

Perspectives on Health Improvement:

A contribution to the consultation on the
Scottish Government's action plan on
health and well-being

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Summary

The following four essays were commissioned shortly before the Scottish Government elections in 2007. They were intended to provide a range of independent perspectives from experts (both within and outside Scotland) on the current and future challenges that Scotland faces in achieving its goals of improving health and reducing health inequalities, and to offer suggestions on how best to tackle these challenges, based on the authors' expertise and experience. The authors were invited to be critical and challenging.

Despite the widely differing geographical and professional positions of the authors, the essays contain a remarkable degree of commonality in terms of the issues that they raise. All of the authors emphasise the cross-cutting nature of the health improvement challenge. High on the list of priorities for all of them was the importance of organisational structure and relationships, and the need to overcome geographical, organisational, cultural, professional and hierarchical boundaries. Genuine and effective collaboration, which is so necessary when addressing cross-cutting issues such as health improvement, cannot be achieved unless the challenges inherent in working across such boundaries are recognised and overcome. Several authors build on this, highlighting the need to recognise the interdependence of global, national and local influences on public health, and the importance of understanding and developing these interrelationships. At a local level these essays highlight, in particular, the need to increase the autonomy and empowerment provided to local agencies and communities in order to improve health within their locality.

The first essay gives an 'outsider's view', providing a perspective on Scotland's achievements to date and future challenges. The author is Bosse Pettersson, a public health expert who has been working in Sweden and active at European and international levels for a number of years. Such an insight gives an impression of how Scotland is viewed elsewhere, and is a particularly useful contribution, given Sweden's impressive record in health improvement.

Bosse commends Scotland's health improvement work to date, despite the continuing health challenges, and believes that Scotland has achieved credibility and visibility. However, he considers that Scottish presence at the governance level in international organisations is lacking. He suggests that such a presence would benefit not just Scotland, but other countries of a similar size and scale. However, he does not explore how this might work in practice, given that the UK is currently the appropriate and accepted level for representation in most cases.

Bosse recognises the scale of the challenge that Scotland faces in tackling health inequalities, although he also notes that the trends reflect those experienced in countries across Western Europe. He suggests that further description of the problem is unnecessary, and he proposes two strands of action to bring about change, namely:

- 1 to apply the strategies and actions outlined in the 'Levelling Up' reports published by the World Health Organization in 2006
- 2 to move away from a national approach, and act more locally.

Although Bosse does not underestimate the importance of national government in setting appropriate policy and a taking a 'whole-of-government' approach, he also reminds readers that at national level many of the most potentially significant health improvement actions are value based, and will differ according to political ideology. He also emphasises the importance of working at the local level through local organisations, using the best available epidemiological information and local knowledge.

Bosse believes that a determinants approach must be integral to any attempt to tackle health inequalities. He suggests that the continued focus on lifestyle-related risks to health often fails to recognise the importance of the 'settings and environments where people live their lives', and the effect that these have on individual behaviours which influence health. The determinants approach helps to explain why individuals' health-related behaviour varies. It also demands a truly multi-sectoral approach across the whole of government.

Building on his experience in Sweden, Bosse advocates the periodic delivery of public health policy reports to Parliament. He suggests that this provides MPs and decision makers with a better knowledge and understanding of current public health trends, as well as their progress towards and fulfilment of political goals. In terms of delivery, Bosse emphasises the need for effective infrastructures for delivering health improvement, and he proposes five functions that should be integral to the delivery system.

In his final comments, revealing what he believes to be the most promising health improvement initiatives in Scotland, he recommends that the Scottish Health Promoting Schools Unit should be maintained and developed, and that the issue of male health should be revitalised as the missing half of a complete gender approach to health.

The next essay in the series is also written by an 'outsider' – although one slightly closer to home – who again has considerable experience of Scotland's health improvement developments. David Hunter is Professor of Health Policy and Management at Durham University, and has recently been involved in two reviews of health improvement policies in Scotland.

His essay focuses on the opportunities afforded by devolution which, he suggests, have not been fully exploited to date. He commends the commitment and innovation that Scotland has demonstrated in its health improvement actions, but he also articulates the challenges facing the current Scottish Government in strengthening these actions in order to achieve real improvements in Scotland's unenviable health record.

David notes that the thinking around health improvement in Scotland and the need for a cross-cutting agenda that links to, for example, sustainability and social justice, is in keeping with the 'Health in All Policies' approach that is being developed in Europe. Through this approach, the well-being of countries becomes the responsibility not only of the health sector and its actions, but also of other sectors which may, in reality, have a greater impact on health and well-being. However, David warns against assuming that intersectoral working is simply a structural issue, and he points out that the cultural differences and interpersonal relationships across organisational boundaries will strongly influence whether and how collaboration occurs. Achieving a genuine cross-government approach poses significant challenges for the whole of government, but David recognises that Scotland's current government has an awareness of these challenges and a desire to address them.

He believes that devolution has brought with it opportunities to act on complex challenges such as health improvement. Scotland's increased self-confidence and its desire to be innovative and to use its small size to best advantage have already brought significant benefits. David highlights this by citing two examples of Scotland's commitment to health improvement since devolution, namely the Breastfeeding Act and the ban on smoking in public places (the latter is highly commended by all of the authors). He also provides two further examples of Scotland's desire to learn from and build on its health improvement actions to date, namely the policy reviews of the Scottish Diet Action Plan and the National Programme for Improving Health and Well-being, which were undertaken between 2005 and 2007 to reflect on policy and implementation in these areas and provide direction for future policy. These have highlighted some of the challenges and complexities inherent in addressing Scotland's health deficit. They both demonstrated the importance of effective joined-up government at the centre, and the need for this to be reflected in more focused and consistent communication with localities, so that local authorities and NHS Boards are clear about what is expected of them, and have the resources necessary to achieve this. David suggests that difficulties in achieving collaboration at national level have made delivery at the front line difficult, and that this continues to limit the effectiveness of the government's attempts to reduce health inequalities.

David suggests that the current government has an opportunity to go further than previous administrations and to lead the way in its approach to complex issues such as health improvement. He believes that the public health challenges that Scotland faces (e.g. obesity and alcohol misuse) provide the government with the chance to adopt what he calls a 'stewardship role in promoting healthy public policy.' This would differ from the approach currently being taken by many other countries, in that it would focus on using networks and partnerships, rather than markets and contracts, to build and deliver policy. However, in order to fulfil its potential, David believes that Scotland needs more passion, conviction and belief in itself and its potential role in people's lives.

The third essay in this series is by three authors from the Scottish Council Foundation – Andrew Harris, Nicole Hastings and Jim McCormick – who draw on their extensive experience and insights achieved in the think tank's ten years of life. They focus in particular on the need to overcome the structural and cultural limitations imposed by the boundaries between government departments and statutory organisations, and to devolve more power to local communities.

The authors begin by reminding readers of the dramatic improvements in health that have been experienced in Scotland in recent years. However, they go on to acknowledge the poor progress in tackling health inequalities and the continuing impact of deprivation on the health of many people living in Scotland. They warn against viewing health inequalities as a separate and discrete policy challenge, but endorse a view that recognises health inequalities as a consequence of problems across the whole system. This 'whole-system challenge' requires a 'whole-system response' that includes not just the whole of government, but also all of the other key players that have an influence on health, including businesses, the voluntary sector, communities and families.

The authors suggest that the dominance of the NHS with regard to public health and health inequalities has not been helpful in achieving support for this whole-system response, and they suggest that use of the term 'well-being', as opposed to 'health improvement', allows wider ownership of the issues. They 'strongly recommend that the highest priority for Scottish Government should be to promote well-being.'

Their description of the system that influences and determines well-being differs from others, but offers useful illustrations of the complexity of the system and the interrelationships at play within it. Complex and intractable challenges must be tackled with an understanding of the context within which they exist, even though some of these will be outwith the control of Scottish Government (e.g. globalisation). Nonetheless, the impact of these must be recognised and the elements that can be controlled must be addressed. The authors also highlight the fact that in such a complex system, all actions will potentially impact upon other parts of the system. This brings their argument back to the need for action on health inequalities to be integral to a wider whole-system approach.

Like David Hunter, the Scottish Council Foundation believes that the new administration in Scotland has a unique opportunity to act effectively to improve health in Scotland. There is already a cross-party consensus on the need to work across the system to improve health. However, the authors emphasise that if effective delivery of national policies is to occur, it will be necessary to alter the way in which health improvement work occurs, and they advocate greater devolution of power to local communities and agencies, and a change in culture within government and public bodies. Cultural change would include, for example, partnership working that allows each agency to understand and accept its own and others' roles and responsibilities, enabling those people who can make change happen to do so, longer-term commitments to funding to allow for planning, development and staff retention, and greater confidence and commitment to community-led approaches.

The final essay focuses specifically on the workforce that is required to deliver the improved health and reduced inequalities to which the Scottish Government and Scotland as a whole aspire. Professor Jim McEwen, formerly the President of the Faculty of Public Health, and currently active in public health workforce development, describes the changes that have occurred in the field of public health over the course of his career. He reflects on how the new approach to public health can best harness the energy and enthusiasm in the potential workforce to successfully address current and future health improvement challenges.

Interestingly, like the other authors, he notes the difficulties that structural changes have brought to effective public health action. Organisational and professional boundaries are not just a challenge at national level, but also impact on the potential to deliver health improvement at local level, despite the rhetoric of the importance of teamworking. The current approach to public health has tried to address these challenges in two ways: first, by recognising and supporting the different types of workers required for effective public health action, and secondly, by supporting and encouraging professional and organisational collaboration. This approach needs to recognise the often forgotten but nevertheless significant contributions of local authority and voluntary sector colleagues to health improvement. Although this has been broadly welcomed, and lays a firmer foundation for the future of public health, the challenge of ensuring that it works effectively remains. The vulnerability of the field to changes in political leadership and ideas adds to this challenge. Public health is currently in some ways a victim of its own success, in that political expectations are high. Jim believes that the system in its present form is unable to meet these expectations, despite substantial developments in training and new ways of working. Like the other authors, he points out that in order to understand and address the complex challenges of health inequalities, we must get better at whole-system working. Although the specialism of public health has a unique role in providing the evidence for change and then supporting that change and enabling it to happen, it relies on the contributions of specialists across a wide range of professions and areas of expertise.

Jim outlines his visions of a national public health 'service' that brings together professional and service development. He proposes that this should be built from existing components, and that it should utilise collaborative and joint approaches to appointing and developing its workforce. However, he acknowledges that this would require a willingness to accept change, new working relationships and new accountability arrangements, although he pleads for these to occur through 'evolution, not reorganisation.' NHS domination of public health thinking and employment would also need to change.

Jim concludes by proposing a new review of public health – focusing not on public health challenges, but on the current workforce and its skills, balance of expertise, training and strength, wherever employed. Such a review would also include an assessment of the likely future needs with regard to staffing, initial education and training, career progression and continuing professional development. As most aspects of service provision already exist, his view is that the review should examine the overall balance of different skills throughout the country, and new ways of integrating the different service components, not just through networks but also directly within a new service.

About the editor

Jill Muirie commissioned and edited this document on behalf of NHS Health Scotland where she is a Senior Public Health Adviser in the Policy Evaluation and Appraisal Team.

Scots can be healthier: preparing for the next phase of health improvement

Bosse Pettersson

This essay is written from the perspective of an ‘outsider.’ My reflections are based around five topics that I regard as central to today’s public health, and I hope they will be of use in considering the possible directions for future health improvement in Scotland.

Where is Scottish public health placed and where could it move to?

Today ‘globalisation’ is everyday language in public health. When considering Scottish public health I have focused in particular on its visibility and credibility, the geopolitical position, population health status and engagement in intra-governmental bodies such as the World Health Organization (WHO) and the European Union (EU).

As early as the 1980s, Scottish health education was repeatedly recognised and referred to. Over the subsequent years, several publications and products from both public agencies and academia in Scotland came to my attention – on evaluation, how to transfer priorities to action programmes, conceptual development on the settings approach, and male gender initiatives, to name just a few.

Scotland’s geopolitical position is, of course, closest to the other UK countries and the Republic of Ireland. Beyond that I would place Scotland in the same category as the North European cluster together with the Netherlands and the Nordic countries, where there is strong public social accountability and a national general welfare approach. Over time, and as devolved political power in Scotland becomes more embedded, the similarities with the Nordic countries might increase. However, it should be noted that, Scotland being a part of the UK but with devolved power, some similarities can also be drawn with Germany and a federal state. If future Scottish public health policy was to move towards a ‘determinants approach’ – that is, to tackle the ‘causes of the causes’ – the restricted control over the major factors influencing health might hamper progress and limit what could be achieved.

With regard to Scotland’s population health status, the papers I found paint a less favourable picture. They state that much remains to be done if the Scottish disease pattern and striking statistics for coronary heart disease, smoking, male alcohol consumption and high unemployment rates, among others, are to be brought in line with those for other countries belonging to the same category as Scotland.

Since the early 1990s I have been involved in the WHO's governing bodies, both in the European region and globally. Although Health Scotland is a WHO EURO Collaborating Centre, active in EuroHealthNet and a prominent member of the International Union for Health Promotion and Education (IUHPE), I am increasingly struck by the absence of Scottish (as well as Welsh and Northern Irish) views and visibility in the UK positions and priorities within WHO governing bodies. Health promotion and the combating of non-communicable diseases (NCDs) are now global concerns, affecting both developing and developed countries. Scotland could contribute much to this work. Similarly, within Europe, Health Scotland has been very active and has taken much European and national responsibility in strategically important projects such as social exclusion/inclusion, health inequalities, healthy ageing, and initiatives in the schools setting. Examples of this include:

- the EC project *Tackling Health Inequalities and Social Exclusion In Europe*, led by Health Scotland (2003–2005)
- the EC project *Closing the Gap: Strategies for Action to Tackle Health Inequalities in Europe*, led by BzG in Germany, in which Health Scotland was a partner (2004–2007)
- the EC *Healthy Ageing* project, led by the National Institute of Public Health in Sweden, and partnered by Health Scotland (2003–2006)
- the *European Network of Health Promoting Schools* (now *Schools for Health in Europe/SHE*), in which Health Scotland has played a significant role. This was a key factor in Health Scotland and its predecessors receiving WHO collaborating centre status.

Yet the views of Scotland do not emerge strongly in the Commission's management and high-level committees and other politically influential bodies.

To conclude my introductory remarks, Scotland has both visibility and credibility in the international public health community. It is important to sustain this in an increasingly globalised world. Developments since the devolution of political power in Scotland are likely to result in increasing pressure for a national model for public health. The coherent structure in which programme design, development of strategies and methods, and programme delivery are kept together has so far proved to be productive in the Northern European countries. Much remains to be done about the improvement of the health status of Scotland's population, so that it becomes comparable with that of countries of similar size and resources. A qualified guess is that the most important components required to fulfil this objective are the further development of policies across all of the relevant sectors, and the strengthening of infrastructures for the delivery of health promotion and disease prevention. A stronger reflection of Scottish priorities and experiences in the governing bodies of the WHO and the EU would help to strengthen the emphasis on NCDs, as well as more closely reflecting the situation for countries of similar size to Scotland. The comprehensive ban on smoking in enclosed public places is an example where Scotland paved the way, taking radical action to both substantially and symbolically improve health.

Health inequalities: implement two mutually supporting approaches

The reduction and elimination of socially driven inequalities in health is the ultimate goal of international health policy targets. This should happen as a result of improving health for all, and improving it most for those with health-related disadvantages. Ever since the expression 'Health for All' was coined in 1977, there has been much debate and discussion, but rather less action. The general impression in Western Europe is that the trends are heading in the wrong direction – health inequalities are increasing, at least when measured as relative differences between the population groups that are most and least affluent. Scotland is no exception in this respect.

Can anything be done to make a change, by moving from talk to action? It certainly can, but only if the issue is taken seriously. It is fundamental to a true human rights approach – no one I have met seriously believes it is fair that a boy with a single mother with a low level of education and living in social housing should have a life expectancy which is more than five years shorter than that of a boy brought up by married parents with a high level of education and living in a house of their own. Over the past 20 to 25 years the literature on and knowledge about health inequalities has grown immensely, and this includes important contributions from Scotland. The social epidemiology is in place, the impact of social and economic policies has been well described, but a comprehensive approach to implementation has yet to be adopted.

I would suggest two approaches for a serious attempt to bring about change. The first is to adapt and implement the strategies, policies and concrete actions described by Göran Dahlgren and Margaret Whitehead in the two 'Levelling Up' reports (actually launched in Scotland in 2006) published by the WHO European Office for Investment for Health and Development, based in Venice. The second approach is to be very practical and empirical and to move from the national to the local perspective – to make use of existing epidemiological data and local knowledge and identify in which local authorities health is most and least equally distributed, and to analyse why this is so. With the exception of targeting vulnerable groups, or people at risk, measures for reducing health inequalities are mainly discussed from a national perspective, while professionals in public health working at the local level are left with little concrete guidance or useful support. What needs to be done – and can be done – at a national level is highly ideological and sensitive from a political point of view. The evidence with regard to reducing health inequalities at the macro and structural levels points clearly in the direction of more equal wealth distribution in terms of real-life opportunities, education, employment and consequently income and housing standards. These are central and value-based issues in politics, where both ideologies and means of achieving public health goals differ between parties.

Public health policy: tackling the determinants of health

The update of the WHO 'Health for All' targets for the European region in 1999 meant a move from disease orientation towards the underlying causes of ill health. This approach is often referred to as the 'determinants of health' or, more recently, as the 'causes of causes' – easier to say, but not easy either to explain or to understand. My experience from Sweden, where the national public health policy was consistently built on health determinants and adopted by the Parliament in 2003, is that much emphasis is still attached to the immediate risks, such as smoking, harmful alcohol use, unhealthy diets, insufficient physical exercise and other individual behaviours. Hand in hand with tackling health inequalities goes the health determinants approach. The latter is intended to link structural societal factors with the settings and environments in which people live their lives, and to bridge over to individual behaviours which are damaging or not conducive to health. In concrete terms, the price of alcoholic beverages does affect their availability, and the social climate for young adolescents is formed by the school, recreation and housing environments in which they learn, play, meet and interact daily. Regarding these as fundamental and environmental determinants provides a better explanation as to why some young people will take up uncontrolled alcohol drinking than regarding it as mainly an individual problem. It is about tackling the fundamental and environmental determinants of health when public health moves beyond health and medical care.

In the Bangkok Charter for Health Promotion in a Globalized World, published in 2005, the expression 'whole of government' is coined. Health Scotland has contributed actively to the development and understanding of this concept. Next comes the challenge of translating the concept of 'whole of government' into political action. I believe that this requires a mechanism whereby health determinants are identified within each government department together with an obligation to contribute to overall health improvement by systematic action as part of a coherent, multi-sectoral public health policy. Consequently, there is also a wider mandate for the national public health agency (e.g. in Scotland this is Health Scotland) to support and facilitate the policy and to monitor how it is implemented. In Sweden, this is the role of the Swedish National Institute of Public Health (SNIPH). The Swedish Public Health Policy Report, published in 2005, was instrumental in promoting multi-sectoral action, and most likely also in progressing public health policy itself. The reason for having a public health policy report delivered as a White Paper from the Government to the Parliament every fourth year is that MPs and decision makers can better follow the fulfilment of agreed political goals, as well as receiving public health reports presenting major trends. It is also helpful in that it keeps public health on the political agenda. Despite these advantages, to my knowledge, only a few countries have as yet embarked on this course. One reason is probably that there are no quick fixes, and one size does not fit all. The theoretical model is not so difficult, but turning it into practice and crossing sectoral barriers will require a profoundly grounded process over many years. Only long-term commitment and process-oriented work are likely to be successful, so without patience and listening this approach is almost bound to fail. My analysis is that national public health strategy in Scotland is comprehensive and

up to date but, as with all the others, the most serious obstacle is knowing how to implement it fully. I also believe that current policy would benefit from a consideration of the impact of globalisation on population health.

Infrastructures for public health delivery

Whatever policy, strategy or great ideas there are around, they have very limited value if they do not reach the community and make sense in people's lives. Consequently, the infrastructures for delivering measures intended to improve health are a critical factor. Yet despite this general knowledge about policy implementation, the links between central policy making and regional/local levels are underdeveloped in public health. What do we mean by infrastructures for delivering health improvement? In my view there are five functions at the core:

- 1 a monitoring and surveillance system that provides local data about the particular features of different communities
- 2 a workforce trained in public health, with advanced knowledge of the strategy and methodology of health promotion and disease prevention, ranging from structural determinants to individual risk behaviours
- 3 provision of a sound knowledge base within a national/central public health function that responds to local needs and problems
- 4 the breakdown of national/central policy to local and regional circumstances in a way that clearly conveys what is within the remit of local and regional authorities
- 5 integration of health determinants in the regular governing and management systems of local and regional authorities.

This task is both ambitious, because it is extensive and embracing, and sensitive, because it deals with the issue of central governance and local autonomy. Nevertheless, it is necessary if we want to achieve change, and it is possible if involved parties focus on the population they are seeking to reach, rather than on administrative borders.

Focus on health promoting schools and male health

With regard to what I have learned and seen from Scottish public health over the years, whether in evaluation, health communication, academic research or health inequalities, I have in general been very impressed. However, if I was to select the most promising developments which I would recommend for retention and development, these would be the Scottish Health Promoting Schools Unit and a revitalisation of the pioneering work on men's health.

The Scottish Health Promoting Schools Unit looks to an outsider to have been successful in comprehending different aspects of health. It is a concrete example of cross-sectoral collaboration, it has a long-term commitment and it reaches out locally. There must be plenty of rich experiences to capitalise on when approaching other sectors with great potential to improve health in Scotland.

Increasing attention is rightly being paid to gender and health – there are differences in health between women and men, and health improvement work must be more sensitive to this fact. However, female health has attracted considerable investment, whereas too little has been done about men's health. This may be due to sensitivity about male health. Scotland is among the pioneers in this field, but the momentum seems to have been lost. In Ireland, initiatives have also been taken on this subject. I refuse to believe that male health is only a Celtic concern, but maybe there is something that is making these countries front-runners. The difference in life expectancy between men and women generally, and the wide differences in life expectancy among men, are neither biological laws nor ordained by destiny. Men must be encouraged to care more about their own health, and must be empowered to do so. In my opinion, Health Scotland is well placed to revitalise its work to promote male health.

Eight cards to play ...

I am aware that having too many proposals for change at any one time seldom results in implementation. With this in mind, I am putting eight cards on the table for consideration. The options are not listed in any particular order, and should be adapted to the development of a master plan for Scottish health improvement.

- 1 Strengthen Scottish involvement in policy and decision making in the WHO and European Union and European Commission bodies.
- 2 Tackle health inequalities at two levels:
 - a national approach based on the most up-to-date policies and strategies
 - a local approach based on empirical practice(and estimate the extent to which health inequalities hamper social and economic development).
- 3 Build up a systematic and long-term multi-sectoral process across government departments.
- 4 Equip the central public health agency with a wider mandate to act across sectors through support, facilitation and monitoring of how the policy is implemented.
- 5 Consider the introduction of a national Public Health Policy Report (in line with Parliamentary cycles) to maintain the momentum of health improvement at the top political levels.

- 6 Conduct an analysis of how population health development will be affected by globalisation.
- 7 Stimulate measures to establish core infrastructures for public health delivery at the local and regional levels.
- 8 Maintain and continue to develop the Scottish Health Promoting Schools Unit, and revitalise the issue of male health as the missing half of a complete gender approach to health.

About the author

Bosse Petterson started his professional work in health education in 1976. Before that he worked for seven years in community spatial and welfare planning as a research fellow in the Swedish Building Research Institute. During the years 1976–1992 he was employed by the National Board of Health and Welfare. In 1992 he was recruited to the re-established Swedish National Institute of Public Health (SNIPH), which he left as the Deputy Director-General when it was relocated to Östersund in 2007. Nationally he has worked in health promotion at all levels of Swedish society, and has been actively involved in Swedish public health policy making. Together with like-minded colleagues, he introduced a public health programme at the Karolinska Institute in 1988, including modules on health education and health promotion, and he is still teaching as a senior guest lecturer. He became internationally involved in the late 1970s, and has been actively involved in all six WHO international/global health promotion conferences. He was the Secretary-General for the third conference (held in Sundsvall, Sweden in 1991 with the theme of 'Supportive environments for health'). In the early 1990s he became a member of the Swedish delegation to WHO governing bodies in the European region and globally with special responsibility for health promotion and disease prevention. After Sweden joined the European Union, he was appointed as a national representative to the public health programme. During 2002–2007 he served as the President of EuroHealthNet, a network of European health promotion and public health agencies, based in Brussels. He is currently working part-time as a senior adviser in national and international public health to the SNIPH, and as a public health consultant.

Health improvement policy implementation in Scotland from a UK perspective

David Hunter

In keeping with the rest of the UK, Scotland has put health improvement and a narrowing of the health inequalities gap at the heart of policy making and of government.¹ The arrival in May 2007 of a new government led by the Scottish National Party is unlikely to significantly modify this priority. For now, the health improvement focus rests on four pillars:

- early years
- teenage transition
- workplace health
- community development.

The intention is to work across Scottish Executive Departments to achieve these objectives.

Every Minister and every portfolio has a strong interest in how health improvement can help them achieve their overall aims, and in how achieving their aims can also help improve Scotland's health. We are taking a cross-cutting and whole-government approach to health improvement – putting health improvement in all our policies, and seeking to support all our policies by improving health.²

Correctly, it is acknowledged that health improvement is a cross-cutting issue that cannot be achieved by the health department acting in isolation or axiomatically assuming a lead role. However, although awareness of what needs to happen is evident, making a reality of joined-up policy and management continues to pose major challenges for governments everywhere, both horizontally across departments and vertically with regard to different levels of government.

Although it is premature to say definitively what has been, or is being, achieved in Scotland by way of health improvement and narrowing the health gap between the most and least disadvantaged, there are pointers with regard to the emerging policy context and desire to do things differently. This commentary considers and reflects upon these issues, locating developments in a wider context where appropriate.

¹ Scottish Executive. *Delivering a Healthy Scotland: meeting the challenge*. Edinburgh: Scottish Executive; 2006.

² *Ibid.*, p. 5.

The arrival of devolution

The advent of political devolution in 1998 afforded important and potentially useful learning opportunities, since divergence is evident with regard to how the various countries of the UK are proceeding to advance the health improvement agenda.^{3,4} Devolution offers opportunities to experiment and innovate and, within smaller polities such as Scotland and Wales, to be more flexible and encourage thinking 'out of the box.' There is some evidence that, albeit often falteringly and cautiously, attempts are being made to move away from a narrow departmentalism and silo-based approach to policy and implementation, and to develop a more unified corporate identity.

However, history did not begin with political devolution, which remains in its infancy.⁵ Since 1885, when the Scottish Office (which preceded the Scottish Executive) was established, Scotland has enjoyed a substantial degree of administrative devolution affecting policy areas such as health and healthcare. Issues of interdepartmental working and overcoming narrow departmentalism were as rife then as now. Indeed, a comparative study of community care in England, Wales and Scotland found that structural divisions between health and personal social services at the centre appeared greater in Scotland than in either England or Wales.⁶ Part of the complexity arising from cross-cutting government lies in the fact that interdepartmental working is much more than a structural matter. Departmental tradition and culture can enable or impede interpersonal contact and contribute to tribalism and/or boundary skirmishes.

A key difference arising from political devolution is the growth of self-confidence coupled with a strong desire to do things differently and exploit the advantages of size and scale. In such a milieu, health improvement is a prime candidate for attention, especially in the context of Scotland's historically poor health record. As the Deputy Chief Medical Officer in the Scottish Executive has commented, Scotland's high prevalence of smoking and alcohol misuse resulted in it becoming known as 'the Sick Man of Europe.'⁷ Furthermore, 'its diet was almost legendary in its alleged awfulness.'⁸ However, it is one thing to describe the problem, but is there evidence of progress and achievement in addressing it? The answer is a tentative yes, although there is much still to do.

³ Greer S. The politics of health-policy divergence. In: Adams J, Schmucker K, editors. *Devolution in Practice 2006: public policy differences within the UK*. Newcastle: IPPR North; 2006.

⁴ Blackman T, Elliott E, Greene A et al. Performance assessment and wicked problems: the case of health inequalities. *Public Policy Admin*. 2006; 21: 66–80.

⁵ Parry R. The Scottish Executive and the challenges of complex policy-making. *Political Quarterly*. 2003; 74: 450–8.

⁶ Hunter DJ, Wistow G. *Community Care in Britain: variations on a theme*. London: King Edward's Hospital Fund for London; 1987.

⁷ Donnelly P. Public health in Scotland: the dividend of devolution. In: Griffiths S, Hunter DJ, editors. *New Perspectives in Public Health*. 2nd ed. Oxford: Radcliffe Publishing; 2007. p. 22.

⁸ *Ibid.*

Meeting the challenge

Two high-profile health improvement initiatives resulting from devolution and the Scottish Government's commitment to health improvement and cross-government working are the Breastfeeding Act, and the ban on smoking in public places which came into effect in March 2006. In the case of breastfeeding, the measure was popular and has gone some way towards meeting the 'early years' health challenge. The smoking ban also received wide political and public support.

Elsewhere, two independent reviews of health improvement policies shed light on progress to date and on the obstacles that need to be overcome in order to secure further gains. The first, completed in September 2006, took the form of an assessment of the Scottish Diet Action Plan (SDAP) which straddled the period before and after devolution. The other is in the final stages of completion and reviews progress with regard to the National Programme for Improving Mental Health and Well-Being.

The Scottish Diet Action Plan

Introduced in 1996, the independent review of the SDAP concluded that it was perhaps too ambitious, and that although there had been some successes, these were largely unexceptional in terms of their 'reach and population impact.'⁹ The review was critical of the poor progress made in implementing changes in food and nutrient intake, and noted that some trends were moving in the wrong direction.

The assessment of the SDAP linked the public health agenda to a wider framework of sustainability and social justice. Policy goals that cut across and link traditional sectors to sustainable development and social justice raise questions – in this instance across the food system – that are broader than the usual public health policies. This focuses attention upstream and on socio-economic determinants of health, requiring changes in the behaviour of important economic players such as food producers, importers, processors, manufacturers, distributors, retailers and caterers. Only governments can address these entrenched interests, working with them to change their behaviour and investment and marketing strategies. However, to do this effectively requires joined-up thinking and action across government, especially with regard to agriculture, education and health.

The review concluded that 'if future food policy is to be truly cross-cutting, policy outcomes and targets need to go beyond the existing dietary targets to incorporate the policy goals of other government departments and to influence the wider food supply chain.'¹⁰ Considerable work remains to be done to secure 'ownership and buy-in from communities, agriculture and the environment.'¹¹

⁹ Lang T, Dowler E, Hunter DJ. *Review of the Scottish Diet Action Plan: progress and impacts 1996–2005*. Edinburgh: Health Scotland; 2006. p. vii.

¹⁰ *Ibid.*, p. 65.

¹¹ *Ibid.*, p. 65.

National Programme for Improving Mental Health and Well-Being

The National Programme, a welcome and widely endorsed initiative, has succeeded in raising the profile of mental health issues and in ensuring that the issue has received attention at ministerial level. It has provided visible leadership and put mental health firmly on the policy agenda, injecting new energy and a sense of dynamism. Located within the Scottish Executive, the Programme is well placed to influence the agendas of other departments and ministers. During its short life it has scored some successes and made inroads into complex cross-cutting issues within the Scottish Executive, especially with regard to education and the workplace, and it has engaged with the well-being agenda. However, mental health improvement work remains fragile, and needs to become more embedded in policy and practice with a clearer focus. Issues of a difficult cross-cutting nature also require further attention, and there is a need to put in place appropriate links between central policy and local implementation and delivery.

However, whatever criticisms can be levelled at the National Programme, the very fact of its existence is powerful testimony to the strengths and virtues of the new devolved arrangements and the room for manoeuvre they provide in terms of finding new solutions to 'wicked issues.'

New government, new ways of working

What both the experience with the SDAP and the National Programme demonstrate unequivocally is the need for more effective joined-up government at the centre, and for this to be reflected in more focused and consistent messages being transmitted between the centre and the periphery, so that local authorities and health agencies know what is expected from them and have the requisite resources to hand.

Following the Scottish Parliamentary Election in May 2007, changes in government that would most likely have occurred at some stage regardless of the outcome of the election were quickly ushered in with the emergence of the Scottish National Party as the majority party in Parliament, keen to put its stamp on a new style of government. The changes focus on making the Scottish Executive 'a fully integrated government', and are the product of work begun in 2006.¹²

Despite some successes, the *Taking Stock* review is critical of progress to date, recognising that the Scottish Executive is 'not yet where we want to be.' In particular, there has been a failure to deliver the changes sought in internal processes and structures, including the 'effectiveness of the corporate centre.' Scotland's poor health status gives added urgency to the task of finding and implementing joined-up solutions to problems that have proved stubbornly persistent over decades.

¹² Scottish Executive. *Taking Stock Review: fit for the future*. Edinburgh: Scottish Executive; 2006.

Looking to the future, reducing health inequalities is a key challenge for the cross-cutting emphasis sought and the new leadership required to bring about improved delivery and change. The *Taking Stock* review reports a perception among staff and stakeholders that 'the senior leadership team lacks passion, pace and drive.' It is not perceived 'as the powerful and united driving force that they aspire to be.'¹³ In particular, there is recognition of the need 'to continue breaking down organisational barriers and encourage working across departmental silos in order to achieve overarching objectives.' It is also acknowledged that the Scottish Executive realises 'that it has a real opportunity to join up more fully and benefit from economies of scale.'

Difficulties in achieving collaboration between departments have created problems for front-line agencies charged with policy delivery. Community Planning Partnerships (CPPs) are hampered by having to respond to too many targets and policy objectives set for them by the centre. Multiple reporting arrangements and funding streams have caused difficulties in delivering objectives and service improvements. For instance, in its review of CPPs, Audit Scotland points out that:

*the lack of integration and prioritisation of the large number of national policy initiatives, and the fragmented nature of funding arrangements to support these, make it difficult for CPPs to achieve their potential in meeting local needs, and create a further administrative burden.*¹⁴

Anecdotal evidence suggests that Community Health Partnerships may not be entirely immune to similar tendencies.

Innovations in government

Although there is clearly much to do to drive cross-cutting policy in areas such as health, the Scottish Executive and its political leaders and officials are well aware of the enormity and complexity of the challenge. Indeed, a report from the influential think tank, the Institute for Public Policy Research (IPPR), on innovations in government claims that Scotland has much to offer other countries, including England, with regard to how to transform the way in which government does its business in the twenty-first century.¹⁵

¹³ Ibid., p. 15.

¹⁴ Audit Scotland. *Community Planning: an initial review*. Edinburgh: Audit Scotland; 2006. p.

¹⁵ Lodge G, Kalitowski S. *Innovations in Government: international perspectives on civil service reform*. London: Institute for Public Policy Research; 2007.

The IPPR report is critical of new public management (NPM) thinking which has held sway in the UK and elsewhere for some 20 years, and which remains a touchstone for many reformers. In particular, NPM encouraged the disaggregation of policy, research and delivery into separate units, with the result that expertise became dislocated and buried within departmental silos.¹⁶ As a consequence, joined-up government remains a core challenge for governments across the world, especially when 'wicked issues' such as health improvement and health inequalities do not fall into neat departmental silos. Horizontal government has been impeded by the grip of NPM on public bureaucracies. Despite this, NPM concepts remain in high fashion, with little sign that they have run their course. Moves to privatise chunks of the state, to hive off delivery functions to arm's-length agencies, and to diversify providers of public services could make cross-boundary working more complicated.

The IPPR report suggests that small countries, such as Scotland, are showing the way forward. The authors write:

Intent on moving on from the departmentalism of Whitehall, Scotland's new devolved government seized the opportunity to start afresh. The Executive has emphasised the maintenance of a unified corporate identity. This has also been promulgated through the matching of ministers to topics that cross departments, rather than identifying ministers clearly with specific departments.¹⁷

In the new government formed in the aftermath of the May 2007 election, the Scottish Executive has been restructured so that the Cabinet comprises the First Minister and five Cabinet Secretaries, one of whom will cover health and well-being. She is supported by two ministers – one for public health, and the other for communities and sport.

Health in All Policies

It does seem as if thinking around health improvement in Scotland and the need for a cross-cutting agenda that links to sustainability and social justice concerns is not only timely but also in keeping with developments elsewhere in Europe. Under the Finnish European Union Presidency between July and December 2006, the European Commission became committed to viewing health as cross-sectoral in its impact.¹⁸

¹⁶ Hunter DJ. Efficiency. In: Marinker M, editor. *Constructive Conversations About Health: policy and values*. Oxford: Radcliffe Publishing; 2006.

¹⁷ Lodge G, Kalitowski S. *Innovations in Government: international perspectives on civil service reform*. London: Institute for Public Policy Research; 2007. p. 28.

¹⁸ European Commission. *Health in Europe: a strategic approach*. Discussion document for a health strategy. Brussels: European Commission; 2007.

Health in All Policies (HiAP) was the main theme of the Presidency, and is a natural continuation of Finland's long-term horizontal health policy. HiAP is proposed as a strategy to help to strengthen the link between health and other policies.¹⁹ It seeks to address the effects on health across all policies, such as agriculture, education, the environment, fiscal policies, housing and transport, through the use of tools such as health impact assessment. Through an HiAP approach, the well-being of countries becomes the responsibility not only of health structures, mechanisms and actions, but also of other sectors which may in fact have even greater influence on health and well-being.

There is nothing novel about HiAP – it echoes WHO thinking enshrined in Health for All and earlier initiatives, notably the Ottawa Charter (1986). It is its revival in high policy-making circles that is significant at a time when notions like health and wealth are seen to go together. Contemporary preoccupations with notions of happiness and well-being are also directly relevant to HiAP.

Conclusion

As Scotland's still young parliament and policy-making freedoms develop and mature, it is likely that a willingness to take risks and explore new ways of tackling deep-seated public policy problems will become more evident, and possibly divergent from elsewhere in the UK. Until now, devolution has proceeded in a fairly cautious way, and although there have been bold public policy moves to improve health, notably the ban on smoking in public places – which preceded similar action elsewhere in the UK – the full potential afforded by a new style of government in a context free from the historical and bureaucratic baggage of a London-based civil service has yet to be realised.

Following the *Taking Stock* review referred to earlier, the results of which are now being implemented with considerable urgency and enthusiasm, the Scottish Executive is positioning itself to ensure that cross-cutting issues, such as health improvement and well-being, are to the fore in terms of structures and priorities. However, it is important that the rhetoric does not run too far ahead of the reality, or even become a substitute for it. Efforts to ensure more effective cross-cutting work will be judged on actions and achievements, and although examples of these do exist, their scale and impact remain modest. The achievement of real and sustainable gains in health improvement will require bold action, on a par with the smoking ban legislation.

¹⁹ Stahl T, Wismar M, Ollila E et al., editors. *Health in All Policies: prospects and potentials*. Oxford: European Observatory on Health Systems and Policies and Finnish Ministry of Social Affairs and Health; 2006.

Faced with complex public health and sustainable development challenges, notably obesity and alcohol misuse, Scotland is well placed to seize the initiative, recognising that government has a vital stewardship role in promoting healthy public policy and thereby reclaiming the public realm that is being progressively eroded by the commodification of public policy.^{20,21} The alternatives currently on offer are, for different reasons, equally unappealing and flawed. On the one hand, there is the so-called 'McKinsey state' – public services driven through a vast bureaucratic public corporation, using crude 'sticks and carrots.' On the other hand, one could resort to the equally crude mechanism of the market with its (largely untested) three Cs – contestability, choice and commercialisation. A different approach is called for, which appreciates how complex systems work. In place of markets and contracts, there would be nurturing of networks and partnerships, through which policy is not simply delivered but also shaped and elaborated through a process of dialogue with key stakeholders and distributed power. As noted above, Scotland is poised to move in this direction, but it is not there yet. It needs to be more assertive and passionate about the public realm and its ability both to preserve it and to shape it.

Looking from outside, and comparing developments with other parts of the UK, Scotland is at a crossroads, hovering between taking on the individualistic, consumerist, choice mantra adopted by the government in England on the one hand, and reasserting its faith in, and confidence to perform, the stewardship role of government on the other, whereby government leads by example, as happened in the case of the smoking ban, school meals, and legislating for breastfeeding in public places. The National Programme for Improving Mental Health and Well-Being is a further example of enlightened policy making that has marked out Scotland within the UK.

Elements of both paradigms – what might be termed *market liberalism* on the one hand, and *enlightened paternalism* on the other – can be found in policy statements as well as in reviews of the public sector and its ability to deliver. Whether they can coexist in a state of mutual harmony or creative tension, or whether there needs to be a decision in favour of one or the other, is a matter for further reflection. It will perhaps emerge in time from the experience of the Scottish Executive as it grapples with health improvement as a cross-cutting issue of considerable significance and complexity.

About the author

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²⁰ Choi BCK, Hunter DJ, Tsou W *et al.* Diseases of comfort: primary cause of death in the 22nd century, *J Epidemiol Community Health.* 2005; 59: 1030–4.

²¹ Shah H, Goss S. *Democracy and the Public Realm.* London: Compass; 2007.

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Scotland's future well-being

Andrew Harris, Nicole Hastings and Jim McCormick

Introduction

Since 2003, Scotland has increasingly been recognised as a country where health improvement is taken seriously.²² It is seen as a place where important and innovative work is being done to develop more effective approaches for addressing poor health generally and health inequalities in particular. Consistent efforts to tackle traditional major killers such as cancer and cardiovascular disease have begun to bear fruit.²³ The introduction of a ban on smoking in public places has reflected both a greater public readiness to tackle major public health risks and a stronger commitment to demonstrate leadership at a national political level. As a result, thousands of people in Scotland are living longer and free from illness – a fact we should celebrate.

However, not everything in the garden is so rosy. Scotland, and the UK as a whole, have improved the health outcomes of the most deprived, but in relative terms they are worse off than before, because more affluent groups have seen their wealth increase and their health improve even further.²⁴ Amidst all the talk of 'affluenza' and the diseases of affluence, it is worth recalling that the single biggest factor in Scotland's variable health outcomes is deprivation. Inequalities in health, either physical or mental, are driven by inequalities in income, education, work, housing, environment, social capital and quality of life. Therefore, if Scotland's health inequalities are to be tackled, this must be in the context of action to tackle the raft of inequalities in areas that underpin population health and well-being. Health inequalities should be seen as the 'presenting symptoms' of wider systemic problems, and not as a discrete policy challenge.

Whole-system challenge, whole-system response

In other words, the health improvement challenge is a 'whole-system' challenge. If we are to genuinely transform the health outcomes of all of Scotland's communities, but particularly the most deprived, action will be required to address factors as diverse as air pollution, job insecurity, violent crime, levels of physical activity, nutrition, addictions, educational outcomes, levels of debt, depth and duration of poverty, social cohesion and trust in institutions. There are no 'silver-bullet' policies that can address such a range of challenges, and no single agency that can cover all of these areas. Therefore a 'whole-government' approach is not just the *best* way for governments to promote better health – it is the *only* way for them to be likely to succeed in this.

²² For example, see Scottish Executive News Release on the impressions of World Health Organization officials during a visit to Scotland: www.scotland.gov.uk/News/Releases/2005/11/29095021

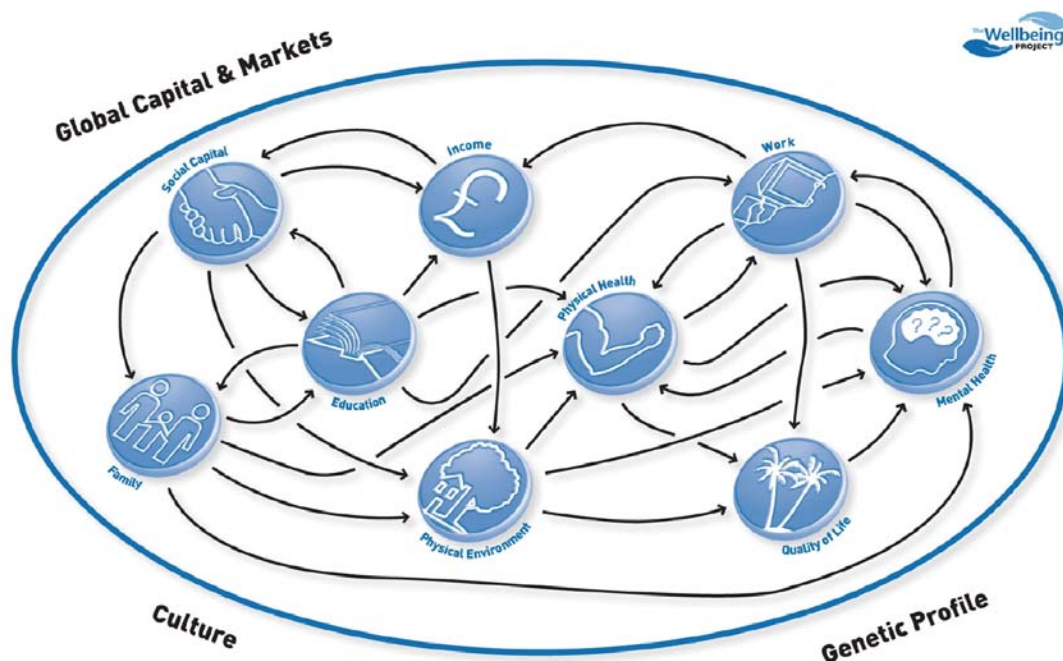
²³ For example, see Scottish Executive News Release on Audit Scotland report of progress in tackling cancer, stroke and heart disease: www.scotland.gov.uk/News/Releases/2005/12/07100656

²⁴ For example, see Scottish Executive (2003) Inequalities in Health. Report of the Measuring Inequalities in Health Working Group. Edinburgh' Scottish Executive' Edinburgh www.scotland.gov.uk/Resource/Doc/47171/0013513.pdf

However, although a whole-government approach is necessary, it is not sufficient. What Scotland needs is a ‘whole-system’ response to the challenge. Government is just one of the players in the complex web of interactions that can either enhance or erode population health. Businesses, voluntary groups, non-governmental and civic organisations, communities, families and individuals are all equally important actors if we are serious about achieving change.

The recent report entitled *Working the System: Creating a State of Wellbeing*,²⁵ published by the Scottish Council Foundation (SCF), described the scope of the challenge and, drawing on previous research, offered some thoughts on how to go forward. The map below is one representation of the challenge. The range of factors that we were able to identify as having an impact on population health was organised into a set of nine policy domains, and the causal connections between the different domains are represented as arrows between them. So, for instance, ‘income’ affects ‘physical health’, perhaps through the affordability of healthy food, but ‘physical health’ also affects ‘income’ – for example, by affecting the ability to work. By mapping all of these interactions on to a single framework, we begin to describe a complex system that will either promote or harm population health and well-being. As can be seen on the map, we can also define some other influences – culture, genetic profile and globalisation – that may be outside the realm of Scottish policy makers, but which have a pervasive influence on our nation’s health. (In fact, some respondents to this work have argued that globalisation may currently be the single biggest influence on any population’s health.)

Figure 1: The Wellbeing System



²⁵ Harris A, Hastings N. *Working the System: Creating a State of Wellbeing*. Edinburgh: Scottish Council Foundation/Pfizer; 2006

Different description, different response

At this stage, we propose that a change of language might help us to address the challenge more effectively. The policy debate in Scotland is dominated by the word 'health.' Unfortunately, this has come to be mainly associated with the NHS, hospitals, doctors and nurses. As a result, policy responses to Scotland's continuing poor health have come to be dominated by discussions of hospital location, access to services, and numbers of staff. Although these are important issues, they are not the most important influences on population health. Meanwhile, we have found that the association of 'health' with 'the NHS' tends to encourage other agencies, particularly at local level, to opt out of efforts to promote better health in the communities which they serve, reasoning that the biggest and best-funded public-sector organisation in the country should be able to tackle population health on its own.

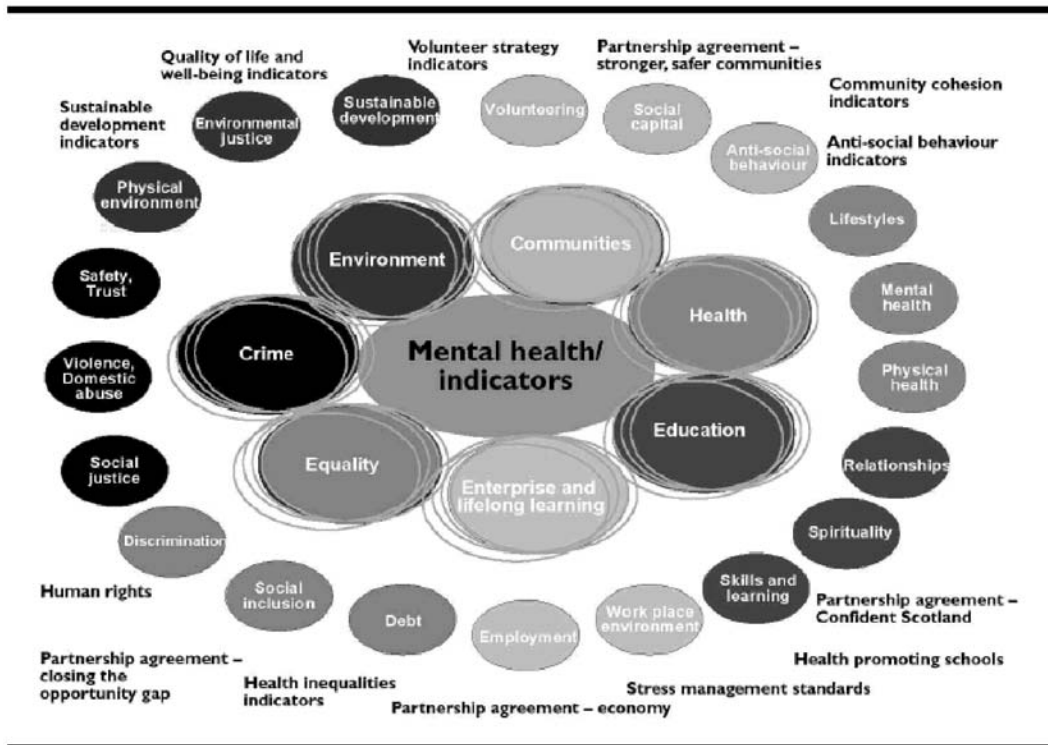
The SCF argues that Scotland's top priority should be to improve population 'well-being.' Well-being is a more difficult concept to pin down than health, as it has subjective elements which can be difficult to measure. However, we have found in discussions with both professionals and ordinary citizens that using the term 'well-being' instead of 'health' encourages a more open, holistic consideration of the challenges and possible responses. For instance, education and housing officials may be wary of 'health imperialism', but they are willing to engage in a process intended to promote well-being, because they can accept it as a concept that transcends organisational boundaries and priorities. We therefore strongly recommend that the highest priority for the Scottish Government should be to promote *well-being*. We believe that it is only by changing our conception of the challenge that we will genuinely begin to tackle it in a 'whole-system' way.

A focus on well-being

The illustration below, taken from ongoing work by NHS Health Scotland on Mental Health Indicators,²⁶ shows one way in which a focus on well-being rather than clinical measures of health can begin to help us to rethink our approaches to the problems facing Scotland. One key feature of Scotland's current well-being challenge – and a challenge that we believe will increase for Scotland over the next decade – is the persistent and growing incidence of mental health problems. A focus on the concept of well-being allows a broader response, that emphasises mental health promotion and the prevention of poor mental health, as well as clinical responses to mental illness. This will be important in addressing growing mental health inequalities.

²⁶ Information available via <http://www.healthscotland.com/understanding/population/mental-health-indicators.aspx>

Figure 2: The cross-cutting nature of mental health and the indicator set



A focus on well-being will include action on all of the elements in the illustration above, or at least efforts to avoid negative impacts. For instance, there may be little that government can do directly to promote healthy relationships, but it can ensure that other policy measures do not act to erode them. This highlights one important facet of any future government effort to promote well-being – it must ensure that policy is sensitive to the ‘softer’ elements of well-being, as well as pursuing initiatives to promote specific well-being outcomes. Well-being is an ‘emergent property’ of the system of factors described in the SCF map above – it is enhanced and sustained by ensuring positive improvements in the various domains shown on the map.

This need to recognise that there is a complex system at work will apply across the full range of seemingly intractable social challenges that Scotland is set to face in the next decade – namely drug and alcohol abuse, obesity, quality of parenting, violence and antisocial behaviour. In tackling these challenges, government and others in Scotland must bear in mind the potential consequences of their actions for other parts of the system. For example, action on antisocial behaviour must not erode community trust in institutions. In general, in tackling these issues, we believe it is more helpful to consider them as the ‘presenting symptoms’ of problems elsewhere in the system.

This is reflected in current thinking about how to tackle ‘multiple and complex needs’, where individuals, families and groups face multiple forms of deprivation and the challenges that are associated with them. Health inequalities may well be

one of the multiple needs to be addressed, but this must be done in the context of action on education, or families, or housing, or indeed all of these – thus requiring a holistic approach with the person or family. This reinforces the point that action on health inequalities must occur within the context of wider action on multiple other inequalities, and in fact may only be possible after other inequalities have been addressed. As one public health professional who was interviewed in the *Working the System* project reported:

... people will say to you, 'Yeah, I really would like to stop smoking, but actually I haven't got a job, my husband isn't very nice to me, the neighbours round here are hellish noisy, there's loads of dog fouling in my garden, and I don't get on with my neighbours,' and then they'll say to you, 'But if that was all sorted then maybe the seventh thing on my list to do might be to stop smoking.'

Although there is clearly a need for innovative approaches to some of these challenges, we believe that some of the existing approaches should be re-emphasised. The breadth of existing evidence with regard to early intervention approaches, the impact of increasing incomes on health and other outcome inequalities, and the potential benefits of much more intensive 'case-worker' approaches are very compelling – particularly the evidence on the benefits of reducing income inequality. We believe that adhering to these relatively straightforward approaches but doing more, with greater consistency, would offer scope for real improvement.

Doing things differently

Our work over the last ten years^{27,28} has highlighted the need for 'holistic' and different approaches to the promotion of health and well-being in Scotland, focusing in particular on identifying ways to unlock more energy from the different parts of the system. These have included:

- asset-based approaches to community development
- efforts to reduce the 'silo' mentality perceived to be dominant across much of the public sector
- the need to recognise the potential of better human relationships to make and sustain positive change for individuals and communities.

We believe that the arguments for these changes are still valid, and that this is increasingly recognised by officials, particularly at the local level, across Scotland.

²⁷ Stewart S, editor. *The Possible Scot: making healthy public policy*. Edinburgh: SCF Healthy Public Policy Network; 1999.

²⁸ Scottish Council Foundation. *Possible Scotland*. Edinburgh: Scottish Council Foundation, Health Education Board for Scotland and Public Health Institute for Scotland; 2002.

Over the last two years, interviews with practitioners in England, Scotland and Sweden have emphasised all of the above themes, but particularly the need to work much more effectively with communities to develop locally sensitive action. It is increasingly evident to the SCF that the best results come from doing things *with* communities, not to them or *for* them. A drive to 'roll out' or 'scale up' successful initiatives may fail to recognise the importance of local context, and we argue that central government in Scotland should be more accepting of local variation in priorities and practice. In fact, we argue that the further devolution of power from Edinburgh to local agencies and to communities may be the key to unlocking their inherent potential to change and make sustainable improvements. Devolution of power in this way may also serve to promote greater citizen engagement in local democracy – greater autonomy and active citizenship being significant factors in promoting greater well-being.

Working the system better

The SCF's most recent report on well-being was called *Working the System* because the authors believe that a better understanding that a system is at work will encourage different ways of working to benefit from the potential within that system. The report identified three 'Big Ideas' and seven 'Actions' that we believe could equip Scotland to meet future challenges to its well-being. Two of the Big Ideas emphasised the need for public recognition that improved population well-being is the most important objective for Scottish policy today, and for a national consensus around the elements of a whole-system approach to promoting well-being. The political changes that occurred in May 2007 could help to promote both of these. The need to improve population well-being is a matter of genuine cross-party consensus already, and we believe that a consensus on practical actions, at least outside the NHS context (which is always an emotive and politically divisive topic), is certainly feasible.

On a smaller scale, we believe that there is both demand and opportunity for a change in culture within the public sector in its approach to a 'cross-cutting' issue of this kind. Important factors that we identified in discussion with Scottish professionals included:

- a reappraisal of partnership working
- liberation of the 'special' people
- unified, long-term funding
- longer-term objectives and evidence
- sharing power and work with communities.

A reappraisal of partnership working

Although partnership working provides an excellent opportunity to promote holistic approaches to systemic problems, the experience for many professionals is of an opportunity wasted. Officials in Community Planning and Health Promotion Partnerships as far apart as Inverness, Glasgow and Dumfries have told us that, with some honourable exceptions, engaging a wider circle of agencies in pursuit of the well-being agenda has simply diluted responsibility for making anything happen, to the point where they are cynical about the prospect of gaining any additional value through partnership mechanisms compared with their own efforts. We would argue that the partnership role should be to ensure both a shared appreciation of local challenges, and an understanding by individual agencies that their work has a wider impact, rather than to force one agency to accept responsibility for an outcome over which they feel that they have little influence. For instance, it may in fact be entirely appropriate for a housing officer to spend no time actively promoting well-being in new ways, so long as they work to ensure that they manage their core responsibilities in a way that respects the significant role of housing quality in enhancing or eroding well-being.

Liberation of the 'special' people

One recurring feature of our previous work, including *The Fifth Wave*,²⁹ and our conversations with professionals about public-sector reform and well-being, has been the need to identify the agents of change – the 'special' people who seem to be able to make things happen – and liberate them from many of the burdens they face. One important role for partnerships locally may be to identify those best placed to make change, and then empower them to act. This particularly applies to budgets and accountability frameworks. If an individual is good at making change happen on the ground, they should be given the freedom and resources to do so, rather than having to spend the majority of their time meeting overlapping and/or disproportionate accountability requirements. This is not a call for an absence of accountability, but for sensible, 'light-touch' reporting that allows effective practitioners to focus on what they do best. An example of the change that we suggest might be the 'liberation' of the Dundee Healthy Living Initiative (DHLI). The DHLI programme is universally cited as an example of best practice by managers on the local health board and local authority, and by Scottish Executive health improvement officials. Yet the team still faces a time- and energy-consuming battle to secure its resources after 2007. This has required the project leader, who is widely acknowledged as an effective and innovative public health practitioner, to devote most of the last 12 months to fighting the project's corner, rather than to making efforts to improve health and well-being in some of the most deprived areas of Dundee. We can see no good reason why, after years of success to date, the project is repeatedly required to go through the same accountability and funding processes, while the basics of this successful project remain unchanged.

²⁹ Lyon A. *The Fifth Wave: searching for health in Scotland*. Edinburgh: Scottish Council Foundation; 2003.

Unified, long-term funding

Local well-being project officers in particular are very clear that the single largest barrier to 'transformational' change in their local outcomes is funding. They are not looking for more money, but for more consistency in funding, over a longer period. Given a three-year budget commitment, a project officer will, on average, have to spend at least 18 months of that period either setting up appropriate monitoring and accountability mechanisms at the start, or trying to find continuation funding towards the end of the project. If a local or national cross-party political consensus can be created on the importance of particular projects, is there any reason why a long-term commitment of up to ten years cannot be made? In addition, it seems clear from experience that creating a single unified budget for a particular programme offers considerable scope for improved effectiveness, compared with the current norm of projects having to scrape together funding from different pots of funding.

Longer-term objectives and evidence

Hand in hand with longer-term, more consistent funding, well-being requires a longer timescale for the setting of objectives. Bearing in mind the complexity of the challenge and the population-level nature of the outcomes, it seems perverse to require initiatives to demonstrate their effectiveness within three years or less. We propose that a ten-year horizon would be more appropriate, with suitable mid-term reviews to ensure accountability around milestones. This would also require new approaches to the gathering and evaluation of qualitative evidence, or the use of 'input' and 'output' measures which might provide the only evidence of effectiveness prior to the end of the longer project period. The work to develop Mental Health Indicators may help to promote this change of approach, by starting to tie specific qualitative and short-term output measures to longer-term quantitative outcomes.

Sharing power and work with communities

The SCF experience is that by engaging groups of ordinary citizens in a deliberative manner, it is possible to design and sustain interventions that both meet communities' needs and engage them as 'co-producers' in making them succeed. There are plenty of examples around Scotland to demonstrate the power of community-led approaches to regeneration and health improvement in particular. We should not underestimate the change of mindset required of public-sector professionals when we ask them to work in this way, but the results can be impressive. The SCF/NHS Health Scotland report *Doing It Differently*³⁰ clearly shows that there are significant benefits to be gained from changing the relationships between local agencies and the populations which they serve, through asset-based community development approaches. However, as we noted above, this would first require the devolution of much more power from Edinburgh to local agencies, and the transfer of assets to the neighbourhood level.

³⁰ Crawford F. *Doing It Differently: an asset-based approach to well-being*. Scottish Council Foundation/NHS Health Scotland; 2005.

Conclusion

It is morally right to focus on action to address health inequalities, and the SCF would argue that more could be done to 'skew' NHS resources in particular away from affluent communities and towards their more deprived neighbours. However, it must be recognised that the most effective efforts to address health inequalities are likely to occur within other policy areas, such as education, regeneration, family policy and, in particular, work and incomes. This being the case, a continued and meaningful whole-government commitment to addressing inequalities of all kinds and improving health and well-being will be essential if health inequalities are to be addressed. This needs to be more than 'policy-proofing', and seems likely to require the shifting of significant levels of resources into the 'wider determinants of public health' and away from traditional health services – preventing poor health rather than trying to treat it. It is also likely that the most effective domain for such action will be at local rather than national level, requiring much greater devolution and autonomy for local government and communities than is currently the case. Most importantly, it may require a change of culture, with the public sector in particular working to improve its ability to think outside the boundaries of existing policy portfolios.

About the authors

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Public health: a future workforce and structure in Scotland for the twenty-first century

Jim McEwen

Introduction: the early days of public health

Scotland has a long and proud tradition of public health. The pioneering work of the medical officers of health and the wider contribution of local government established a system of public health that transformed the health of Scotland. Many accounts testify to the commitment and professional excellence that developed. The range of skills that were available is most impressive. They include hygiene, engineering, preventive medicine, health education, welfare, environmental health and a range of clinical expertise that covered areas such as maternity and child health, mental health, geriatrics, port health and infectious diseases. These highly skilled teams were all deployed in the comprehensive public health service that existed in cities, towns and counties. The teams were appropriate for the public health challenges that existed at that time, but the emerging challenges of the twentieth and twenty-first centuries have required a different approach.

Rather than discuss how to return to the golden age of public health, this essay will explore how we can learn from and build on past structures and educational systems to develop a public health system that is able to meet the needs of Scotland now and in the future.

Change and uncertainty

When the author started his career in public health, the system described above was coming to an end. Some of the members of the old teams, such as those working in different areas of welfare and the sanitary inspectors, were moving to become independent professionals – social workers and environmental health officers, respectively – who would establish their own formal service structures. At the same time, the issues for public health were changing, and major concerns, such as the impact of chronic disease and the delivery of health services, were emerging. Uncertainty about the role and purpose of public health, a lack of recruitment to the specialism, and isolation from mainstream medicine all contributed to the recognition that radical change was required. As a result, the separation of public health from the NHS ended and the concept of 'Community Medicine' emerged. However, although this new integration with clinical medicine brought advantages, it was not always welcomed by senior consultants, who still regarded public health as a second-rate specialty. At the same time, the links with previous colleagues in environmental health, who had previously been effective partners in meeting public health issues, were weakening, and the focus for public health action at local government level had almost vanished. Confusion and fragmentation of responsibility became a serious problem.

For many years there was talk of the need for teamworking, closer links with other professionals and overcoming structural barriers, but relatively little was achieved. On several occasions, when there were administrative changes within the NHS, it was said that this was the 'last chance for public health to prove itself.'

A new approach

Without a new approach, public health would have disappeared, especially in a climate where finance was increasingly the driver. The specialism had to be clear about the benefits that it brought and how well it could meet the new and emerging public health challenges, such as continuing – and indeed increasing – inequalities in health, traditional and emerging infections, climate change and environmental disasters. The importance of the underlying health determinants was emerging, as was the concept of sustainable development.

The new approach that emerged in this climate had two distinct but linked and complementary strands, namely training and workforce development, and professional collaboration.

Training and workforce development

It was obvious that new skills and enhanced teams would be required. Traditionally there had been formal training programmes for professional groups such as medical officers of health, health visitors and sanitary inspectors. New categories of practitioners, often with a specific remit (such as smoking or sexually transmitted diseases), were developing and, at the same time, training had become more flexible and often less certain. Career pathways were not clearly defined, and were sometimes non-existent, and there was the constant threat of structural reorganisation. Gradually, in response to this, there was a move towards models of education and training based on estimation of the tasks required, assessment of the necessary skills for these tasks, and finally a grouping of these into specific training programmes. As a result, skilled public health professionals were increasingly appointed to posts, and their expertise was recognised and welcomed. At the same time, there has been an emphasis on continuing professional development to ensure that individuals are competent for specific posts.

As part of these developments, the widespread acceptance of the following description of the public health workforce provided clarification and reassurance to a somewhat disparate range of professionals. It was described as having three components:

- full-time skilled specialists
- those for whom public health is part of their role – sometimes working in public health at the practitioner level
- the wider group, whose post is related to public health (e.g. those working in the areas of housing or town planning).

Professional collaboration

There has been an unfortunate tendency to equate public health with what is carried out in the NHS and in NHS Boards. Although part of this was related to the separation of services, there was failure to recognise the very substantial contribution of many of those working in local authorities and in the independent sectors. Many voluntary organisations make enormous contributions. The development of the concept of multi-disciplinary public health, the revision of roles and training of professionals working in the many different areas of health, and the direct action of professionals themselves have all contributed to an increasing recognition of the real potential for a highly skilled, comprehensive and professional public health workforce. The push for professional recognition and registration with the dual purpose of public protection and professional recognition is the culmination of the action for real multi-disciplinary public health, whatever the professional origin or place of work.

For many years there have been calls to improve collaboration within public health. Reorganisations since 1974 have usually improved on one link, but damaged another. Now there seems to be a real attempt through the two strands of workforce development and new formal working relationships to actually achieve this. One interesting example is the field of environmental health, which from 1974 onward was regarded as separate from public health. Now the two are increasingly considered to be closely linked, with much common ground in training and work.

There have been many initiatives and working groups, often tackling the issues in a limited and piecemeal fashion, but as there is now a real emphasis on collaboration, this is considered to be an appropriate time for review and examination of possible future directions.

Current position

With small teams and limited resources, public health has had to concentrate on responding to the most pressing issues, and there has been little in the way of real progress. Reading any of the accounts of public health in the early twentieth century, there was a palpable enthusiasm about tackling new problems such as housing or infectious disease. New services for special groups such as children and expectant mothers were regularly being developed. However, over the years, because of its very close association with 'management', public health has been the victim of political uncertainty and administrative change, and there has not always been clear leadership at national and local levels. Thus the adoption of new ways of working and the translation of research into practice have sometimes been slow. However, as the new approach described above develops, a sound basis for future public health is being laid. Recent developments include a major commitment to review professional education and training, and a new approach to collaboration between the various statutory and independent organisations with responsibility for aspects of public health.

A whole range of organisations is currently (and has been for a number of years) seeking to identify the basis of public health as a science and a discipline. The Faculty of Public Health and Skills for Health produced a set of competencies for specialist practice, and Skills for Health is completing a similar approach for public health practitioners. The development within the UK of the concept of the Career Framework is currently of immense significance, and was consulted on in the summer of 2007, with workshops being held in all four countries of the UK (see Appendix). It symbolises the new collaborative approach that is pushing for change and development. The process of consultation itself is likely to lead to careful evaluation not only of the document, but also of current practice with regard to the present workforce, their skills, career patterns and training. When revised, it could provide the basis for long-term planning and a workforce 'fit for the future', but only if it is used and not just left on a shelf as an interesting report. Within nursing, environmental health, nutrition, pharmacy and other areas, the specific competencies in public health required at the end of professional training and undergraduate courses are being identified. Similarly, those competencies that are required for different categories of practitioner and specialist, whatever their main professional background, who have a role within public health are now being formalised. Training programmes for categories of those working in specific areas of public health, such as health promotion, health protection and other areas of health improvement, are now in preparation. This is building on the earlier development of the concept of multi-disciplinary public health, bringing together all those working in public health, whatever their basic qualification and irrespective of their place of work. Formal recognition in public health of professional status at specialist/consultant level for those not covered by existing statutory regulators is now in place for both generalists and defined specialists through the UK Voluntary Register for Public Health Specialists. The Register provides formal recognition of both prospective training programmes provided by the Faculty of Public Health and the Royal College of Surgeons training in dental public health and also, through its pioneering approach of retrospective portfolio assessment, those senior specialists who are working either in general public health or as specialists in defined areas of public health. Recognition of new training programmes is currently under discussion.

Scotland is very fortunate in that it has established public health teams in NHS Boards, collaborative links with local authorities and specialised national resources in fields such as health protection, cancer surveillance, information and intelligence, and health promotion. It has not suffered the effects of frequent structural reorganisations, which have had a deleterious effect on the public health services in England, where established and effective teams have been dispersed and staff have been deskilled by having to become 'jack of all trades.' However, the potential for existing local and national components of public health in Scotland to provide the leadership that might be expected does not always seem to be realised. Some of the teams are under-resourced, and in some places the available expertise is not fully recognised and valued.

Within clinical medicine there has been a move towards managed clinical networks that are designed to bring together individuals with specialised expertise in a particular clinical problem, such as cancer, to provide highly specialised care of a type that would not be possible in every locality. Similar approaches are now being developed within public health, and although there will always be a need to provide public health services at a local level, these networks indicate possible new ways of collaborating. The area of health protection is an example of this approach seeking to link the various existing components and make specialised skills available throughout Scotland.

However, there is a limit to what can be achieved with networks, and there are still important core components of public health that are not effectively integrated. Is a more radical approach needed to provide a service of excellence and to make full use of the highly skilled professionals who are located within Scotland?

The way ahead

At present there is political, public and professional support for public health, and high expectations of what it can achieve. But is the public health workforce able to meet the role that is required of it? Although there have been substantial developments, the simple answer to this question is 'not yet.' The advances are moving in the right direction, but much more will be required if the major challenges of health inequalities and understanding the complex influences of the wider determinants of health are to be effectively tackled. There will need to be new ways of working not only within public health, but also with other colleagues, such as those in planning, transport, sport, leisure, catering and education, to provide the whole-system approach that is essential. Public health always did have and still has a unique role in providing the evidence for change and then, through collaboration and leadership, ensuring that change occurs. This cannot be done in isolation.

What is required to bring together the two developing strands of professional development and organisational change to produce a public health service that is comprehensive, integrated, and provides the necessary leadership? It will not just happen. It did not happen in the past. Is there something to encourage us to believe that it could happen now? The developments described above suggest that the time is right for real advances to be made.

The driver for advancement must be within our organisations. Formal regulation and recognition of professional status do much to enhance service delivery and to gain respect from colleagues and members of the public, but career opportunities are essential. Senior staff with administrative responsibility must ensure that there is a real commitment to continuous training and the finance that is required to make it happen. Professionals must equally be sufficiently flexible to take advantage of the new systems. Professional barriers and old tribalism must be replaced by an acceptance of the diversity of skills that are required for a comprehensive public health service. Scotland lags behind England and Wales with formal training programmes and the necessary funding for those seeking careers in public health

who are not medically qualified. While there is currently a real desire to work together on all aspects of professional education and training, career development, regulation and employment in organisations at national levels, there needs to be a national commitment to training a multi-disciplinary workforce and capacity building. This should be explicitly stated and published.

In the developments to date, one of the neglected areas has been the role and status of practitioners – often taken for granted with regard to the enormous and committed service provision, and barely considered from the perspective of seeking to enhance their career. With the development of the career framework and the new professional collaboration, practitioners are firmly on the agenda. This has been encouraged by the general impetus to require ‘registration’ and ‘regulation’ of some form for all health professionals. Following extensive consultation, some form of ‘accreditation or registration’ for practitioners in public health is being considered by the UK Public Health Register. This needs to be linked to a clear possibility of career progression for those who desire it.

The public health workforce needs to be looked at as a whole if we are to achieve a coherent, flexible, cohesive and flexible system, regulated at all levels, that is ready to respond to the current public health challenges and produce services that are cost-effective and evidence based. To use the current jargon, we need a public health workforce ‘of all the talents.’

In Scotland, unlike some other countries, there has never been an entity labelled a national public health service. However, it is possible to see the existing components as pillars of a new ‘service’ that, through increasingly close collaboration, joint appointments and development of planned and skilled teams, could become an effective national public health service. There would need to be a willingness to accept change, new working relationships and new accountability – achieved through evolution, not reorganisation. Much of the thinking in public health is still NHS dominated, with regard both to the provision of services and to the terms and conditions of employment. This will also need to change if there is to be the possibility of advance.

Progressive change and integration are possible, bringing together the two strands of professional and service development. This would need formal support from employers in the NHS, local government and the independent sector, and respect from professionals for the competencies and work of colleagues. It would also require formal recognition at government level, through the Chief Medical Officer and clear leadership at ministerial level.

Action

Progress is likely to be slow and patchy unless formal action is taken. There have been advances since the last Public Health Review in Scotland. Today there seem to be particular challenges and at the same time real catalysts for change. It is therefore recommended that a new Review of Public Health in Scotland be undertaken, focusing on the workforce and the organisational structure that will be

most appropriate for the next 20 years, rather than on health challenges. This should begin with a review of the current workforce skills, balance of expertise, training and strength, wherever employed, followed by a critical assessment of the likely future needs with regard to staffing, initial education and training, career progression and continuing professional development. The opportunities for enhanced public health roles for other professional staff should be explored, including how practitioners and specialists of different kinds should work together. With regard to organisational structure, most aspects of service provision already exist. The review should examine the overall balance of different skills throughout the country, and new ways of integrating the different service components – not just through networks, but directly within a new service.

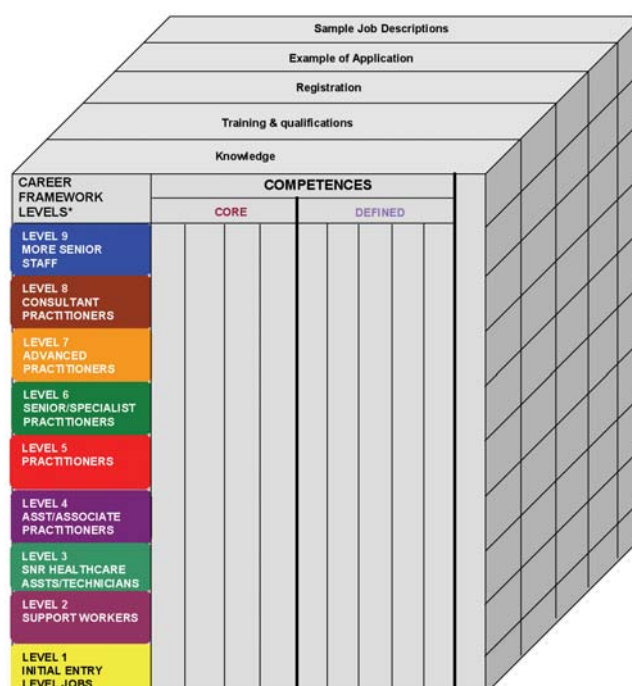
Such a review will achieve little more than this paper if there is not a commitment to implement it, to provide the necessary funding for training and professional development and, where deficiencies in provision are detected, to establish the required additional posts. Formal accountability and review of the new service will also be necessary.

It is both possible and realistic at this time to aim for a highly skilled, flexible, competent and ethical workforce with a rich diversity of public health professionals working together at national and local levels in a new accountable National Public Health Service for Scotland.

Appendix

An introduction to the Public Health Skills and Career Framework: a framework for multi-disciplinary, multi-agency, multi-professional public health skills development

Figure 3: Framework layout



What is it?

Skills for Health is leading a process to develop a coherent and flexible public health career framework for use across the UK. For the first time, public health competences, underpinning knowledge, training and qualification routes, registration requirements and a database of job descriptions across nine career levels are being brought together in a user-friendly format. The aim is to create a framework that can be used as a route map for careers in public health regardless of starting and intended end points. The flexibility and versatility of the framework mean that it can be used alongside existing professional routes in public health. It is not intended to be a driver in public health career development, but rather an information source to be drawn upon.

It will initially be a document, but the intention is to develop the product as an interactive Web-based tool.

Why?

Widening health inequalities, interest in health improvement and major public health issues, including climate change, are examples of challenges that demand a strong, collective response from the public health workforce. This workforce spans different organisations and different professions, and operates at every strategic, service and operational level. There is an urgent need for a mechanism that facilitates collaboration and coherence across this diverse workforce, in order to maximise its collective contribution and underpin the influence of public health in the UK. The public health career framework can provide this by ensuring rigour and consistency of skills, competence and knowledge at all levels regardless of professional background, and enabling flexible career progression in public health.

Who is it for?

The framework is both for those already working in any field of public health, and for those who wish to do so. It is designed for those involved in commissioning, organisation and delivery of public health training, for those involved in workforce planning, and for employers. The key professional groups that have been involved in the development of the framework are those working in environmental health, health improvement, public health research, pharmacy, nutrition, health psychology, public health nursing, health protection and health economics. However, the aim is to have an inclusive tool that can be used by any individual working in any aspect of public health (e.g. oral health, sexual health, sport and exercise, etc.). The framework will facilitate horizontal, vertical and diagonal movement across public health careers that are consistent with an increasingly flexible approach to all career progression.

How?

The framework is being developed and populated through 'bottom-up' multi-disciplinary and multi-professional stakeholder workshops run by Skills for Health, working with the Departments of Health and local partners in each of the four UK countries. Skills for Health has worked closely with the Public Health Resource Unit (PHRU) to develop the vision for the career framework.

Principles

The competences in the framework are categorised as core (required by all those working in the field of public health) and non-core (applying to specific broad domains). Each competence, and the knowledge necessary to underpin it, is described at nine levels of application. Key principles of the career framework are that it should be simple, easy to use, widely applicable and useful. To this end the descriptions of the competences at each of the nine levels capture the essence of the competence, not the detail. The descriptions are backed by discipline-specific,

more detailed work – for example, the extensive work that has already taken place on health promotion competences and is currently taking place on public health information competences.

The next stage

The framework is very much a work in progress. Refinements include checking the competences at each level for completeness and duplication, ensuring that 'knows how' and 'shows how' are linked and consistent at each level, and checking against the Knowledge and Skills Framework and public health national occupational standards. Further detail that is relevant for each country needs to be added to the training and qualifications section. It is anticipated that the detailed information on training and qualifications, and in the registration section, will be much informed by the project being led by the UK Voluntary Register for Public Health to scope the benefits of UK wider regulatory frameworks for public health practitioners. A completed draft of the framework was piloted with a range of professional groups, disciplines and public health provider systems between January and May 2007, followed by extensive consultation in the spring and summer of 2007.

The framework layout 'cube' at the beginning of this appendix sets out in visual form the aims of the framework.

How to obtain further information

For further information, or if you would like to be involved in the piloting and consultation phases as the framework develops, please contact Karen Walker at Skills for Health (karen.walker@skillsforhealth.org.uk).

Updates on progress will be posted on the news section of the Skills for Health website (www.skillsforhealth.org.uk).



About the author

Jim McEwen is Emeritus Professor in Public Health at the University of Glasgow, where he previously held the Henry Mechan Chair of Public Health. He currently chairs the UK Voluntary Register for Public Health Specialists, the Health Protection Scotland Advisory Group and PharmacyHealthLink. His previous posts include the following: President of the Faculty of Public Health; Professor of Public Health at King's College, University of London; Director of Public Health, Camberwell Health Authority; and Chief Medical Officer, Health Education Authority. He has acted as consultant to the World Health Organization, and has gained further overseas experience through academic visits and external examining. His special interests include postgraduate education and training, the public health workforce and health services research.

