact of outdoor air pollution on the public health. This is an issue of special concern to people with asthma and their families. As we said in our initial consultation response, air pollution and specifically traffic pollution is a concern for people with asthma and that is why it is a concern for Asthma UK. A National Asthma Panel survey found that almost half of people with asthma strongly agree that traffic fumes make their asthma worse.

7. Many report that pollution aggravates their isolation, restricts their access to exercise and even makes them more likely to travel by car. 42% report that traffic fumes stop them walking or shopping in congested areas occasionally, sometimes or often, one in four say fumes discourage them from cycling and 39% are discouraged from exercise. There is also a strong sense among people with asthma that the Government has been too slow to act.

Are the proposals appropriate, will they be effective and do they represent value for money?

Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

8. Our greatest area of concern refers to the provisions for protecting people from second-hand smoke at work and in public places. Occupational Asthma is the most common occupational respiratory disease in the UK and occupational exposure to second-hand smoke has been demonstrated to double the risk of the onset of asthma. In terms of health and safety at work the rationale to protect bar staff only where food is served seems unfair—the SCOTCH report states that “some groups, for example bar staff, are heavily exposed at their place of work”. We don’t agree that working in a pub that does not sell food should exclude staff from the protection against second-hand smoke. We note that the proposals will prohibit smoking in the “bar area” but this cannot provide adequate protection for employees or members of the public. Smoke cannot be confined to one area of a pub and ventilation systems are expensive and ineffective. The impact of this must surely be to aggravate inequalities in health by giving most protection in venues attracting higher socio-economic groups and least in those venues that are most common in area of greater social deprivation.

9. We are pleased to see in the White Paper, the Government acknowledge that asthma attacks are linked to inhalation of second-hand smoke. Often, it really is the case that a small amount of second-hand smoke can trigger an instant attack that could prove fatal. For the 3.5 million adults with asthma in England the Government’s proposals are potentially, a major concern. Our research suggests that 40% already find that they are discouraged from accessing smoky pubs and restaurants and, while the proposals mark a very great step forward in this regard, they leave open the question of an action under the Disability Discrimination Act (DDA). Such an action would apply only pub by pub and so would add to the confusion among publicans and their customers while affording protection only to those who are able to seek redress under the law. The proposed exemptions will add an unnecessary burden on business and local enforcement bodies—comprehensive protection would be fairer, simpler, and more effective.

10. The assertion since the publication of the White Paper that comprehensive action on smoke-free public places might result in a displacement of smoking from public places to the home is contrary to the available evidence. The consistent evidence on smoke-free workplaces shows the reverse; people whose workplace goes smoke-free are in fact more likely to quit or to smoke less at home. Exposure to second-hand smoke at work doubles the chance of an adult developing asthma.

RECOMMENDATIONS

In order for the Government to be able to meet its targets on public health we strongly believe that it should consider the impact that asthma has on the ability of our children to be physically active.

We urge the Government to reconsider its plans on smoke-free public places and to follow the example set by Ireland, Scotland and other countries in Europe.

The Government should make a commitment to introduce legislation to prohibit smoking in all places of work in England in the next Queen’s Speech.

January 2005

183 The Health & Safety Executive estimate between 3,000 and 5,000 new cases of Occupational Asthma per year.
Memorandum by the Child Growth Foundation (WP 96)

1. Will the White Paper’s proposals enable the Government to achieve its public health goals?

1a. In a word, it’s “questionable” as far as far as childhood obesity is concerned. We still do not know exactly how HMG plans to combat the epidemic. Despite very publicly setting itself the Public Service Agreement [PSA] target of halting the year-on-year rise of obesity among children under-11 by 2010, HMG tells us still to await a Delivery Plan before finally (?) discovering how the PSA is planned to be delivered [p 178]. Unless the Committee has a draft preview copy of the document or is scheduling its Inquiry until a date after the Plan is expected to be published [9 March] it may be in no better position to comment on the strategy than we. One certainty remains, however, and that with 2010 now less than five years away, the strategy will have to be dramatic.

1b. It is true that the White Paper does have firm proposals—ie the increase in school nurses—but when the all nurses are not anticipated to be in post until 2010, we wonder how HMG thinks halting the rise to be possible. It will be increasingly impossible if HMG waits for NICE to publish its advice on the identification, prevention and management of obesity in 2007. Another two years will have been squandered confronting the problem with only three years remaining to clear up the mess.

1c. Identification of obesity could actually start to-morrow in the age range that really matters—birth/four years. Tackling the likelihood of obesity in pre-schoolers—where opportunities for successful intervention and prevention are considerably higher than in primary school—should be the real target to be addressed. At this age there is a veritable army of health visitors, nursery nurses, practice nurses etc to nip the first signs of unhealthy weight gain in the bud. The Chief Medical Officer for England [CMO] identified these health care professionals by name when he recommended the action they should take in his 2002 Annual Report but, by virtue of staging an average of two growth/obesity training courses per week throughout the country, the Foundation knows that virtually nothing has been done to implement the CMO’s wishes. Indeed, when he recommends that Public Health Observatories also produce regular public reports audit progress, the White Paper appears to condone the PHOs’ inaction by not anticipating any reports until 2006!

1d. Tragically, we believe that HMG may actually have damaged the chances of ultimately winning the fight against childhood obesity by setting such a ludicrous 2010 target date. Though there must be political reasons for it having done so, the likely result of failure to achieve anything comprehensive by that date will be that everyone gets “switched off” and the epidemic will continue inexorably to increase with it off a priority list. The Foundation believes that HMG should have had 20/20 vision—opting to halve the childhood obesity rise by 2010 and then halting it by 2020. This is no less than its approach to eradicating poverty and is an approach which has a better chance of success.

2. Will the proposals be appropriate, effective and represent value for money?

2a. Hopefully they will be all of these but this can only be conjecture at this stage. If a lot of the promises listed in CHOOSING HEALTH are implemented with vigour and common sense, the Foundation believes that they could have substantial long-term pay-offs.

2b. For instance, we believe that if the Delivery Plan confirms that HMG has accepted the Committee’s recommendation for an annual BMI measurement in [primary] schools the outcome could be invaluable. Though CHOOSING HEALTH does not specifically state that it has [see p 86], a workshop on BMI that met in London before Christmas heard that the DH/DfES were actively talking about it. For the first time, therefore, Directors of Public Health will have yearly prevalence data on which to base their health/environmental planning initiatives to curb obesity at local, regional and national level but also a rolling audit to quantify how they are working out. In addition, the yearly screen should identify the early signs of overweight/obesity developing in primary school since one cannot be certain that its roots of obesity are put down pre-school. A third attribute to a yearly BMI screen is that children who have a more traditional endocrine [growth] abnormality may also be picked up sooner: the UK does not have an enviable record for the early detection of such problems.

2c. What the Delivery Plan must do is state who is taking the measurements and, if it is teachers, who will train them and equip them to do a proper “medical” job **. Given that they are trained and properly kitted out the Foundation would welcome teachers being given the job since yearly measurements also have considerable “educational” advantages. Growth projects [ie studying how little flowers and bunny rabbits etc grow] take place annually in every UK primary school: what could be more natural therefore when working up to National Curriculum Key Stages 1 and 2 maths and science attainment standards than to handle dynamic growth data from the pupils themselves?

— The weighing equipment used will have to conform to the EEC Directive regulating weighing for medical purposes. This is not as straightforward as it would seem . . .

2d. Measurement by teaching staff is the only solution since, in its First Inquiry, the Committee was hoodwinked by the Minister of Public Health into believing that there were enough medical staff to do it [Vol 1 p99 and see copy of letter to your Committee, 9 June 2004]. School nurses cannot even complete the...
single school entry growth screen recommended by *Health for All Children* and the CMO’s National Screening Committee, let alone multiple measurements. HMG has for years deluded itself into believing that its Healthy School Policy can be delivered with only 2,500 school nurses to cover approximately 25,000 schools which why more nurses [2–3 times more!] should be scheduled for 2010.

2e. It is not clear from HMG’s response to your First Inquiry if BMI data will be sent to parents despite your recommendation and the even stronger recommendation made in the US blueprint “Preventing Childhood Obesity” [IOM Washington DC 2005]. Will parents receive it or won’t they? According to experts at a high profile BMI workshop held in London pre-Christmas, it might be both ethically and legally wrong for data to be withheld. As a parent group the Foundation would view keeping such data from the family as “nannism” in the extreme.

3. Does the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

3a. The White Paper acknowledges that its proposals will be delivered only if the right [number] of people, with the right skills are in place. Given that HMG knows that the NHS is 40% short on public health practitioners, it needs to satisfy the Committee that it will aggressively recruit and train these staff. Community and hospital dieticians should be as far up the list as school nurses but with midwives coming not far behind. Dr Laurel Edmunds who advised you on your First Inquiry may also have told you of the need to have a completely new kind of health professional—a “lifestyle” nurse whose job it would be to support mothers-to-be and new mothers give their children the best start possible. If a Committee member knows of a “doula”, this is the kind of professional that we have in mind. We see great advantages in vetting “grannies” to become doulas—or something akin to being so—since experienced grannies are women who should have all the experience of a doula but are free from responsibility of bringing up their children. own. Increasingly grannies are wanting to get back into the workplace.

3b. HMG must clarify how it thinks a new child health promotion policy, trumpeted in the National Service Framework for Children and supported by the White Paper, will help to deliver its target. As currently published, the policy would be quite incapable of identifying any early sign of obesity either before or after the child has entered school. Though the Foundation has little time for growth monitoring recommendations in the traditional manual for child health promotion, *Health For All Children* [OUP January 2003], it is immensely preferable to the new programme. This calls for neither weight, length/height or BMI measurements to be taken until school entry and for none afterwards. HMG knows full well that the best opportunities to nip obesity in the bud are during the pre-school years [see above] yet follows a programme that ignores them. Rapid weight gain in the child’s first year of life is the first risk age for later obesity and the period before the adiposity rebound [c 3½ years in children with a high BMI] is a second.

3c. Little of the White Paper addresses the key issue of prevention in the years before birth. The Foundation is now of the opinion that we need to be teaching much more carefully the schoolchildren of to-day to become responsible parents of the future. We would like to see children exposed to breastfeeding [literally] from primary school onwards so that this fashion of infant feeding is second-nature to them by the time they reach adulthood—and we need to teach them to prepare first foods and cook as well. The December BMI workshop heard horror stories of infants being fed pureed Chinese take-away and three year-olds being given baby food because it was simpler to grab if off supermarket shelves! We acknowledge that the majority of UK parents do find their way to acquire parenting and lifestyle skills “on the job”—but a significant number may not. A bit of schooling wouldn’t come amiss for anybody and the National Curriculum needs to be adjusted accordingly.

3d. The Committee was kind enough to credit the Foundation in its First Report re physical activity [Vol I p72] and we despair that the White Paper’s proposals are still woefully inadequate. Again its promises are too late if not too little. Since the Foundation is working with sports specialists and the Central Council for Physical Recreation, all of whom have indicated will be making their own submissions to you, we will carp no further. It must be said however that the importance of pre-school play “play” has not been properly touched on in the White Paper and the £200 million already previously promised to Frank Dobson’s play review has, allegedly, also not been delivered.

3e. The Foundation would also like to see further positive fiscal measures being used to encourage parents to give their children the best start in life as recognised by Wanless. The “Healthy Start” programme, providing disadvantaged pregnant women and mothers of young children with vouchers for fresh food and vegetables is a step in the right direction but incentives to comply with other HMG measures should also be considered. The Foundation is particularly pleased to see the White Paper promise that it will reimburse local authorities fully for any extra costs they face as a result of the policies in the White Paper. Undoubtedly, the Wanless’ Reports have stung HMG into acknowledging that if we don’t invest now the UK will reap the cost of obesity heavily in the future. The Foundation believes that £1 billion per annum is the figure required.

4. footnote: As an illustration of how CHOOSING HEALTH gives the impression that HMG neither understands nor may care little about obesity in childhood, the Foundation would refer to Chapter 6 Paragraph 62. In a section exclusively devoted to children, adult BMI values for overweight/obesity have been inserted. Whitehall may choose to brush this aside as an error of little consequence but, even to the
casual observer, it calls into question whether some people at the Department of Health really are on top of their subject. It is vital that everyone realises that the static adult BMI values should never apply to children and the Foundation would be grateful if the Committee highlighted the children’s ranges by illustrating its 2nd Inquiry Report with a UK paediatric BMI chart.

February 2005

Memorandum by the National Heart Forum (WP 97)

PURPOSE

To set out the National Heart Forum’s (NHF) initial views on the Choosing Health White paper to the Health Select Committee.

There is much to commend in the White Paper however we do have concerns which we have set out below within the framework of the Health Select Committees three questions and hope these will be addressed in the delivery plan due to be published in the next few months.

ABOUT THE NATIONAL HEART FORUM

The National Heart Forum is the leading alliance of 48 organisations working to reduce the risk of coronary heart disease in the UK. Member organisations represent the medical and health services, professional bodies, consumer groups and voluntary organisations. Members also include many individual experts in cardiovascular disease research. Government departments have observer status.

The views expressed in this submission do not necessarily reflect the opinions of individual members of the alliance.

OBSERVATIONS AND RECOMMENDATIONS

A. General opinion and introduction

The NHF welcomes the Choosing Health public white paper, which if properly resourced and fully implemented is a good start in moving towards “fully engaged scenario” as described by Derek Wanless in the Treasury review of public health investment—which was the stimulus for the white paper.

The White Paper is thus a good start for public health as it sets out an initial three-year programme of action on which to build sustainable foundations for public health. Very significantly 10 of the Department of Health’s 20 Public Service Agreements are now public health. The White Paper sets out an ambitious programme of change with the main aim goal being to mainstream public health in the NHS and schools and ensure greater engagement of Local Government. If successful this will bring about a long overdue cultural change to promote health. One billion pounds is the biggest single new investment in public health in England. For the first time a public health white paper sets out a clear set of state level responsibilities and public health rights that once and for all should end the nonsensical debates about the nanny state. Public health functions and organisations are to be strengthened, particularly social marketing, research and development, information, development and performance management.

The White Paper goes a long way to establishing for the first time a comprehensive cross sectoral approach to preventing obesity.

Most importantly the White Paper combined with the children’s national service framework have for the first time since the start of the NHS, established a national plan of action to promote the health of children and young people. Most of the recommendations of the National Heart Forum’s young@heart policy framework are addressed in the White Paper with the exception of play which we hope will be identified in the DH’s physical activity plan which should include wider government action from other government departments.

B. “Whether the proposals will enable Government to achieve its public health goals?”

Resources

— A major critical success factor will be to ensure that the resources to deliver the plan are made available and go for the purposes intended. In launching the new white paper, the Secretary of State for Health announced that the Government would make available one billion pounds over the next three years. (2005–6/2007–8). The NHF has concerns that within the spirit of “the new localism” local NHS primary care and acute trusts could divert the money for other purposes—they have sovereignty over these resources. Given the pressures on PCT’s; the public health targets could be seen as long term deferrable deliverables and could be postponed especially as they are difficult at this stage for the Department of Health and the inspection agencies to properly
scrutinise. The NHF recommends that a fully costed three year delivery plan be made publicly available and a clear audit trail is kept to ensure that the Department of Health and the NHS utilise the resources solely for public health investment. This should be scrutinised by parliament through the HSC and through the National Audit Office. The NHF also recommends that the HSC keeps a watching brief to ensure that further resources are made available for 2008–09 onwards to stay in line with the public health investment recommended by the Treasury’s reviews undertaken by Derek Wanless (2003 and 2004). The NHF would like a public statement on the Governments commitment to the public health components of the “fully engaged scenario” Does the Government accept the scenario and will it invest accordingly in public health developments.

There are no quick fixes to address the lack of historical investment in public health. The success of the strategy will depend upon the quality of the delivery plan. The fundamental message from the Treasury’s Wanless review of public health makes clear the need to undertake public health properly. The NHF recommends that the DH prioritises public health infrastructure developments as its first priority to provide a public health system for England that is capable of delivering the ambitious programme of action.

The Choosing Health white paper states that the Secretary of State will coordinate action nationally through a new Cabinet subcommittee that will oversee joined up development and implementation of the government’s policies to improve public health and reduce inequalities [pg 177:12]. The NHF has concerns about the lack of any substantial input from the Department of Transport and hope that this will be addressed in the physical activity plan which should include wider Government action. Indeed the Department of Transport is notably absent at all DH physical activity meetings. Likewise the food and health action plan needs to include real buy in from other government departments. The critical question is what happens if they do not co-operate as this is so often the nemesis of effective public health action. Clearly the Secretary of State has assumed a greater responsibility for public health than his predecessors but it is unclear if he or through the mechanism of the newly announced cabinet sub committee will have the necessary powers to ensure that public health is a key consideration in all government policy, particularly departments such as department for transport where health promotion is not a central consideration and polices are sometimes in conflict with efforts to promote health.

Tobacco

The exemption to the smoking ban in enclosed public places is highly undesirable as this is likely to worsen health inequalities, fail to protect bar staff and encourage pubs to stop selling food to escape the ban (which is counter to the Government’s drive to reduce harmful drinking) The position in England will become increasingly anomalous and anachronistic as a complete ban is likely in Scotland and Wales in addition to the very successful ban in Ireland. We believe the Government has misjudged the public mood and should take further steps to secure a total ban. The NHF recommends that the Government immediately invests in a public education campaign to prepare the ground for a full ban to be introduced by the time the Government intends to take forward and then strengthen the necessary legislation for England.

Nutrition

The NHF was pleased to see that the white paper defined a clear set of principles for the role of the state in public health but regretted that these were not interpreted in all avoidable chronic disease risk factor areas equally. In particular action on food, nutrition and physical activity lags significantly behind the comprehensive action taken on tobacco and smoking. In respect of nutrition and obesity the NHF believes that the priorities for Government should be developing consumer friendly nutritional profiling/signposting of all processed foods, effective regulation of the food and marketing industries and school food. We do not believe that self regulation of the food and marketing industry will be effective given the global nature of these highly competitive industries. The WHO announced in December 2004 that self regulation of the food industry will not work and other forms of regulation need to be enacted. Obesity increased by 400% in the UK in the last 20 years and it will probably take 20 plus years for the obesity epidemic to be reversed even if the government take a “fully engaged” approach. Given the rate of increase in obesity in the UK—the fastest in Europe—any further delay on effective action will worsen the situation. Radical action is needed immediately. There is little indication of meaningful action from the producers of low nutrient value, salty and energy dense foods. The food marketing activities and claims of progress require close monitoring for implementation and impact. Often reforms are claimed but do not materialise or are of no significance. The European Union Health Commissioner Marcos Kyprionou has signalled that the European Commission may take legislative action within one year if the industry does not reform. The UK government agenda is already out of kilter with Europe and the WHO therefore the NHF recommends that (1) the UK government in the absence of comprehensive industry wide action, advances its review to early 2006 on legislative action to control the marketing of foods high in salt, sugar and fat to children
and young people and on the provision of consumer friendly “front of pack” nutritional information on all processed foods, (2) The UK takes a lead in its forthcoming presidency of the EU to champion a pan European approach to nutritional profiling and signposting (similar to that being pursued in the UK) for action on food composition, labelling, promotions and health claims (3) In the meantime establishes competent monitoring systems for all forms of food marketing in England.

— We would like to see nutrient based standards underpinning the supply and inspection of all school food. Achieving rigorous school meal standards will be important in setting similar standards in other public settings. The NHF would like to see minimum expenditure levels for school meals. The current situation is iniquitous. Adequate resourcing of the “food in schools” programme is vital to achieving the obesity target.

Physical activity

— The National Heart Forum awaits the long overdue national physical activity plan which we hope will address the following issues.

— The NHF would like to see the full contribution of other government departments in the production of the national physical activity plan. (see note above on role of Secretary of State for Health) In particular the NHF believes that this has led to a lack of attention to the important role of a health supporting environment with an emphasis on individual behaviour. Particularly in respect of transport policy and the built environment.

— The NHF believes that actions to support children’s play are a serious omission from the White paper especially given the importance of play in child development and the need to motivate the unengaged and inactive. Play offers a key strategy to meeting many Government policy goals as well as the physical activity and obesity targets.

Hypertension

— The NHF continues to be concerned about the need to have a nationwide strategic approach to the prevention and management of hypertension. The potential health gain is huge, thus it is surprising that it is not included more comprehensively in the white paper.

Social marketing

— The NHF is pleased about the increased investment in social marketing of health; if done properly this will be a key investment for positively altering the UK’s food and physical activity and health culture. However we have concerns about alcohol and food and marketing industry organisations having any involvement in the implementation of this work as this could dilute its effectiveness. This would be through two means—partnership compromise and by sending confused messages to the public. We believe the role of industry should be complementary and set against Government determined standards. The evidence from public health literature is that the public wants to be informed from an independent, authoritative and credible messenger. The NHF recommends that any funding from the alcohol, food and marketing industries should be administered through a blind trust with independent governance. We believe in a dialogue with industry but have concerns about the inevitable trade offs that arise from inappropriate partnerships.

— There are conflicts of interest between the marketing industries in working for the food industry and Government which are not necessarily in the best interests of the public. We note this was a concern of the recent HSC review on Obesity. We do not feel this has been addressed and is a value for money issue and a positive lever the Government could employ to shape the market. We recommend that the Government should set similar standards with the food (and alcohol) industry as they did for tobacco and not allow any marketing company to bid for Government sponsored information campaign contracts if they also market products high in fat, sugar and salt to children and young people.

— From the perspective of the appropriate usage of public resources the NHF believes here is plenty of scope to explore utilising taxation and fiscal incentives to shape the market for health. We feel that the Treasury has not given the Health Select Committee an adequate response to the recommendation about reviewing VAT on foods made in its enquiry on Obesity. If the government is serious about the “polluter must pay” principle to which it subscribes then the NHF feels that there should be further exploration of levies on health damaging industries for improving the public’s health. This works well with the energy industries. Why could it not apply to others such as food, alcohol and tobacco.
Measuring success

— The Summary of Intelligence supplement to the White paper states that success in raising physical activity levels will have been achieved if there is a 3% increase in the prevalence of people undertaking at least 30 minutes of moderate intensity sport at least three times per week. It is unclear why this target has been chosen since it does not relate to the target set out in Game Plan. (70% of population active by 2020) or to the CMO’s recommended levels of physical activity for health (30 minutes moderate intensity activity on at least five days of the week). It also specifically mentions “sport” rather than “activity” which is surprising. The NHF believes that the national target should be similar to Scotland’s i.e. A 1% year-on-year increase in the prevalence of people achieving the CMO’s recommended levels of activity for health.

— The White paper states that the government will sponsor debate on corporate citizenship across the public sector that will lead to firm recommendations for public and private sectors to demonstrate how they can organise their activities in ways that improve the health of employees and the wider community [pg 96:65].

— The White paper fails to emphasise the role that the NHS has in encouraging staff and patients to travel to and from its sites by foot, by bicycle or by public transport. One of the targets set out in the NSF for CHD is for the NHS to introduce travel plans and this would have been an ideal opportunity to reiterate the benefits that such travel plans can have on health by increasing physical activity levels.

— The Department for Transport will work with the cycle industry to produce user-friendly guidance on the tax-efficient bike purchase scheme to promote cycling [pg 165:22]. The NHF believes that the opportunity should have been taken to explore other fiscal incentives to encourage behaviour change, such as employer tax breaks if health-promoting facilities are provided on-site.

— The Investors in People Standard will develop a new healthy business assessment for incorporation when the Standard is reviewed in 2007 [pg 166:27]. It is unlikely, however, that this will have much impact on small and medium enterprises, for whom tax-breaks would be more of an incentive.

D. “Whether the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?”

— The NHF welcomes the developments in strengthening the public health infrastructure which as Derek Wanless identified is weak from years of under-funding and under-development. However we have concerns about the very limited capacity within the DH civil service establishment, the need to develop a joined up public health system for England, insufficient investment planned for developing the public health system, the need for an independent public health institute and lack of public health watchdog(s) on the tobacco, alcohol, food and marketing industries as well as the capabilities to organise and deliver competent social marketing campaigns. The NHF have made the case in previous submissions to the Department of Health and the Health Select Committee. We are astonished that the DH civil service dedicated establishment for public health is being cut at a time of apparent expansion for public health investment. This is a time to ensure that DH has the requisite number of civil servants. There are as little as four, two and two civil servants working respectively on tobacco, physical activity and nutrition which will have serious consequences for the quality of the delivery of the white paper.

— The importance attached to the promotion of physical activity needs to be increased. The NHF believes that the situation could be improved by establishing a standing expert committee on physical activity akin to those on nutrition and tobacco.

— The NHF welcomes the development of public health organisations but would like to see a joined up public health system for England developed along the lines of those in Scandinavia, Scotland and Wales. We have particular concerns about the lack of a dedicated government funded organisation to commission sophisticated social marketing campaigns. The white paper does not clarify the situation as to how such work is to be taken forward.

— The NHF believes that an important part of the fully engaged scenario is to achieve a fully engaged corporate sector and move towards a health promoting economy. To achieve this we would like to see public health watchdog/regulatory organisations for controlling the whole spectrum of the marketing of food, alcohol and tobacco.

— The NHF welcomes the commitment to health impact assessments of government policy and action. We would like to know when this will happen and the scope for the assessments and if the government will establish an independent mechanism such as a public health institute to undertake the work in a transparent way. The NHF would also like to see the health impact assessments and regulatory impact assessments made available to Parliament, Select Committees and the Governments regulatory and inspection organisations.
Finally the NHF does not want “Choosing Health” to be what Derek Wanless described as “yet another public health report that gathers dust on the shelf”. The NHF will be playing its part to ensure this does not happen.

January 2005

Memorandum by Amicus (Health Sector) (WP 98)

1.1 Amicus (health sector) welcomes the opportunity to submit evidence to the Health Select Committee related to Choosing Health the Government’s Public Health White Paper.

1.2 Amicus (health sector) represents over 80,000 employees within the NHS. Within its membership are a number of professions sections including The Community Practitioners and Health Visitors Association, The Medical Practitioners Union, Mental Health Nurses Association, Sexual Health Advisors Association and Guild of Healthcare Pharmacists.

Whether the proposals will enable the Government to achieve its public health goals?

2.1 The roots of this document are in an individualistic approach to health. The problem is seen as being that people do not make the right choices. We reject this victim blaming approach. People should make choices where they can, but often the only choices it will be possible for them to make are those they can make collectively. There is no mention in the White Paper about how the Government defines communities, as these are very diverse and complex. Often the rational choice for each individual in isolation may aggregate into a state that none of them would have chosen. Moreover we believe in the duty of governments to protect citizens from serious harm. Like Nye Bevan we believe that liberty is the freedom to choose, not merely the absence of constraint. It is necessary to address the barriers to healthy choices rather than just to proclaim an individual responsibility. We welcome the fact that the White Paper seems to have adopted this analysis. But it has often fallen short of pursuing it.

2.2 Amicus (health sector) are pleased to see that the Government has achieved a dovetailing across between the White Paper and the Children’s National Service Framework. However, within the White Paper there is little mention of Governance or Local Strategic Partnerships.

2.3 Amicus (health sector) are also delighted to see the commitment to modernise and promote school-nursing services and we look forward to working with government to achieve this.

2.4 The inclusion of mental health is also very welcome however the implementation is still somewhat vague.

2.5 We are disappointed that the Government has not put a greater emphasis on older people within the White Paper. Given the demographic shift in the age profile, it would seem shortsighted not to invest more in strategies that are aimed at older people.

Whether the proposals are appropriate, will be effective and whether they represent value for money?

3.1 Amicus (health sector) are also disappointed that the Government have not has not been more assertive in its action on obesity and in particular the impact on children. Amicus (Health Sector) fully endorses The Children’s Food Bill campaign co-ordinated by Sustain: the alliance for better food and farming and Sustains current submission to this enquiry. The Government needs to go further than strengthening the voluntary codes on food advertising to children and a strong consideration in relation to standards for school meals.

3.2 Amicus (health sector) are concerned that there is an assumption that that providing communities with high quality information will automatically lead to people making healthier choices but there can be a number of barriers, which impact on those, who are often, most disadvantaged including those with visual, language and learning difficulties or those where English is not their first language.

3.3 Amicus (health sector) would also urge that if the tobacco trade is to decline then action must be taken by Government to protect the workers and communities dependent on that trade.

3.4 The promotion of exercise involves more than just an assertion of the responsibility of the individual. Amicus (Health Sector) feel the Government has missed many opportunities here. It is important to promote public policies aimed at making it easier for people to choose to exercise for example:

— Developing safe cycle networks.
— Vastly improving the scope for using cycles in combination with trains as in the case of the successful Californian initiative by Cal Train.
— Developing aesthetically attractive walking networks with safe convenient crossings over major roads (there is evidence that people will regard walking as an option for longer distances if the networks are aesthetically attractive).
— Encouraging employers to encourage walking and cycling.
— Developing “green gym” projects which have the double advantage of promoting exercise and improving the environment.
— Promoting decentralised public services so that people can walk to public services.
— Preserving public footpaths, instead of seeing them as security hazards.
— Extending open space in the inner city by using earth sheltered buildings and roof gardens when redeveloping brownfield sites.

Whether the necessary public health infrastructure and mechanisms exist to ensure that the proposals will be implemented and goals achieved?

4.1 Amicus (health sector) welcomes the White Paper’s acceptance of occupational health as a public health issue. But we urge for it to go farther. Around a third of inequalities in health arise from work, which is not surprising since people spend about a third of their waking lives at work. Occupational health services should be universally available and the Medical Practitioner’s Union has produced detailed proposals for this. We envisage that they should be funded by employers, provided or licensed or commissioned by a public body (the HSE and local NHS Trusts and PCTs have roles here—the HSE for large industry wide services, NHS Trusts for services marketed to individual large and medium size workplaces and PCTs for group services for small and medium size enterprises grouped on a geographical basis). They should be jointly controlled by employers, trade unions and local communities.

4.2 Nationally the Minister for Public Health should be leading cross-governmental strategies. The emphasis should be on developing healthy public policy. There must be a continued commitment to integrated working between government departments so that the broader determinants of health are tackled at both national and regional levels. There needs to be increased support for and reinforcement of cross-government targets. Instead the post has been reduced to Parliamentary Secretary, far too junior to play such a role, and has been allocated work coordinating certain healthcare programmes that have a preventive element. In this way the great step forward that Labour promised in 1997 has been neutered. Indeed the post in not significantly different from the one that Julia Cumberlege held in the Conservative Government. The Minister for Public Health must be seen as a powerful force with access to Cabinet.

4.3 Public health organisation at local level must:
— Operate to local government boundaries at least where single tier local government is in place (it is more difficult in two tier areas).
— Empower the Director of Public Health to be a significant authoritative figure.
— Recognise the professional nature of the relationship of public health professionals to a population.
— Be led by an organisation which has public health goals at its forefront and does not see them as secondary to other more important corporate goals.
— Have money to bargain with.
— Have adequate capacity. The specialist public health workforce capacity in the NHS and beyond is wholly inadequate to the challenges faced. Many primary care trusts still have single-handed DsPH. This must be addressed to enable delivery by public health practitioners and the wider workforce in and beyond the NHS.

4.4 Amicus (health sector) are also concerned that that Primary Care Trust commissioning function is now going to practice base based commissioning as this poses real issues for certain minority groups within the community such as the homeless and travellers.

4.5 We are delighted with the Government’s move on Extended Schools as there is a body of evidence (world wide) that demonstrates the impact that extended schools can have in reducing health inequalities, if a socio-economic approach is taken, and it is not solely driven by education. However as we are not starting with a level playing field an issue of concern must be; to what extent are all schools able to sustain the extended school model? It is clear that larger schools with good facilities and external areas will be able to offer local communities a range of activities. But there are many schools, particularly in inner city, deprived areas, which due to space and the general fabric of their buildings are struggling to provide the educational provision for their pupils let alone for the community. The inverse care law will prevail, in that those who have will have more.

February 2005
Memorandum by the Department of Public Health, University of Oxford (WP 99)

I am writing from the Department of Public Health, University of Oxford. We welcome the Choosing Health White Paper and the government’s commitment to improving the public’s health, with particular emphasis on research and development.

In Oxford, we are committed to the development of innovative public health work to create the evidence base on effective intervention to improve health and reduce inequalities. We are also interested in finding ways to increase the capacity of academic public health to redress the problems highlighted by Sir Derek Wanless in his reports.

Whilst the proposals move us in the right direction, and we are pleased to see additional resources, we need to make the most effective use of R&D resources and the Innovations Fund. We believe that achieving this will require coordination of resources, part of which can be achieved by developing academic networks for public health at a regional level, not just creating the academic networks as proposed. This would create mechanisms that are transparent and engage all areas of the NHS and other agencies whose services impact on health, especially local authorities, to respond at national and local level to important public health issues.

We believe the development of regional academic public health networks should be part of the infrastructure, if the opportunities of Choosing Health are to be fully realised. This would provide greater emphasis within the implementation of the White Paper to promote academic and service departments working together, not only for research but also to build up much needed academic public health capacity.

February 2005

Memorandum by Food Justice (WP 100)

1. FOOD JUSTICE.

Food Justice is the umbrella organisation that has been campaigning for a national statutory strategy to end food poverty—via the Food Poverty Eradication Bill and the more recent Food Justice Strategies Bill. Our Chair is Alan Simpson MP (Labour) and our other “lead” MPs are David Amess MP (Conservative) and Don Foster MP (LD).

Our steering group consists of representatives from the Black Environment Network, Child Poverty Action Group, Crisis Fareshare, the Family Budget Unit, the Food Commission, Friends of the Earth, Groundswell, Help the Aged, the National Housing Federation, the Public Health Alliance, the Small and Family Farmers’ Alliance, the Soil Association and Sustain: the alliance for better food and farming, the Women’s Environmental Network and the Zacheas Trust.

2. SUMMARY OF SUBMISSION

This short submission is very simply that:

— The White Paper does not deal with the issue of food poverty;
— That problem is a very large one;
— That issue has very profound effects on health; and
— Therefore we request that the Health Committee initiatives its own investigation into food poverty—causes, effects and solutions.

3. FOOD POVERTY

3.1 Food poverty is the inability to afford or have reasonable regular access to a range of foods from which to select a healthy and varied diet. A healthy diet does not consist solely of low fat spreads, salads, brown rice and lentils. Rather it means having the freedom to make healthy, varied and balanced food choices. This is caused by

— Inadequate income;
— Difficulties of access (ie transport, geography);
— Inadequate information or education.

The first two are the most important.
4. The Problem of Food Poverty in the UK

4.1 There is wide acceptance now, including inside Government, that food poverty does exist in the UK, and that it is a big problem that affects a large number of people. A recent Joseph Rowntree Foundation report\textsuperscript{184} found that there were four million people in the UK who did not have access to a healthy diet—for varying reasons. Others put it higher. There are over 14 million people in this country who live below the poverty line—many of these people will experience food poverty in some form during their lives. And there is evidence to show that current benefit levels are not adequate to purchase a healthy lifestyle—including food.\textsuperscript{185} There are four million pensioners alone on benefits.

4.2 Suzy Leather, the former Vice Chair of the Food Standards Agency has said, “The total excess deaths in the more disadvantaged half of the population is equivalent to a major air crash or shipwreck every day . . . nutritional inadequacy is an important contributory factor.”\textsuperscript{186}

4.3 Up to 5,000 people in each parliamentary constituency may be malnourished.\textsuperscript{187} One in seven people over 65 are malnourished or at serious risk of malnourishment and Malnutrition affects up to two million people in the UK.\textsuperscript{188}

4.4 An ordinary healthy diet suitable for pregnancy is unaffordable for the one in four pregnant women who live in poverty. Their babies are much more likely to be born at a low birth-weight than the babies of women who can afford an adequate diet. These low birth weight babies are at a greatly increased risk of dying in infancy, disability and chronic heart conditions in later life.\textsuperscript{189}

4.5 This is but a small selection of the evidence on this issue. If the Committee does decide to initiate a full investigation we will be happy to make a far more detailed submission.

February 2005

Memorandum by the NHS Alliance (WP 101)

1. The NHS Alliance represents the frontline of the NHS. It is the voice of clinicians, managers and lay people working in primary care and of Primary Care Trusts (PCTs). Most PCTs are currently members and 98% belong to NHS Alliance Networks which includes a Public Health Network led by professor Sian Griffiths.

2. The NHS Alliance welcomes the White Paper and commend the government on its publication. We believe that to achieve the goals aspired to will require sustained commitment to improving health, keeping this as a mainstream policy thread at national level across government departments and at local level through Local Strategic Partnerships.

3. Are the proposals appropriate, will they be effective, are they Value for Money?

The proposals sensibly build on existing policy initiatives such as Every Child Matters in a number of areas. This is to be welcomed but there is a need to ensure that policy, targets and performance management criteria all pull in the same direction.

(i) This is a particular issue with regard to the Quality and Outcome Framework for the new GP Contract. This framework is made up of a number of points, which have monetary value, that are awarded on the basis of delivering specified outcomes. There are for example 72 points for asthma management and 105 points for hypertension management. The Alliance is concerned that there are only 41 points allocated for mental illness. This represents around 5% of the total points which is in contrast with the fact that GPs are estimated to spend 30% of their time dealing with mental health problems. In addition the 41 points are made up of 23 points for reviewing patients with severe long term mental problems, 1 point for lithium monitoring and seven points for production of a register of patients with severe long term problems. This does not reflect the bulk of mental health problems that GPs deal with, which are largely related to stress, anxiety and depression. This means that there are no incentives for GPs to look at how they might strengthen and support individuals through promoting self-esteem and through encouraging wider participation by referral to exercise programmes and arts on prescription programmes. Research evidence increasingly suggest that mental health is a key determinant of good health outcomes and

\textsuperscript{184} Poverty and Social Exclusion in the UK September 2000.
\textsuperscript{185} “Low Cost But Adequate”—Family Budget Unit.
\textsuperscript{187} Malnutrition Advisory Group Information Sheet No 1.
\textsuperscript{188} Malnutrition Advisory Group Press Release 5 December 2001.
\textsuperscript{189} Dallison J and Lobstein T “Poor Expectations: Poverty and Under-nourishment in pregnancy”—Maternity Alliance and NCH Action for Children.
that people who are stressed, anxious and depressed find it harder to make healthy choices. *We recommend that the Department of Health needs to review the Quality and Outcome Framework to look at how it might more effectively incentivise mental health promotion.*

(ii) The Alliance also has concerns about how best use can be made from the introduction of practice based commissioning from 1 April 2005. The Alliance view expressed in our evidence to the Choosing Health consultation was that commissioning for health needed to be separated from commissioning for sickness and that it should be a joint responsibility of PCTs and local authorities. There is an opportunity to develop co-terminosity between local authority local areas structures and locals clusters of practices so that practices in partnership with local authorities and the local community can develop locally appropriate ways of improving the health of the local community and of managing demand for expensive hospital care. This approach would be consistent with the White Paper recommendations on the development of local area agreements. *We recommend that the Department of Health should be asked to explore how practice based commissioning could be developed into an effective model for improving the health of the local community and for addressing inequalities in health.*

(iii) The Alliance is concerned about the total number of proposals in the White Paper. We hope that the delivery plan will outline clear priorities. We also hope that PCTs will be encouraged to build on the good work that is already going on across the country rather than necessarily introduce a whole new set of initiatives.

4. *Is the infrastructure sufficient?*

(i) The Alliance welcomes the introduction of Spearhead PCTs and coterminous local authorities in the areas of greatest social disadvantage. These areas because they have the poorest health also have the greatest demand for existing services and therefore the least capacity to focus on health improvement. They will therefore need more infrastructure support in order to improve the health of the local population. *We would welcome clarification of the sort of support that they can expect.*

(ii) The Alliance believes that public health capacity needs to be strengthened both by increasing the specialist public health function and by developing new roles and raising the awareness of all frontline staff to the importance of public health and health improvement. In particular we believe that more opportunity should be provided for GPs and community nurses to develop competence in public health. These practitioners working with PCT Directors of Public Health could then provide a local support function for practice based commissioning for health.

(iii) Health trainers provide an excellent opportunity for PCTs to explore how unemployed people in disadvantaged local communities can be provided with training and employment opportunities so that they can act as health link workers between the local community and frontline staff. We believe that this initiative needs to take account of the many other people already working in community development and of the many examples of good practice. This is not necessarily a new cohort of people to be employed by the NHS, they could instead be employed by the voluntary and community sector. As the White Paper rightly points out the voluntary and community sector are often much better than the statutory sector at engaging with groups of people who face most difficulties or who do not access traditional sources of advice on health.

(iv) We welcome the proposals for increasing skills in the community and for improving leadership for health. We would wish to be reassured that training in these areas will be available to local authority staff and to staff in the voluntary and community sector and that resources will be made available to all staff who have a key role to play in local partnership working.

(v) We also welcome the establishment of an Innovations Fund and the plans to develop good practice. This is consistent with the NHS Alliance approach which has aimed to foster a “can do” approach in Primary Care Trusts through the publication and dissemination of “CANDO!” which disseminates examples of good practice being delivered by PCTs.

(vi) We welcome the plan to employ more school nurses and to develop more healthy schools and extended schools. We hope that the work of the nurses will be integrated with GP practices and with other primary health and social care professionals and with the existing good work going on in Sure Start programmes.

February 2005

Memorandum by Dietitians Working in Obesity Management (WP 102)

DOM UK (Dietitians Working in Obesity Management), a specialist group of The British Dietetic Association welcomes the Government’s White Paper, entitled *Choosing Health: Making Health Choices Easier.* *Choosing Health* addresses a wide range of health issues; nutrition and diet are integral to many of the issues highlighted. Consequently, dietitians have a key role to play in the delivery and promotion of the healthy lifestyle featured in the White Paper.
1. Will the Proposals Enable the Government to Achieve its Public Health Goals?

The need for the Government to work in partnership with others to create an environment that promotes health is central to proposals in the white paper. There are no quick solutions and DOM UK welcomes the opportunity to work in partnership with other organizations, looking to Government to take a lead on establishing working groups as required.

DOM UK is delighted to see progress in this area over the last six months where the Department of Health has already established some working groups: a group to develop NICE (National Institute of Clinical Excellence) guidelines on obesity, another group will develop an obesity pathway and in addition DOM UK has been commissioned to work with other obesity organizations and produce a directory of obesity training for PCTs.

2. Are the Proposals are Appropriate, Will They be Effective and do they Represent Value for Money?

By 2007, the White Paper proposes that NICE will prepare definitive guidance on the prevention, identification, management and treatment of obesity. DOM UK welcomes this long term vision and is delighted to be in this working group. However we also recognise the importance of ensuring that recommendations for the medium term can be achieved. For example recommendation no 66, to develop “a comprehensive ‘care pathway’ for obesity, providing a model for prevention and treatment” and no.68 “we will also commission production of a weight loss guide to set out what is known about regimes for losing weight”. Development of these tools will be more straightforward than practical implementation. The infrastructure needs to be developed in primary to enable these tools to be used effectively.

3. Do the Necessary Public Health Infrastructure and Mechanisms Exist to Ensure that Proposals will be Implemented and Goals Achieved?

The infrastructure in primary care requires much refining to enable obesity to be addressed. Historically almost no doctors or nurses have had any training in the area of nutrition and obesity. On 30 December the government announced £3 million funding for up-skilling the workforce which has been welcomed by all groups. A major challenge is that the level of funding available will support only isolated training courses and the level of training required fits a longer term strategy. Training needs to support organizational change not only clinical knowledge to be effective. If training is a one off and there is no support in practice when clinicians return to the workplace this will affect effectiveness of the new initiatives. The Counterweight programme has demonstrated that intensive training over a six month period enabled primary care clinicians to effectively manage obesity.

Additional time required to address obesity is a barrier for weight management systems being implemented. There is huge reluctance to allocate more time is also influenced by obesity not being a priority in the GMS contract. In summary funding for training is a great start, but training programmes need to have a long term vision and addressing the cost of clinical time needed to systematically manage obesity in primary care still needs to happen.

Dietitians are already involved in a number of initiatives, but in order to maximize the potential of this highly skilled workforce, the DOM UK recommends that:

— A dietetic adviser at the Department of Health;
— A public health dietetic post at regional level.

Dietitians—key to delivery of Choosing Health

Registered dietitians in the UK hold the only legally recognised graduate qualification in nutrition and dietetics and work to promote nutritional well-being, treat disease and prevent nutrition-related health problems. Their unique skill is to interpret and translate the science of nutrition into practical, impartial and safe information about food and health. Therefore they have a key role to play in the implementation of the recommendations made in the White Paper, particularly in relation to the promotion of a healthy diet and preventing and treating obesity. In terms of obesity their training provides them with an understanding of the causes, consequences and treatment strategies (including dietary approaches, physical activity, behaviour change skills, drug treatment and surgery). They understand the public health issues in addition to the clinical implications of disease. Dietitians do not see their role as solely managing those who are overweight/obese, but also have a role in working within PCTs to help develop strategic approaches, involving all agencies (leisure services, slimming clubs, local government, schools, workplace, minority groups and those from lower socio-economic groups) to improve the health of their population as a whole.

January 2005
Memorandum by Counterweight (WP 103)

The Counterweight programme was established in 2000 by a group of consultant physicians with a special interest in obesity. The remit was to develop a treatment model for obesity management, facilitate the implementation into primary care and evaluate the impact of this model of care. Preliminary results were published in June 2004 showing that primary care can be effective in weight management. The Counterweight Project team welcomes the Government’s White Paper entitled “Choosing Health: Making Health Choices Easier”.

1. Will the proposals enable the Government to achieve its public health goals?

No 65. “We have put action in hand to strengthen the evidence base on effective interventions. The Department of Health has also commissioned NICE to produce definitive guidance on prevention, identification, management and treatment of obesity and this is due to be available in 2007”.

Counterweight welcomes the long term vision to develop NICE guidance on obesity prevention, identification and management. While this long term goal is very welcome, the Counterweight project team recognise the important of ensuring that approaches which are adopted between 2005 and 2007 are evidence based where possible. The white paper highlights areas of priority but whether the Government can meet public health goals is dependant on support which is available from the government now that the Public Health White Paper is in the public domain.

No 61. “Recent studies have found clinical services for obesity wanting with significant variations across England. Although there are examples of good practice preventative action is only taken when obesity co-exists with other chronic diseases, rather as a clinical problem in its own right”.

Counterweight recognises the need for obesity to be addressed in the GMS contract before it is likely to be addressed in its own right. The counterweight programme is undertaking a health economic analysis of the burden of obesity on primary care and the cost benefit of intervention. (York Health Economic Consortium) This data will be available in April/May.

No 61. “Research has found that there is a reticence among health professionals about raising the issue of obesity with patients, a lack of necessary skills to deal with obese patients, and a lack of clear referral mechanisms and services. Around 10% of areas did not have written information about services available. There is a need for much improved information for health professionals and the public on how to prevent weight gain”.

The Counterweight Programme offers an evidence based model to enable healthcare professionals to address weight management and prevention of weight gain.

No 67. “More specifically the prevention and treatment of obesity will ensure that”:

— That there are clear referral mechanisms to specialist obesity services which will be staffed by multidisciplinary teams with specialist knowledge and training in obesity management.

Specialist services at secondary and tertiary have historically suffered from lack of resource. This impacts on implementation of obesity pathways which depend heavily on referral to secondary and tertiary care level. The Counterweight Programme offers expertise in this area. Lead clinicians from the Counterweight programme would welcome the opportunity to discuss how best specialist obesity services at secondary and tertiary level can support primary care.

No 68. “We will also commission production of a weight loss guide to set out what is known about regimes for losing weight and help people select approaches that are healthy and the most likely to help them lose weight and then maintain a healthier weight”.

Counterweight have been invited to feature in a directory of obesity training programmes for PCTs which is being collated as a resource in response the release of funding for obesity training. This programme is the only national weight management programme in primary care which has been established and has evidence from pilot phase.

2. Are the proposals are appropriate, will they be effective and do they represent value for money?

No 64. We shall build on good foundations already in place to implement the NSF for Coronary Heart Disease and Diabetes. Guidance for PCTs on priorities and planning includes the need to give advice on diet and activity. The next priority will be to act on obesity in its own right using levers such as the new primary medical care contracting arrangements, through enhanced services and through negotiated changes which may be possible in the quality and outcomes framework.

Counterweight has audited the burden of obesity on primary care resources which provides a strong case for obesity being addressed in its own right. Initial recommendations in the White Paper have been supported with release of funding for training for clinical staff. New funding to support obesity training is very welcome, however no additional time will be provided to extend clinical time to address obesity.

No 66. We will develop a comprehensive “care pathway” for obesity, providing a model for prevention and treatment.
The counterweight programme has evaluated an obesity pathway over the past four years. The Counterweight Project team welcome any request to discuss learnings from the development and implementation of the pathway. A qualitative research programme is also underway at present to identify factors which have influenced practices which have successfully implemented the programme and those who have dropped out of the programme. This research offers vital learnings about factors which have influenced the ability of primary care to adopt a more structured approach to intervention.

3. Do the necessary public health infrastructure and mechanisms exist to ensure that proposals will be implemented and goals achieved?

No 63. The basic messages about how to maintain a healthy weight by balancing energy in and out through diet and activity are clear. But there is currently less evidence about effective ways to help people who are obese or overweight. Although we need better evidence the urgency of the problem means developing, rapidly evaluating and implementing new approaches to managing obesity alongside research on what works.

The counterweight programme which has been evaluated 2000-2005 provides an effective model for implementation of an obesity pathway in primary care. Preliminary results were published in June 2004 and final outcomes will be submitted for publication mid summer 2005.

No 69. We will commission further studies to support development of new approaches where there are gaps in the evidence base within the new framework for research discussed in Annex B.

The Counterweight Project team have a vision to extend the Counterweight model in a roll-out across England. The programme has an existing infrastructure of a statistical, health economic and qualitative research team to assess effectiveness of a roll-out. The project team plan to pursue funding to measure effectiveness of the roll-out.

Annex

THE COUNTERWEIGHT PROJECT: EXECUTIVE SUMMARY

BACKGROUND

The Counterweight Project was launched in 2000 as the result of a group of consultant physicians recognising the need to tackle obesity management in primary care. The Counterweight Board was established for project guidance and management. Counterweight is a multi-centre practice nurse led obesity management project being conducted in 80 general practices in seven regions of the UK: Aberdeen, Bath, Birmingham, Glasgow, Leeds, London and Luton. There is a Weight Management Adviser (WMA), a dietitian with specialist training in obesity management in each region to facilitate the process.

AIM

The overall aim is to improve the management of obesity in primary care, thus reducing the disease burden of obesity in the population.

OBJECTIVES

— To collect national anonymised weight management data from primary care registers.
— To develop a treatment model for obesity management.
— To facilitate the implementation of this treatment model into primary care.
— To evaluate the impact of this model of care, and lead future practice.

STRATEGY

Seven WMAs and a national co-ordinator facilitate the implementation of the project. The WMAs conduct a review of baseline medical practice, train staff participating in the project, and then provide ongoing support for the practice nurses for a minimum of six months.

AUDIT AND NEEDS ASSESSMENT

The WMAs conduct audit in each practice. An audit of patient screening, practice equipment and patient education literature is followed by a detailed patient audit. A randomly selected sample of 100 obese patients is audited in five practices in each region. In a second five practices, 50 obese patients are randomly selected, and then age and sex matched with the same number of both normal weight and overweight patients for within practice comparisons. Data is gathered to achieve a comprehensive clinical picture on each patient
including demographic characteristics, and screening for and recording of co-morbid conditions. NHS resource use including primary and secondary care contacts, hospital admissions and prescribing rates are also examined.

**Intervention Programme**

Following the development of a structured pathway for management of obesity in primary care, GPs and PNs are offered one hour training on screening and recruitment of appropriate patients. WMAs then conduct a six-hour training programme for practice nurses. Guidance is provided on evidence-based treatment, and the Counterweight weight management programme. Clinical support is provided in the practice to assist the nurses in care of patients in weight management clinics, groups or opportunistically. An integrated package of patient education materials has been developed to support the Counterweight programme. The WMAs work with the nurses to guide them on the implementation of the programme until the desired level of competency has been reached. The nurses are advised to see individual patients for six appointments of 10–30 minutes duration or in six group sessions lasting one hour, over a three month period. Patients are then followed up at least quarterly until 12 months and reviewed annually thereafter.

**Evaluation**

Weight loss will be the primary way of evaluating the success of the pathway, and the Counterweight weight management programme. The number of patients reaching weight loss targets deemed clinically beneficial (ie 5% and 10% of initial body weight) will be examined. Secondary endpoints such as changes in blood pressure, lipids and diabetes control will also be considered.

**Benefits to Primary Care**

The intervention programme offers the following:

- Guidance for practices developing or considering the provision of a weight management service.
- Support for practices already providing a weight management service.
- A consistent evidence based model of care for patients requiring weight management intervention.
- Structures to support clinical decision making, data collection and prospective audit of clinical outcomes.
- Resources for patients and clinicians.

**Project Sponsors**

This is a non-promotional five year project funded by a non incumbent educational grant-in-aid from Roche Products Ltd. It is managed by a clinician-led project board. There are no contractual obligations between the Counterweight Board and the sponsor.

**Project Governance**

The Counterweight Board includes membership of seven leading experts in the field of weight management from both academic and NHS clinical backgrounds. Other members of the board are the director of the West of Scotland Cancer Surveillance Unit (data and statistical analyst), the National Coordinator, representatives from the British Dietetic Association and the NOF, two of the seven WMAs, two representatives from the project sponsors. Other attendees at board meetings have been/will include a health economist, representation from the Department of Health, and a qualitative research group.

All components of the project are formally agreed by the project board. The project chair and national co-ordinator manage the Counterweight budget. The lead clinicians/academics receive no remuneration for any of their work in the programme and their affiliated hospitals/universities provide bases for the WMAs.

**Qualifications and Institutional Affiliation of Board Members**

Aberdeen: Professor John Broom, MBChB, MRCP(Glas), FRCPath, Research Professor and Consultant in Clinical Biochemistry and Metabolic Medicine, The Robert Gordon University, School of Life Sciences, Aberdeen.

Bath: Dr John Reckless, DSc MD FRCP, Consultant Endocrinologist and Hon Reader in Medicine & Biochemistry, University of Bath, Royal United Hospital, Bath.

Birmingham: Professor Sudhesh Kumar, MD FRCP, Professor of Medicine, Diabetes and Metabolism, Warwick Medical School, University of Warwick.

Glasgow: Professor Mike Lean, MA, MD, FRCP, FRCPs, Glasgow University Department of Human Nutrition, Glasgow Royal Infirmary.
Leeds: Dr Julian Barth, MD FRCP FRCPath, Consultant in Clinical Biochemistry and Immunology, Dept of Clinical Biochemistry and Immunology, Leeds General Infirmary NHS Trust.

London: Dr Gary Frost, PhD SRD, Head of Therapy Services, Honorary Reader in Nutrition, Imperial College London, & Hammersmith Hospitals NHS Trust.

Luton: Dr Nick Finer, MBBS, R Nutr, FRCP, Consultant Endocrinologist, Centre for Obesity Research, Luton and Dunstable Hospital NHS Trust.

West of Scotland Cancer Surveillance Unit: Professor David Hole, MSc FFPHM, Public Health and Health Policy, Division of Community Based Sciences, University of Glasgow.

British Dietetic Association: Lyndel Costain, BSc SRD, Chairman, Public Relations Committee, BDA, Charles Street Birmingham.

National Obesity Forum: Dr David W Haslam, MBBS DGM, GP and Chair National Obesity Forum, PO Box 6625, Nottingham.

Memorandum by the UK Public Health Association (UKPHA) (WP 105)

EXECUTIVE SUMMARY

We welcome the white paper for its commitment to action to improve health and to avoid the fate of previous attempts to do so. There are positive aspects of the proposals which we fully support. However, we believe the White Paper will only “make a real difference” as it intends if a number of serious weaknesses are addressed as its implementation proceeds.

The UKPHA is a multidisciplinary membership organisation, whose members share a common commitment to promoting the public’s health. We assess the White Paper against each of the UKPHA’s key priorities.

Combatting health inequalities

— There should be a refocusing on addressing underlying health determinants, with stronger measures put forward to lift people out of poverty.
— Implementing a strategy to address mental health problems should be made an integral part of the Government’s aim to tackle inequalities in health.
— There should be a recognition that choice is a spurious, and largely irrelevant, concept in public health and that health education will make a negligible, and possibly harmful, difference to health status and inequalities.
— Efforts should be made to act on best evidence, to make better use of current staff and resources, and to make creative connections across issues and government departments, seeking cost effective win-win solutions to health inequalities.

Promoting sustainable development

— There must be central Government leadership and integral local authority involvement to sustain improvements.
— Changes to the workforce should learn from, and build on, other recent and current work.
— Public sector workplaces should be examples of “healthy” environments.
— Initiatives should be properly piloted and evaluated before being adopted nationally.
— The training and capacity building essential for partnership working should be identified as a specific auditable requirement within the public sector.

Challenging anti health forces

— The Government needs to play industry at its own game, and adopt a sophisticated level of social marketing.
— Legislation should be introduced to control advertising to children.
— The smoking ban should be applied to all work places, so that all hospitality industry employees are equally protected from the harmful actions of others.
— Education in schools should be planned with positive health in mind and in particular school meals should be regulated for health.

For all our misgivings and concerns, there is much to welcome and be positive about in the White Paper. It signals a reassuring shift in focus towards greater health promotion and protection by the health services. There are a number of proposals that could have a positive health impact.
CHOOSING HEALTH OR LOSING HEALTH?

A response from the UK Public Health Association to the White Paper “Choosing Health—making healthy choices easier”

Persistent socio-economic inequalities in the UK, combined with a greater severity of market failures affecting lower socio-economic groups, seem to have contributed to significant inequalities in health outcomes which, unless tackled, will present a significant barrier to many in society becoming “fully engaged”.


INTRODUCTION

The UK Public Health Association welcomes the White Paper for its commitment to action to improve health and avoid the fate of previous unsuccessful initiatives. It puts good health centre stage in regard to the policy agenda and begins to address some of the barriers which hamper individual health and well-being. To that extent it offers real opportunities for a significant change of direction in the management and delivery of health promotion and health, as distinct from health care, services. However, our response considers whether the White Paper will in practice “make a real difference” as it intends. Will it help achieve the “fully engaged scenario” to which the government is committed? We conclude that the hope must be that it will, but only if a number of serious weaknesses are addressed as its implementation proceeds.

Three principles underpin the public health White Paper, Choosing Health: Making healthier choices easier:
— informed choice;
— personalisation;
— working together.

Though important, we doubt whether they are the most critical issues in addressing the poor state of the public’s health and the widening health gap.

The UKPHA is a multidisciplinary membership organisation, whose members share a common commitment to promoting the public’s health. Its three key priorities are:
— combating health inequalities;
— promoting sustainable development;
— challenging anti-health forces.

We assess the White Paper against each of these priorities.

COMBATING HEALTH INEQUALITIES

White Paper recognition of health inequalities

We welcome the White Paper’s acknowledgement of the “need to focus specifically on tackling inequalities in health”. This is in line with a clear commitment made by the Government since coming to power in 1997 in a number of reports and policy statements culminating in the Department of Health’s 2003 report, Tackling Health Inequalities: A Programme for Action. We would regard tackling inequalities a more important principle than promoting informed choice and are disappointed that it is not cited as such by the White Paper.

Tackling health inequalities by promoting choice

In contrast to these earlier reports, which emphasised the importance of the wider social and structural determinants of health, the Government’s approach to tackling health inequalities has shifted—and, in our view, in the wrong direction. The White Paper aims to reduce health inequalities, not by tackling the wider determinants, but by promoting choice. While accepting that “such inequalities are not acceptable”, it states: “Our fundamental aim must be to create a society where more people, particularly those in disadvantaged groups or areas, are encouraged and enabled to make healthier choices”.

The relevance of choice in public health

We welcome the recognition given in the white paper to the legitimate role of government in creating healthier environments and shifting social norms in order to support individuals and protect the health of vulnerable groups. However, we fundamentally disagree with the portrayal of personal choice as the key issue for improved public health and the focus within the white paper on individuals as consumers, and not as citizens.
What does choice mean in public health? Public health is principally about organising society for the good of the population’s health; at this level of concern, it is no more a matter of individual choice than the weather.

Many individuals cannot choose whether or not they have sufficient income to live in warm safe housing and eat healthy food. They cannot choose to walk or cycle when both pedestrian and cycle routes are often neither safe nor pleasant and dominated by the needs of the car. Those who suffer the worst health inequalities cannot choose to enjoy the benefits of local safe green spaces to pursue healthy outdoor activities or to breathe clean fresh air.

Even when choice can be exercised, consumer decisions are profoundly affected and influenced by the powerful and all pervasive impact of the advertising and promotional activities of the food and drink industry, which is driven by the need to increase sales and maximize shareholder value rather than to promote the public’s health.

Other Government interventions on inequalities

The Government’s progress on improving social justice, defined as “a fair distribution of advantages across society”, leaves much to be desired. The pro-New Labour think tank, IPPR, reports a mixed picture in its recent social justice audit. The economy has grown, the nation is healthier, living longer, and experiencing less crime than a decade ago. But inequalities in disposable income have slightly increased since 1997, wealth distribution has continued to get more unequal in the last decade, the rich have continued to get richer, progress on the gender pay gap has been slight, intergenerational social mobility appears to have declined, the poorest people continue to be more likely to suffer from crime, and deprived communities suffer the worst effects of environmental degradation.

Although the UK has moved from its ignominious position of having the worst child poverty in the EU, to being rated 11th out of 15, it is, as the IPPR reports, still the case that in 2001, 23% of children in Britain were living in households earning below 60% of median income, compared with just 5% in Denmark. Furthermore, the alleviation of poverty should target not only children but also pensioners, and childless, lowly paid adults.

Populism rather than good governance

The public consultation preceding the White Paper has been selectively drawn upon to support the Government’s stance. On close inspection, the outcomes of some questions contradict the outcomes of others (eg compare: “Three quarters of respondents . . . agreed that the Government should prevent people from doing things that put the health of others at risk” with the contradictory statement: “only 20% of people choose ‘no smoking allowed anywhere’ [in pubs]”). The Government’s partial smoking ban carries out the wishes expressed in the second statement, but overrules the view expressed in the first. The Government appears to have opted for the route that it perceives will attract less negative “nanny state” press coverage. It has put media advantage before good governance.

Old fashioned health education

We question whether this is in fact a public health White Paper at all in the widest sense of the term. It smacks of an old fashioned, medically dominated, health education approach that fell into disrepute some years ago because it has been seen to be completely ineffective. In 1976 a similar policy document "Prevention and Health—Everybody’s Business" (subtitled A Reassessment of Public and Personal Health) was published based on the principle that “we need to interest individuals, communities and society as a whole in the idea that prevention is better than cure” The failure of Preventing Health to bring about the changes, both within the NHS and society in general, necessary to achieve the improved personal and public health it claimed to seek has never been fully investigated or learnt from and yet here we are again going over similar ground. Choosing Health puts most of the responsibility onto the individual, whilst, paradoxically, recognising that many disadvantaged individuals cannot respond positively to health education messages, because of circumstances beyond their control. The White Paper is not aiming to change their circumstances, but to help them cope better with their continuing disadvantage through a mix of education, advice, and personal support in order (hopefully) to make informed lifestyle choices.

Although social marketing is referred to, and is an important strategy for promoting health in the 21st Century, to be effective it must promote a concept of public and individual health which is perceived and developed as an overall state of well-being and a balancing of the physical, emotional and spiritual. There is a real danger that health will be marketed and defined in terms of personal fitness, body imagery, and individual achievement.

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**Mental health**

There is some limited reference to mental health in Choosing Health but little action proposed. This is despite the fact that the UK is a signatory to the WHO European Declaration on Mental Health and Action Plan. This was signed by all 52 member states at an historic meeting in Helsinki in mid-January 2005.\(^{192}\) Mental health is an overarching issue connected to, and affected by, inequalities, and which is linked with all four of the major problems identified in the White Paper: obesity, sexual health, smoking and alcohol. A White Paper aiming to make a fundamental improvement to the nation’s health should be setting out plans to address mental health problems, particularly as experienced by people in economically disadvantaged groups. Prof Richard Layard, Co-Director of the Centre for Economic Performance at the London School of Economics, has commented that if you wish to see an improvement in health and well being—and consequently people’s ability to exercise more choice and control over their lives—society will need to invest heavily in mental health services.\(^{193}\)

**The UKPHA recommends that:**

— There should be a refocusing on addressing underlying health determinants, with stronger measures put forward to lift people out of poverty.

— Implementing a strategy to address mental health problems should be made an integral part of the Government’s aim to tackle inequalities in health.

— There should be a recognition that choice is a spurious, and largely irrelevant, concept in public health, and that whilst the UKPHA would not disagree with the possible marginal positive effects of many of the measures proposed, we maintain that both the available evidence and experience show unequivocally that health education will make a negligible, and possibly harmful, difference to health status and inequalities.

— Efforts should be made to act on best evidence, to make better use of current staff and resources, and to make creative connections across issues and government departments, seeking cost effective win-win solutions to health inequalities. We cite, as an example, the tackling of fuel poverty. Through effective, subsidised and easily available insulation schemes the burden of ill health is reduced on those living in cold damp homes, their disposable income is increased and their quality of life improved. Simultaneously carbon emissions are reduced and long term financial benefits accrue to the Treasury through the reduction in costs to the NHS of treating the ill-health resulting from living in cold damp homes.

**Promoting Sustainable Development**

The principle of working in partnership to make health everybody’s business is supported as this is essential to achieve UKPHA’s commitment to sustainable development. Again, we would have preferred to see partnership working as a major principle in the White Paper. The basis of the UKPHA’s commitment to promoting sustainable development is a recognition that good health is dependent upon achieving the social economic and environmental conditions which support healthy lifestyles. This has been acknowledged by the commitment of successive UK governments (in 1992 and again in 1997) to implementing Agenda 21, the UN Action Plan for sustainable development agreed at the Rio Earth Summit and by the World Health Organisation through the Healthy Cities initiative.

Sustainable development is an essential precursor for the achievement of good public health. As the 21st Century unfolds, it is clear that unsustainable development, resulting in environmental pollution and climate change, poses significant threats to the public’s health. Toxic residues, polluted air and waterways as well as the changed disease patterns and extreme events associated with climate change are factors which have been given scant attention in the White Paper.

The Government should recognise that the health education measures put forward in Choosing Health will have little or no effect without a concerted effort to arrest the ever increasing degradation of the environment.

It verges on the naïve to talk of encouraging individuals and communities to enhance their health by becoming more active when the environment and infrastructure within which they live their daily lives offers no accessible, affordable and convenient public transport system and very little high quality outdoor space, in which physical activity or community interaction can naturally take place.

Given the significant interconnection of polices aimed at the promotion of the public’s health, and those which are aimed at achieving sustainable development, we believe Choosing Health is too focused on the Department of Health and NHS as the primary locus of activity and drivers for change. The White Paper does not unequivocally assert that the state of the nation’s health is dependent upon cross governmental


joined up working which provides the context within which healthy choices can be made. A failure to address wider governmental responsibilities reinforces both a narrow view of health and the prevailing fragmentation of policy agendas and silo thinking.

Real opportunities exist both to re-invigorate neighbourhoods and communities and to plan and develop new communities which are sustainable and health promoting. The new Spearhead Initiative and urban development programmes, such as the Thames Gateway, must be based on creating sustainable neighbourhoods and communities where the social, economic and environmental fabric supports and promotes health and well-being.

Need for leadership at Government level

To make the White Paper vision a sustainable reality, there has to be leadership from Government. This cannot effectively come from the Department of Health. Its culture and ethos are so interwoven with the NHS and its fate, that to expect the mindset to switch from health care to health on the scale required is asking a great deal. Since previous attempts have not succeeded, if history is any guide then it is unlikely that the future will be so different without a different approach. What is needed is a paradigm shift through the creation of a wholly new “Landmark” cross governmental coordinating function to arch across departmental and ministerial silos in a way which allows public health to become a defining issue of our time.

Cabinet Minister

We believe there is a case for relocating the public health ministerial portfolio from the Department of Health to the Cabinet Office, thereby reflecting its cross-governmental nature. Regrettably, the White Paper has missed an opportunity to re-energise this post and remove it from the shadow of the NHS.

The CMO role

To support the Minister of Public Health in the Cabinet Office, we propose a system of dual accountability for the CMO so that the post’s clinical responsibilities remain located in the Department of Health, with accountability to the Health Secretary, while its health responsibilities move to the Cabinet Office, to support the Minister for Public Health and be accountable to her or him. But this is only one possible option for a new approach. We think the time is right to consider the CMO’s public health responsibilities in the light of the range and scope of challenges ahead. We therefore propose an independent review of the CMO’s public health role and function, including an exploration of alternative ways of organizing the function and its responsibilities.

Local authorities and community development underplayed

The impact of local authority services is greatly underplayed in the White Paper, despite the fact that local government may be regarded as the natural leader for public health. Local authorities control the majority of the services and environmental factors that affect people’s day to day lives. Indeed within Agenda 21, chapter 28, it is acknowledged that “As the level of governance closest to the people, local authorities play a critical role in educating, mobilising and responding to the public to promote sustainable development”.

Branding the White Paper as a Department of Health/NHS production risks alienating local government because it is regarded, and tends to see itself, as the junior partner to the NHS. Unfortunately, the White Paper simply reaffirms the power imbalance that has undermined rational argument of the location of public health since 1974 when the public health function was removed from local government and transferred to the NHS. We do not favour further organisational restructuring but do believe local government should at a minimum get equal billing with the NHS for its contribution to improving health and tackling health inequalities.

Community development has a track record of success in empowering communities, and, thereby, individuals, and a strategic approach to health promotion recognises this. With the focus in the White Paper predominantly on individuals this may prove to be ineffective without the concomitant development and strengthening of community confidence and action.

Capacity and capability of the workforce

Choosing Health makes reference to new tasks for the public health workforce and, in Annex B, sets out the detail on roles, training and competence. We agree that it is desirable to review the workforce deployment, to reconsider what new skills are needed, and to make optimum use of what already exists.

Particular mention is made of the importance of partnership working and yet throughout the public sector there has been no real attempt made to tackle the cultural and inter-professional adjustments required to ensure effective partnership working. Despite the research evidence on what makes for effective
partnerships, it does not appear to have been drawn upon to take forward the thinking on the subject or to modify practice. Too often partnerships are arbitrarily drawn together either as a response to a government edict or in the pursuit of partnership funding and the key players are either unable or unwilling genuinely to become more than the sum of their parts. Not only are these partnerships often ineffective when occurring between professionals, they can also be ineffectual and inappropriate when operating at the community level. Currently the Audit Commission undertakes a limited role in assessing the evidence and effectiveness of partnership working within organisational structures. There is however little to indicate that the training and capacity building essential for the development of “fruitful” partnerships is identified as a specific requirement within public sector organisational management systems.

New categories and definitions of the workforce

In an era when the need for evidence based policy and practice is recognised as being of paramount importance in public health interventions it is curious to see the proposal for the introduction of Health Trainers contained in the White Paper. We are not convinced that the proposal is either desirable or has been sufficiently thought through. The case for their introduction needs to be demonstrated. We have serious misgivings about their role and responsibilities, insofar as these are described in the White Paper. Health trainers run the risk that, far from strengthening the public health workforce, they could paradoxically weaken it by creating another professional grouping with skills and boundaries to be developed and managed thereby adding to the already considerable and complex partnership challenge. We are not convinced of the need for such an army of helpers drawn from the community nor do we think a demand for this sort of intervention exists on a sufficient scale to warrant such an initiative. The idea may symbolise government’s desire to be seen to be doing something but we think it is a costly distraction with minimal value. We question whether their introduction will give added value above strengthening the role of, say school nurses and health visitors, and promoting a true community development approach to these existing professionals’ work. This would, of course, require attention to be given to their falling numbers, low morale and recruitment difficulties currently exacerbated by changes in training and the closure of the health visiting register.

Given the experience of health promotion within PCTs, we question whether it is realistic to expect PCTs to have the time, skills, or motivation to undertake the tasks envisaged in the White Paper. Again, we urge the involvement of local authorities and suggest that many of the initiatives contained in the White Paper might best be led from a local authority base or by a joint local authority/NHS team.

We are surprised that the term “Community Matrons” is used (will male incumbents be so called?) given that “nannying” is out of fashion. Is there not an inconsistency here? When the term Matron was in widespread use in the first half of the last century, it referred exclusively to hospital posts. There is a danger that its use in this context suggests a wish to bring institutional values to the community, which rather contradicts the idea of personalising services.

We further suggest that careful thought be given to the scope of the school nurse posts, and urge that expectations of what is achievable should be realistic and should be seen as part of an integrated public health workforce.

A healthy public sector

We welcome the specific mention of the NHS implementing good public health policies within its own organisation. However, we are concerned that the opportunity has not been taken to apply the same policies to all public sector workplaces.

Piloting before plunging

Choosing Health proposes and refers to many initiatives currently running or about to be set up. We hope that current pilots, such as the “Spearhead PCTs”, will be evaluated before decisions are taken on whether to mainstream them, and that new concepts, floated in the White Paper, such as Health Trainers, will be piloted before being rolled out nationally.

UKPHA recommends that:

— There is a need for central Government leadership and integral local authority involvement if these proposals are to be realised and sustained.
— Overall public health must be distinguished from health improvement; the responsibility for the public’s health should be removed from the silo of the NHS to a cross-governmental cabinet level sphere of influence and operation.
— Changes to the workforce should learn from, and build on, other recent and current work, especially with regard to health promotion.
— All public sector workplaces should be examples of “healthy” environments.
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- Initiatives should be properly piloted and evaluated before being adopted nationally.
- The training and capacity building essential for the partnership working which will underpin the successful implementation of the White Paper should be identified as a specific auditable requirement within public sector organisational management systems.
- Public health should be recognized as a natural consequence of health promoting social, environmental and economic conditions and should therefore be a central integrating function of the government’s new Sustainable Development Strategy.

**Challenging Anti-health Forces**

**Social marketing**

We agree with the White Paper’s statement on the need for creative social marketing techniques in promoting health. Whilst welcoming the co-operation of industry, as in the case of the Portman Group, we caution against assuming that it is always best for industry to be a partner especially where successful intervention will inevitably run counter to short-term commercial interests. And where Government and industry do collaborate, the Government should be in the driving seat.

We note that the Department of Health intends to appoint an independent body to implement its marketing strategy. We suggest that this will be most effective if it is independent of industry and adopts the same sophisticated marketing techniques that are successful in industry.

We suggest that there would be widespread support for this, and cite the recent call from Alcohol Concern (www.hda.nhs.uk) for Government to fund television and other advertising on excessive drinking.

There is a dichotomy here in approaches to marketing. When the Government seeks to influence people’s behaviour, it is called nannying, but when big business does it, it is dressed up as offering choice. The consequence of this is firstly, a failure to properly regulate, or to protect and promote the public’s health and secondly, the extension of the potential scope for market, and public, exploitation by industry.

**Regulation**

Curbing the relentless and sophisticated marketing of foods high in salt, fat and sugar to children is the single, immediate step that the government should take to protect children from unhealthy eating patterns. It is disappointing therefore that we must spend the next three years watching the inevitable failure of voluntary controls before the government is willing to introduce the necessary statutory legislation.

The proposals for smoking restrictions in workplaces and enclosed public places are a significant step forward for public health. We welcome the ban, but are seriously concerned that the anomalous exemption of some pubs and clubs will leave bar staff working in those premises unprotected from the health hazards of second hand smoke. This could also result in health inequalities being widened, as smoking only pubs will tend to be predominantly located in poor areas. We question the long time scale for the implementation of the proposals and strongly urge government to strengthen the restrictions to achieve a comprehensive ban in the shortest possible time.

It is also a matter of concern as to how the partial ban will be enforced, whether the responsibility will be passed to local councils and whether they will be given the necessary resources. Similarly, we would like to see a commitment to a tobacco control and prevention programme of the kind developed in California which aims to denormalise the acceptability of tobacco use in communities through a comprehensive programme of measures and education which includes revealing and countering the influence of the tobacco industry. We note the initiative in the North East of England to establish a Tobacco Control Office which draws on the Californian experience.

We welcome the move to revise school meal standards, and express the hope that this will result in unequivocal regulation which ensures that all pupils are provided with healthy food and drink at school. Ensuring that education is planned with positive health in mind will require co-operation between Government departments at the highest level to ensure a curriculum which not only develops healthy lifestyle choices from the earliest age but which inculcates a sophisticated understanding of the consumer society within which those choices operate, including the role, methods and influence of the advertising industry.

**UKPHA recommends that:**

- For health messages to be successfully delivered, the Government needs to play industry at its own game, and adopt a sophisticated level of social marketing.
- Legislation should be introduced to control advertising to children.
- The smoking ban should be applied to all work places, so that all hospitality industry employees— who are typically on low pay, and so may be starting from a disadvantaged health standpoint—are equally protected from the harmful actions of others.
Education in schools should be planned with positive health in mind and in particular school meals should be regulated for health.

CONCLUSION

Will Choosing Health “make a real difference” as is hoped and intended? Will it help the nation to be, in Derek Wanless’s famous phrase, more “fully engaged”?

For all our misgivings and concerns, there is much to welcome and be positive about in the White Paper. It signals a reassuring shift in focus towards greater health promotion and protection by the health services. There are a number of proposals that could have a positive health impact, including the planned Local Area Agreements, greater co-operation between agencies, projects to increase physical activity, the partial smoking ban, standards for food in the public sector, the initiatives to make better use of professionals such as dentists and pharmacists, the focus on occupational health, the gearing up of the workforce, the approach to social marketing, and food labelling changes. But to ensure that these improvements are sustainable and effective, the government must provide sound leadership from within the Cabinet; apply principles of good governance rather than rule by inconsistent opinion polls and focus groups; it must also bring local authorities in as equal partners as a matter of urgency if local government is not to be marginalised; build on existing workforce insights and conclusions, when developing new workforce initiatives; pilot and evaluate initiatives before extending them; grasp the principles of social marketing and take a strong lead on advertising to children and imposing a total smoking ban in work places, through legislation.

It is said that the White Paper marks the end of the beginning and that the journey to a state of improved health will proceed in myriad ways which cannot be entirely foreseen or predicted. We agree. But we regret that the White Paper is not more bullish about the enormity of the challenges ahead and about the actions needed to tackle them effectively. Sadly, too many punches are pulled to give confidence that the Government does really mean business this time round.

Memorandum by Kings’ Fund (WP 106)

SUMMARY

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

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

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

What is in the White Paper?

Selected highlights include:

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

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

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

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

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

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

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

**What is to be welcomed in the White Paper?**

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

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

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

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

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

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

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

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

— **An obesity strategy.** This outlines a strategy for preventing, identifying, managing and treating obesity, informed by guidance from the National Institute for Health and Clinical Excellence.

— **The NHS to lead by example.** The NHS is to promote health through its corporate activities, such as food purchasing, capital development, providing a smoke-free environment, and healthy working conditions. The Sustainable Development Commission is to help develop good corporate citizenship.

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

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

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

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

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

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

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

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

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

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

**Questions and challenges**

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

— **Is there enough money?** The Department of Health plans to invest at least £1 billion in public health over the next three years to help implement the White Paper, but it is not clear whether this is all new money, where it comes from and what it is expected to cover.

— **How much of it will be implemented and by when?** The Department of Health released its implementation plan in March 2005. Everything depends on the quality of implementation, and on how well the many component parts of the White Paper fit together and work in practice.

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

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

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

— **What can be done to evaluate the cost effectiveness of a range of health-promoting interventions?** There is an urgent need for a programme of research to assess the impact of both the more specific (yet complex) interventions to improve the health of people with chronic conditions and those designed to improve health more widely. Evaluation of such complex, and often multifaceted, interventions is difficult, but in the short term it will be critical to examine their impact specifically on the use of health care, to test the assumption that better health reduces use as asserted in the first Wanless Inquiry. There may be a role for the National Institute for Health and Clinical Excellence in this respect.
The Government issued *Choosing Health*, its new White Paper on public health, on 16 November 2004. It has now released its implementation plan to clarify how the initiatives will be carried out. The plan makes the new expectations and responsibilities clearer to public health professionals, but the impact of the initiatives on improving public health and reducing health inequalities will take longer to assess. The strengths and weaknesses of the White Paper will also influence the potential success of the new strategy.

**BACKGROUND AND CONTEXT**

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

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

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

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

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

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

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

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

1. **A new sense of urgency about the need to prevent illness.** This is distinct from improving health care and was largely prompted by the Wanless reviews, which had begun to estimate the price of failing to take prevention seriously.

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

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

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

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

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

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

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

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

What is in the White Paper?

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

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

COMMENTARY

Chapter One: Time for action on health and health inequalities

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

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

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

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

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

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

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

Chapter Two: Health in the Consumer Society

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

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

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

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

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

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

— Possible development of a national centre for media and health to provide an independent forum for national and regional media to discuss major health issues.

Improving information to the public on food, drink and tobacco

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

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

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

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

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

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

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

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

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

— School nursing to be “modernised and promoted”, with new funding from 2006–07 to ensure that all Primary Care Trusts, starting with those in the most disadvantaged areas, can provide at least one full-time qualified school nurse for each “cluster” of schools.

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

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

— A new “lad’s magazine” called FIT to promote health information for young men aged 16–30.

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

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

Promoting community health

— Public Health Observatories are to produce reports designed for local authorities, using a standard set of local health information, linked to other data sets.
— Primary Care Trusts are to develop local health targets, agreed with partner organisations, to meet national targets and priorities set by the White Paper and the NHS Improvement Plan.
— The Healthy Communities Collaborative is to be extended to tackle obesity and other issues.
— A scheme called Communities for Health is to be launched in spring 2005, to promote action across local organisations on locally chosen priorities for health.
— A network of local “health champions” is to be developed. These will include local authorities and other organisations and individuals who want to lead local action to improve health. They will be supported by “arrangements” to share good practice and celebrate success through an annual award scheme.
— Pedometers are to be encouraged by Primary Care Trusts and in schools.

“Good corporate citizenship”

— The UK Sustainable Development Commission is to be given funding by the Department of Health to develop the capacity of NHS organisations to act as “good corporate citizens”, namely, to use their corporate resources as employers, purchasers, landholders, managers of energy, waste and travel and commissioners of new buildings and refurbishments to promote health and sustainable development. This work will focus initially on food procurement and capital development.
— The Government will sponsor a debate on good corporate citizenship, leading to “firm recommendations” for all public and independent bodies to organise their activities in ways most likely to improve the health of their employees and the wider community.

Smoking bans

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

Chapter Five: Health as a way of life

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

— “Health trainers” to be available ultimately to any individual who wants one, starting with those in disadvantaged neighbourhoods. These trainers are themselves trained and accredited by the NHS and are expected to come mainly from the communities where they work. Their function is to help individuals be aware of health risks and how to change their behaviour to lead healthier lives. They can be accessed through health centres, NHS Direct and possibly through other local organisations.
— “Personal health guides” can be developed by individuals who want to do so, with help from a health trainer. These are custom-made plans that set out, in the individuals’ own terms, their current state of health, what changes they want to make and where they can get help to do so. The guide may be electronically stored and linked to HealthSpace, a secure personal health organiser on the internet, as an “online personal health planning kit”. It can build on the Children’s Health Guide.
— A “stock-take” of health will be offered to individuals at key life stages such as new employment, childbirth, entering a new relationship, and preparing for retirement. This provides an opportunity to review the personal health guide, with help and support from a “health trainer” or other NHS personnel.
Chapter Six: A health-promoting NHS

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

General measures to improve NHS capacity to focus on prevention

- National Clinical Directors to work with clinicians across the NHS to find opportunities to extend primary and secondary prevention. They will work with the Chief Medical Officer to recommend a “comprehensive and integrated prevention framework, linking all areas covered by National Service Frameworks”.
- Primary Care Trusts will receive funding to enable them to give higher priority to areas of greatest health need, and become a “tool to assess local health and well-being”.
- A National Health Competency Framework is to improve the skills and capacity of NHS staff to promote health and prevent illness, including obesity prevention and treatment.
- A strategy for pharmaceutical public health, to be published in 2005, is to show how pharmacists can contribute to health improvement and reducing health inequalities.
- Dentists are to be given a new focus on prevention in contractual arrangements coming into force in October 2005.

Managing long-term conditions

- Community matrons to provide personalised care and health advice for those with long-term conditions such as diabetes, asthma and arthritis, and to be responsible for case-managing patients with complex health problems. By 2008, there will be 3,000 community matrons and they will be supported by health trainers (see above).
- The Department of Health will bring in independent sector “partners” to develop new approaches to managing chronic conditions, including personal health guides.

Addressing major health risks

- Mental health. New models of physical health care for people with mental health problems and new approaches to help people with mental illness to manage their own care.
- Smoking. A national taskforce to help improve NHS services to help stop smoking. The Healthcare Commission is to assess progress. (See also Smoking Bans above).
- Obesity. Definitive guidance from the National Institute for Clinical Excellence on prevention, identification, management and treatment of obesity is to be available in 2007. A “weight loss guide” is to be produced and a “national partnership for obesity” is to be established. A “patient activity questionnaire”, available by the end of 2005, is to help NHS staff improve patients’ physical exercise.
- Sexual health. New capital and revenue funding for tackling sexually transmitted illnesses. Improved chlamydia screening, possibly using independent partners such as retail pharmacists. Audit of contraceptive services and a target wait of a minimum of 48 hours by 2008 for those referred to a GUM (genito-urinary medicine) clinic.
- Alcohol. A programme to improve alcohol-treatment services, based on demand audits and “Models of Care” guidance from the National Treatment Agency, with additional funding from Pooled Treatment Budget for Substance Misuse.

Chapter Seven: Work and health

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

- The production of evidence-based guidelines on occupational health.
- Sport England is to provide free consultancy to government departments on how they can encourage staff to be more active.
- There will be pilots to develop the evidence base for effective health promotion at work.
- Investors in People (IIP) are to develop a new “healthy business assessment”, to be incorporated in the new IIP standard when reviewed in 2007.
- All government and NHS buildings are to be smoke free and a campaign to help nurses to stop smoking is planned.
- The NHS is to become an exemplar, providing healthier workplaces and encouraging people back to work after injury, illness or impairment. Its progress will be assessed by the Healthcare Commission.
Guidelines on managing mild to moderate mental ill-health in the workplace are to be published in 2005.

Chapter Eight and Annex B: Making it happen

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

— Health will be a component of regulatory impact assessment of all future legislation.
— There will be new funding for health education campaigns, more school nurses, health trainers and obesity and sexual health services.
— The Department of Health is to publish six-monthly reports on progress towards health improvement targets.
— Extra government funding will be available for councils that achieve more ambitious local targets, for example, on tackling health inequalities.
— Funding for public health research is to reach £10 million by 2007–08; a public health research consortium and a National Prevention Research Initiative will be set up.
— An Executive Director for Health Improvement will be appointed within the National Institute for Health and Clinical Excellence (a merger of NICE and the Health Development Agency), to provide professional leadership.
— A Health Information and Intelligence Task Force will be set up to oversee information gathering and knowledge management. £10 million a year from 2006 will be made available for Public Health Observatories.
— Training for “health trainers” and other frontline staff will be developed with partner organisations, possibly leading to a new national Health Trainer Certificate.
— The Department of Health and partners are to identify core skills and competencies needed for public health leadership.
— A Health Improvement Workforce Steering Group is to be established to develop strategy and coordinate action needed to deliver the White Paper’s objectives.
— Implementing the White Paper will be the priority of the Modernisation Agency and its successor organisation (when it has taken in the NHS University). A new Innovations Fund (£30 million in 2006–07 and £40 million thereafter) will support and evaluate new ways of working.

What is to be welcomed in the White Paper?

— Scale and scope. This is a wide-ranging, ambitious exercise that covers a great deal more ground than was ever suggested by the media reports that accompanied its launch. It claims to instigate a great many changes and contains many more practical initiatives than earlier public health policy documents.
— Embedding change. There are clear attempts to embed change in the operational processes of the NHS, as well as in other relevant organisations and relationships. Implicitly, the White Paper acknowledges the need not just to introduce new measures or pursue targets, but to change the culture and practice of the systems that deliver them.
— A strong local dimension. The White Paper recognises that locally focused activities by local organisations are essential to tackling health inequalities. Primary Care Trusts are to set local targets, informed by customised intelligence from Public Health Observatories, and the NHS is expected to work with local authorities and other organisations at that level.
— Focus on partnership working. The value of joint working between the NHS and local government, businesses and voluntary organisations is firmly acknowledged as essential to effective implementation of the White Paper’s proposals. It sends out an unequivocal message that NHS organisations are expected to play a leading role in local partnerships for health.
— Support for disadvantaged groups and neighbourhoods. A clear theme throughout the White Paper is that people who are poor, socially isolated or otherwise disadvantaged can find it harder than others to make “healthy choices” and therefore need additional support. Many initiatives are targeted in the first instance on disadvantaged communities; these are quite obviously essential if inequalities are ever to be reduced.
— Engaging with the media. Following consultations with media organisations conducted for the Department of Health by the King’s Fund, it has been suggested that there should be a more proactive dialogue with regional and national media, and possibly also a “national centre for media and health” along the lines of the National Centre for Media and Science. We welcome the fact that these ideas are reflected in the White Paper; it will be essential to guarantee genuine independence for any such centre.
— **Serious about schools.** The White Paper holds out a reasonable prospect of ensuring that schools create a healthier environment for children and play a stronger role in promoting child health. Helpful moves include increasing numbers of school nurses, improving nutritional standards of school meals, encouraging healthy eating and physical activity, and extending the scope of Ofsted inspections to schools’ overall contribution to health and well-being, including—specifically—healthy eating.

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

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

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

— **Changing the relationship between the individual and primary health services.** The proposal to introduce children’s health guides, personal health guides and periodic health checks or “stock-takes” is welcome. The King’s Fund has argued for a change in the way individuals relate to the health system—from a passive doctor/patient relationship to one where individuals are seen as co-producers of their own health. We have suggested that individuals might have “health and lifestyle checks” at key life stages and produce a “personal health plan” that sets out their current state of health and what needs to be done to maintain and improve their health, with plans stored electronically and updated by the individual over the life course. Very similar ideas have been set out in the White Paper. We should welcome further testing of this approach, as one means of shifting the emphasis from treatment and cure towards health maintenance and improvement. There is a particular need to test whether this approach works for those at greatest risk of ill health—those in the most socially deprived groups and from minority ethnic groups.

— **Community-based health advocates or “trainers”.** The King’s Fund has called for community-based advocates for health—already a well-established model for helping disadvantaged individuals and groups gain access to the knowledge and services they need to maintain and improve their health—to be further developed and brought into the mainstream of the health system. We welcome the proposal to introduce “health trainers” (a concept that closely mirrors this idea), and for the NHS to invest in training and accrediting them. Given that people’s mental health is as important as their physical health, we believe mental health should be a core competency for all health trainers.

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

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

**Shortcomings and weaknesses**

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

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

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

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

— **Too much dependence on voluntarism.** In a similar vein, it is a pity that the carrot-and-stick approach to restricting food and drink promotion to children has not been extended to efforts to improve food content and labelling. It is doubtful whether “discussions with the food industry” will lead to prompt and effective action, unless there is a promise of enforcement if voluntarism fails to show results within a specified time frame.

— **Shortage of detail on critical points.** In spite of its prodigious length and breadth, and its multitude of announcements, the White Paper has too little detail on a number of critical points. Some proposals sound intriguing but lack substance. For example, how will the Child Health Promotion Programme, the Communities for Health scheme and “health champions” operate, and how will the latter relate to the proposed “health trainers”? How, if at all, will “health trainers” relate to the large numbers of health advocates already operating at community level? Part of the problem may lie with an apparent reluctance to connect the White Paper with its antecedents, or to develop ideas that have originated in local government rather than in the NHS. Other themes, such as mental health and alcohol, are dealt with at some length but there is little said about upstream prevention.

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

Questions and challenges

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

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

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

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

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

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

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

February 2005

Memorandum by the National Aids Trust (NAT) (WP 107)

I am writing to present some points which I hope can be taken into account by the Health Committee as part of their inquiry into the Public Health White Paper.

I am sure the Committee’s analysis of the sexual health component of the White Paper will be informed by its current inquiry into New Developments in HIV/AIDS and Sexual Health. Having listened to the evidence presented to the Committee during that inquiry, I felt it important that NAT also contribute to your consideration of the White Paper to reiterate for the record some of our major concerns. I realise that this letter comes after your deadline for evidence but I hope it can nevertheless inform your questioning and your final report.

We believe there is much to welcome in the White Paper with respect to the broader sexual health agenda, including the target of a 48-hour waiting time for GUM appointments, the commitment of an extra £300 million to improve sexual health services, and targets for gonorrhoea and chlamydia. There are also, however, missed opportunities which we hope the Committee will bring to the attention of the Secretary of State.

1. HIV

1.1 On the day of the White Paper’s publication NAT pointed out that HIV was almost absent from the document. Discussions since then have confirmed this to be a major disappointment and concern throughout the HIV sector. For HIV to be mentioned only three or so times in passing in the whole document sends out entirely the wrong signal when new diagnoses have been increasing over the last few

years by up to 20% per annum, over a quarter of positive people are unaware of their status and there are significant increases, for example, in the percentage of gay men reporting high risk sexual behaviour with casual partners (from 6.7% to 16.1% 1998 to 2003).

1.2 Although there is general discussion of health inequalities in the White Paper, there is no focussed analysis of the health needs of gay or bisexual men or African communities.

1.3 There is a well-documented and recognised problem of the performance management of sexual health within the NHS. With HIV sidelined in the White Paper, with no explicit HIV-related core or developmental standards in “National Standards, Local Action”, there is a real question as to whether PCTs have the necessary incentives to tackle HIV.

1.4 Drugs budgets for WV treatment will continue to increase and there is evidence that this is at the expense of HIV prevention work. We believe the Secretary of State should be challenged on the goal contained in the National Strategy for Sexual Health and HIV to reduce new HIV infections by 25% by the end of 2007. How has the Public Health White Paper contributed to achieving this goal? There is a promise to improve accessibility to GUM clinics but this is an inadequate response to the seriousness of the situation.

1.5 We need a clear message from the Government that HIV is at the top of its public health agenda. We also need increased funding for HIV prevention and the necessary incentives from the centre to ensure that HIV is prioritised at the local PCT level and effectively performance managed.

2. Sexual Health Campaign

2.1 We welcome the sexual health education campaign planned for later this year. Details of its content remain unknown. We were pleased to hear Melanie Johnson tell the Committee that she thought its scope should extend beyond the 18 to 25 age range. We are looking for confirmation that the campaign will include appropriate reference to HIV. It is vital that there is an understanding in the general population that HIV remains a serious and life-threatening communicable disease and that people are equipped with accurate information on risk and safer sex.

3. Primary Care and Sexual Health

3.1 We welcome the determination to roll out sexual health provision into the community through primary care settings. The Committee has already explored the deficiencies of the current GMS contracts in relation to sexual health and we believe a review of the GMS contract should take place in the near future to ensure the contracts are consistent with the aims and messages of the White Paper.

3.2 There are also significant implications for clinical knowledge of HIV, for confidentiality and for training to avoid HIV-related stigma and discrimination. As sexual health provision, including HIV testing, is made more widely available there must be a clear and properly funded training strategy to ensure primary care is a well-informed, safe and supportive environment.

4. Sex and Relationships Education (SRE)

4.1 Whilst the White Paper includes a commitment to improve SRE, the failure to make SRE in its fullest sense a compulsory part of the National Curriculum perpetuates inequalities amongst schoolchildren, with some attending schools which prioritise PSHE and its SRE component and others attending schools which ignore these subjects.

4.2 We believe that PSHE should be a compulsory part of the National Curriculum and should include age-appropriate information on sexual health and relationships, HIV (including HIV-related stigma and discrimination), sexuality and homophobia.

February 2005