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**Working Together for a Healthier Scotland**



A Consultation Paper

**Working Together for a Healthier Scotland**

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THE SCOTTISH OFFICE DEPARTMENT OF HEALTH

# Working Together for a Healthier Scotland

A Consultation Document

Presented to Parliament by the Secretary of State for Scotland  
by Command of Her Majesty  
February 1998



30 FEB 1988



Health Service Commission, Edinburgh, Scotland

1988

# Working Together for a Healthier Scotland

A Consultation Document

The Commission for Health Services

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1988

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*James D. Stewart*

## Foreword by the Secretary of State for Scotland

For 50 years, the NHS has helped people who fall sick. This Green Paper is about helping people stay well. It is about respect, self-confidence and the firm belief that Scotland need not remain trapped at the foot of the health league. We produce good food, and can eat well. We live sport, and can be fit. We are known for the quality of our education and ideas, and can turn these towards better health. We are entering a new millennium, regaining powers to legislate and act in our own health and interests.

So this Paper is about a twin health challenge for Scots and for Scottish institutions:

- We can all act to improve our own lives, avoiding illness as we would accidents.
- Public and private bodies - Government, local authorities, agencies, companies - can protect health through their policies, plans and actions.

Both approaches together will have real impact: one alone is not enough.

Poverty, unemployment, poor housing can blight lives and destroy health. Brave attempts to tackle ill-health have often foundered on the rocks of real lives, poor prospects and counter-pressures. This Paper is about planning for health, through personal and community efforts. Our challenge to **institutions** comes through health impact assessment, health improvement programmes, healthy eating, help in the planning of community development to secure health gains. The challenge to **people** is to look after the health interests of themselves, friends and family.

Age at death is a crude measure, if a hard test, of our health progress. In reality, good health is the basis for happy childhood, achievement in middle years and independence in old age. It is not just death but pain, depression, fear and disablement that put a limit on lives, and impose social and economic burdens.

I intend this Green Paper to engage ideas and start a broad process of commitment towards improving the quality of Scotland's health. We all know the mountains to climb in tackling heart disease, cancers and mental illness; and to reduce substance misuse. There is increasing evidence of steps that work and steps that do not, although measurement, like action in this field, is complex.

It is right that the Government leads this process and contributes across its many functions. That is why, along with Sam Galbraith, our Health Minister, all my Scottish Office



Ministerial colleagues are signing this Green Paper, as affirmation of our collective commitment to improving health in Scotland. But there are local frameworks and initiatives well down the road, with much to teach. We need to listen at this stage to expert views and local voices before framing the White Paper that will follow. There must be scope within national strategies for breaking new ground locally.

I am confident that contributors will tell us what the Government can and should do. I hope that they will also tell us about the ways they will join in and help us in working together for a healthier Scotland.



Minister for Health and the Arts



Minister for Local Government and Housing



Minister for Education and Industry



Minister for Home Affairs, Devolution and Transport



Minister for Agriculture, the Environment and Fisheries

## Summary and Invitation to Comment

Good health is more than the absence of disease. It has to do with the way we live, the quality of our life and our environment. That is what public health - and this Green Paper - is all about.

Overall the health of Scotland is improving. The drive to act for our own health has had some impact. Many fewer adults smoke, and we are now less likely to die from heart disease or cancer in middle age. But the improvement has neither matched progress by similar countries nor reached all Scots equally. Smoking, poor diet, too little exercise and misuse of alcohol and drugs stand in the way of better health: their roots lie partly in poverty, unemployment, poor housing and poor environment. Ill-health is not a problem for patients or health services alone, but impacts on family and community life, and on local services.

Care for our own health throughout life is a strong theme in this Green Paper. But broader changes in how people live - which they are not in a position to control - are as important. True public health policies are embedded in action to improve our quality of life and protect our environment, to tackle social exclusion, in improving housing and educational achievement, in addressing poverty and unemployment and in the re-structuring of the National Health Service as a public health organisation with health improvement as its main aim. It is the business of Government - all of Government - and all those who are in a position to influence and contribute to our quality of life.

The policy changes heralded by this Green Paper will link these broader programmes to their impact on our health and well-being; encourage stronger collaboration between health services and the many organisations whose actions impact on our health, especially Scotland's local authorities; and give priority to the communities and groups that have the worst health.

This Green Paper seeks views from the public, from councils and agencies, from health bodies, voluntary organisations, employers and employee representative organisations, on how we can work together towards better health and well-being. In our White Paper later this year we expect to favour practical policies for joint action that will be widely supported, and likely to be effective. More than anything, however, this new drive towards a healthier Scotland demands a carefully planned approach with new ways of thinking and working together, particularly at local level.

### **Making Our Efforts Count**

Making an impact on public health means acting on the **life circumstances** that underlie poor health, including a worthwhile job, a decent home, a good education and a clean environment. It also includes personal investment in **healthy lifestyles**, backed by sound policies and, more rarely, regulation. And we must target the places where people are, including schools, workplace and community settings, and the Health Service. Success will require strong partnerships between health professionals and other local bodies within a national framework. (paragraph 95)

So our proposed priorities are improving **life circumstances**, such as tackling deprivation and



encouraging individuals to adopt **healthier lifestyles** by not smoking, by eating for health, taking greater physical exercise, and avoiding alcohol and drug misuse. (paragraph 81)

We propose, for Scotland's main 'illness' priorities, coronary heart disease and stroke, cancer, mental health, sexual health (including teenage pregnancies and HIV/AIDS), dental and oral health, and accidents. (paragraph 46)

For each of these priorities, **tackling inequalities** will be our first challenge.

## Working Together

The Green Paper suggests ways of working together and invites comments and further suggestions for action. Our main proposals are:

- **Health impact assessments** for use in central government and its agencies and in local government to consider the consequences for health of all major policies. These assessments should be effective without being overbearing. Guidance is sought on where and how they are best applied. (paragraph 103)
- **An expert working group**, chaired by the Minister for Health, to draw up a strategic framework for strengthening and regenerating communities, particularly disadvantaged communities. (paragraph 108)
- Broad programmes for **area regeneration** in places where Scotland's health is poorest. How can we achieve best results through the work of Priority Partnership Areas and the urban partnerships? (paragraphs 113-117)

## Tackling Lifestyles that cause illness

Changes in lifestyle will be far more effective, when linked to steps that address the root causes of ill-health. Major challenges remain and views are invited on:

- Changes in the regulation of **tobacco** will be set out shortly in a separate White Paper. How can smoking be stopped, especially by young people and those living on low incomes who paradoxically smoke more and are least likely to stop? (paragraph 121)
- How can harm from **excessive drinking** be reduced? (paragraph 122)
- How can we address both health and community safety issues which derive from **drug misuse**, particularly in areas of high use? (paragraphs 123-128).
- Should preventive work aimed at young people target **alcohol, illegal drugs and tobacco** separately, together or through more general lifestyle approaches? (paragraph 128)
- Does the new emphasis on tackling health inequalities, and boosting local health networks give opportunities for improving **diet**, beyond the extensive plans in the 1996 report "Eating for Health"? (paragraphs 129-130)
- How can we stimulate **physical activity** in Scotland, particularly by those currently taking little or no exercise? (paragraphs 132-137)
- What more can we do to protect **children's teeth**? (paragraphs 139-142)

- Reducing **teenage pregnancies**, improving **mental health** and tackling **domestic violence** are health issues that draw, and impact broadly, on society. How can we achieve greater effectiveness? (paragraphs 143-146)
- **Accidents** still cause much disablement and death especially in poorer areas. How can these accidents be prevented? (paragraph 150)
- **Infectious diseases** still pose a threat in Scotland. The Government propose a review of existing public health legislation. (paragraphs 151-153)
- **Other countries face similar problems**, but enjoy better health. What can we take from their approaches which can be made to work here in Scotland? (paragraph 97)

### Completing the Jigsaw

Many things that **local authorities** do affect health and local policies and strategies need to take this into account. Our proposals on which views are sought are:

- **Directors of Public Health**, as the designated medical officers for local authorities, should help them assess the health impact of local policies, and be co-opted, or appointed, to appropriate council committees (for example, housing, social work and education). (paragraph 154)
- The Scottish Office should fund a **public health post in COSLA**, to develop good practice and to help to co-ordinate healthy local authority policies. (paragraph 157)
- The Health Education Board for Scotland, the Scottish Consultative Council on the Curriculum and COSLA should set up a small specialist unit to help develop **health promoting schools** throughout Scotland. (paragraph 180)

Under proposals launched in December 1997 in the White Paper *Designed to Care: Renewing the NHS in Scotland*, Health Boards, as public health organisations, will be responsible for securing **health improvement** in their area. Health Boards, NHS Trusts and primary care services already work together to draw up health improvement programmes. Many professionals employed in the NHS, from public health doctors, through hospital staff, family doctors, health visitors, retail pharmacists and health promotion officers have relevant skills to work with the public and will be expected to target resources to help people in disadvantaged communities.

- How can the overall contribution of **the Health Service** be maximised? (paragraphs 158-175)
- How, in particular, should the **Health Education Board for Scotland**, which leads health education, best contribute? (paragraphs 176-184)
- How can the explosion in **information technology** be harnessed to health improvement? (paragraph 182)
- Other parts of Scottish life include direct contributions to health. How does **industry** consider the public health impact of its actions both in the **market** and in the **workplace**? (paragraphs 186-190)
- How can the distinctive role of the **voluntary sector** assist health improvement? (paragraphs 191-194)



## Indicators, Targets and Research

The success of our policy will be measured by our impact on health in Scotland. **Indicators and targets** must be seen as relevant and credible, and be owned by the people who work towards them. Before agreeing them, with the help of an expert group, the Government would welcome views on the priorities to set, the indicators and targets which should follow, and the period that they should cover. Our Green Paper suggests **health outcome targets** for coronary heart disease and stroke, cancer, teenage pregnancy, dental and oral health and accidents. **Lifestyle targets** are proposed for smoking, alcohol misuse, eating for health and physical activity. Views are sought on whether targets should be set also in the mental health, HIV/AIDS and drug misuse fields. (paragraphs 196-212)

Good **research** is vital to guide the development of effective public health policy. What priorities should be set for a research programme to inform, guide and evaluate Scotland's health efforts? (paragraphs 214-218)

## Commitment

The Government are committed to tackling public health on a broad front, enlisting the help and support of all those who can make an impact, including members of the public and local communities. Please help us work together towards a healthier Scotland through your ideas, comments and commitment.

*Comments should be sent by 30 April 1998 to The Public Health Policy Unit, The Scottish Office Department of Health, Room 433, St Andrew's House, Edinburgh EH1 3DE, marked "For the attention of Mrs J Niven". The Government may wish to publish these comments or make them available to others. You are asked to make it clear if you would prefer your comments to be treated in confidence.*

"Good health helps us reach the top of the hill."

"Engaging lifestyle must continue to be  
which recognizes and  
underlying social  
environmental  
influence health"

*“Good health helps us each to live life to the full.”*

*“Improving lifestyles must continue to be rigorously tackled, but within a framework which recognises, and focuses on, the underlying social, economic and environmental circumstances which influence health.”*

## Chapter 1 Introduction





"Good health helps us enjoy life to the full."

Amalgamating statistics on the methods to be

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## Chapter 1 Introduction

1. Good health helps us each to live life to the full. It is worth investing in for that alone. But a healthy population is also crucial to our national prosperity and well-being. Our cultural attitudes and lifestyles have a vital bearing on our health. So, too, do the circumstances in which we live. Poverty, unemployment, housing and the environment around us are all inextricably linked with health. Only by tackling these vital issues will we achieve the sustained health improvement we need, in the spirit of the World Health Organisation's vision of health, which was defined as long ago as 1948, as

“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

That is why the Government's Scottish manifesto promised that -

“We will aim to improve public health in Scotland with new initiatives on preventative health care that recognise the impact that poverty, poor housing, unemployment and a polluted environment have on health.

The Government will join with local government in a concerted attack against the multiple causes of social and economic decline - unemployment, bad housing, crime, poor health and a degraded environment.”

2. The 20th century has seen dramatic improvements in Scotland's health as once common diseases like polio were conquered. As the century ends, there are positive trends. Men and women live longer than at any time in the past; premature deaths from the two main killer diseases - coronary heart disease and cancer - are decreasing; and the oral health of adults is improving. But deep-seated problems remain. Lifestyles that lead to poor health are common. Smoking, especially among young people, is unacceptably high. Many of us do not eat a balanced diet. Too few of us take adequate exercise. The dental health of children is poor. Alcohol misuse remains a serious problem. Drug misuse continues to grow. What is more, the progress that has been made is relatively modest in relation to advances in other developed Western nations and our position in the international health league is unenviable. Overall progress, nationally, also masks increasing health inequalities between social classes and wealthy and poor areas. Health inequalities also reflect gender and ethnicity. Environmental and social conditions in many areas of Scotland still fall below standards acceptable in a modern society and, where deprivation exists, health is much poorer.

3. A fresh approach is necessary - a public health strategy which addresses the root causes of our health problems. Improving lifestyles must continue to be rigorously tackled, but within a framework which recognises, and focuses on, the underlying social, economic and environmental circumstances which influence health. *A worthwhile job, a decent home, a clean environment, are all key health determinants. A good education increases self esteem and enhances employment prospects.* The Government's policies are geared to creating a climate in which these basic social rights are brought

within the reach of all. The need is to ensure that each strand of policy, and every new initiative, is taken forward within a coherent framework, so that health gain is maximised. Above all, we need to attack the inequalities which scar our health record.

4. True public health policies are imbedded in action to improve our quality of life and protect our environment, in improving housing and educational achievement, as well as in addressing poverty and unemployment and in the restructuring of the National Health Service as a public health organisation with health improvement as its main aim. Collaboration, involving all partners with an interest in health, is the key. A Scottish Parliament, with its wide-ranging powers, will facilitate the cohesive approach to health improvement we have hitherto lacked. This Green Paper offers suggestions on how co-ordination can be improved. It is not concerned with the structures of the National Health Service as such, though clearly the location and delivery of health services are vital to good health and health professionals have a crucial contribution to make to health improvement, as discussed in the Government's White Paper *Designed to Care: Renewing the NHS in Scotland*<sup>1</sup>, published in December 1997.

5. The Green Paper is a genuinely consultative document on which the Government would welcome comments - **a strategy for all must be a strategy by all**. It describes in Chapters 2 and 3 Scotland's current health status, the associated life circumstances and lifestyles, and the remedial action which has so far been taken. Chapters 4 and 5 set out, for comment, the Government's proposals and how the various interests can work together to improve Scotland's health. Chapter 6 seeks views on indicators, targets and research. In the light of the responses received, the Government will develop a White Paper which will, in effect, be a blueprint for a healthier Scotland. It would be wrong to think that all the solutions lie at our fingertips. What we need are new ways of thinking, better ways of working together and a considered and measured approach to health promoting action.

...and a greater number of  
...than other developed countries.  
...the number of people among the  
...  
...



*“Scotland carries a greater burden of ill-health than other developed countries, with the problem being greatest among low income groups.”*

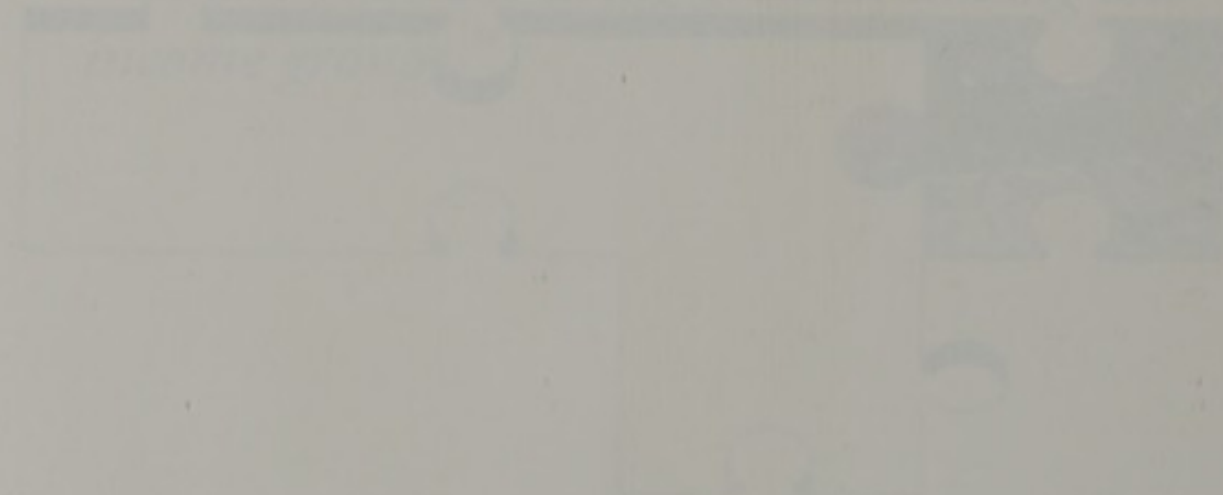


## Chapter Two Scotland's Health



George and Elizabeth

"Scotland carries a greater burden of  
ill-health than other industrial countries,  
with the exception of the United States."  
— *Scottish Health Survey*



**Major Health Problems**

6. Tackling Scotland's health problems is not just about confronting major diseases and illness. It is also about recognising and attacking the health inequalities which have increasingly seen the more affluent enjoy much better health than people who are less well off.

*Coronary Heart Disease, Cancer and Stroke*

7. The two most common causes of death in Scotland are coronary heart disease (CHD) and cancer, each of which accounted for approximately a quarter of all deaths in 1996. In the same year, among people aged under 65, cancer was responsible for almost one third of deaths, and CHD for just under a fifth. Stroke is the third largest killer, and the three diseases are increasingly referred to as 'Scotland's Big 3' in attempting to place them firmly on the public agenda. It is no surprise that cardiovascular disease (including CHD and stroke) and cancer have been identified as major priorities for the NHS in Scotland.

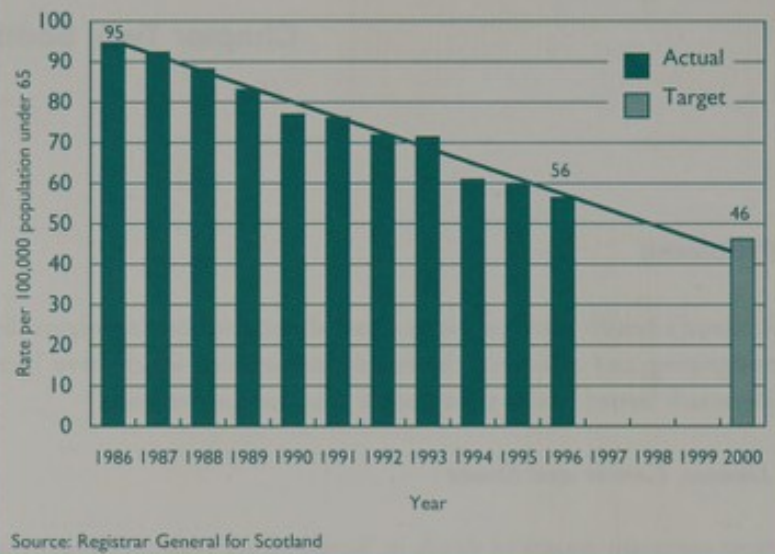
Table 1: Causes of Death in Scotland, 1996

<i>Causes of Death</i>	<i>Aged 0-64</i>		<i>All Ages</i>	
	<i>Number</i>	<i>%</i>	<i>Number</i>	<i>%</i>
Cancer	4,030	31.8	15,175	25.0
Coronary Heart Disease	2,454	19.4	14,650	24.1
Cerebrovascular Disease (mainly stroke)	594	4.7	7,130	11.8
Other Causes	5,599	44.2	23,716	39.1
Total	12,677	100.0	60,671	100.0

Source: Registrar General for Scotland, Annual Report 1996

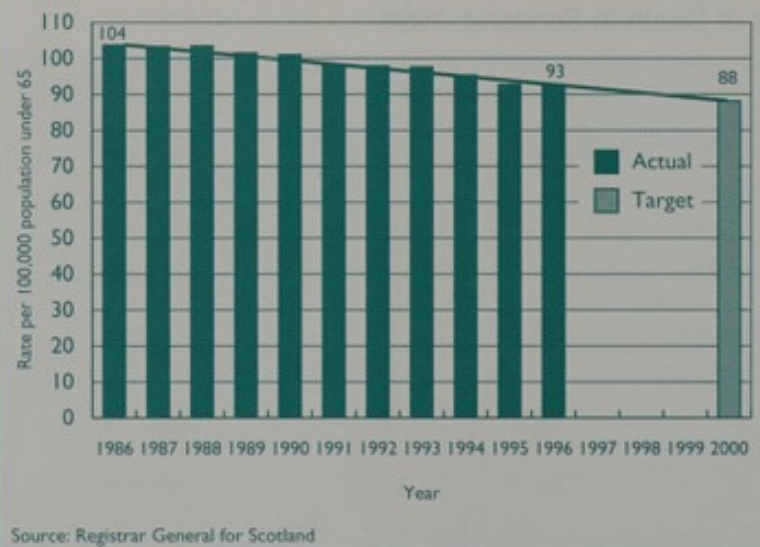
8. Targets for reducing premature deaths from CHD and cancer were set in *Scotland's Health: A Challenge to Us All*.<sup>2</sup> That for CHD is a 40% reduction in mortality between 1990 and 2000 among those under 65; and, for cancer, a 15% reduction between 1986 and 2000. Significant progress has been made towards these targets. Over the last decade the mortality rate from CHD has fallen by 40%, and if this trend is maintained, the target set for the year 2000 should be met (Figure 1).

Figure 1: Deaths from Coronary Heart Disease per 100,000 Population Under 65 and Target for the Year 2000



9. The progress in reducing premature deaths from cancer has been more modest, but again the target set for the year 2000 should be achieved if recent trends continue (Figure 2).

Figure 2: Deaths from Cancer Per 100,000 Population Under 65 and Target for the Year 2000



10. Despite the improvements that have taken place since the mid-1980s, Scotland's health record remains poor. The £1.25 billion in 1996-97 for incapacity and invalidity benefit paid in Scotland to people not well enough to work is one measure of the extent of our ill health. The life expectancy at birth of both men and women in Scotland in 1994 was lower than that in many other industrial countries (Figures 3 and 4).



Figure 3: Life Expectancy of Men at Birth

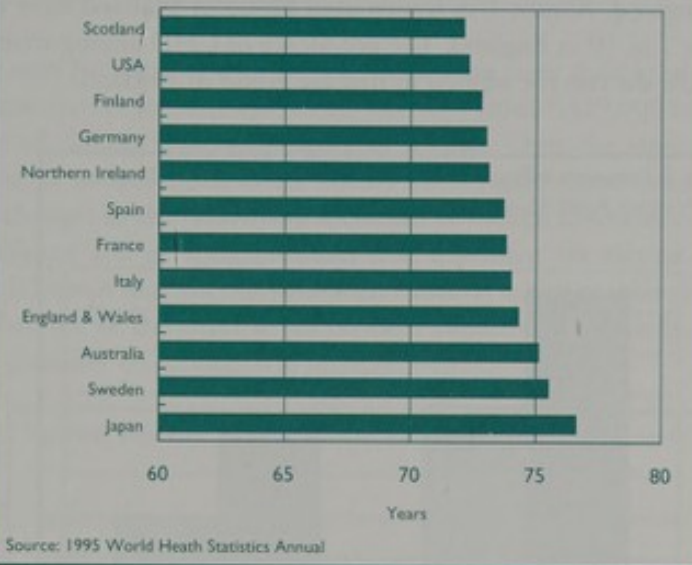
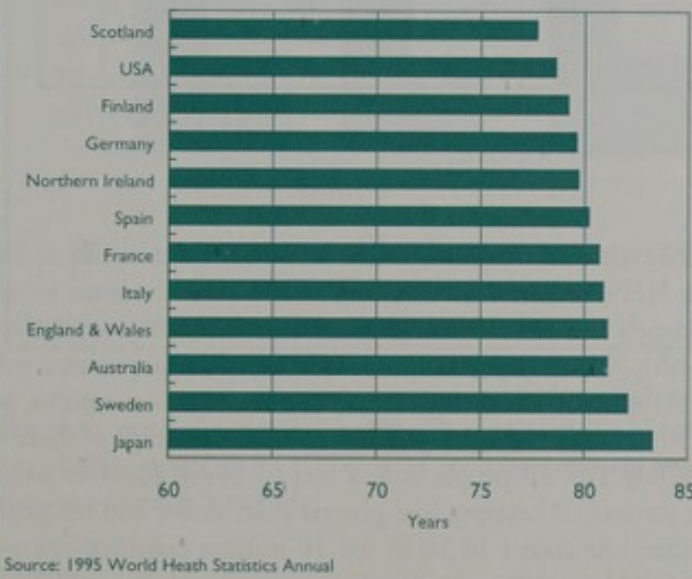


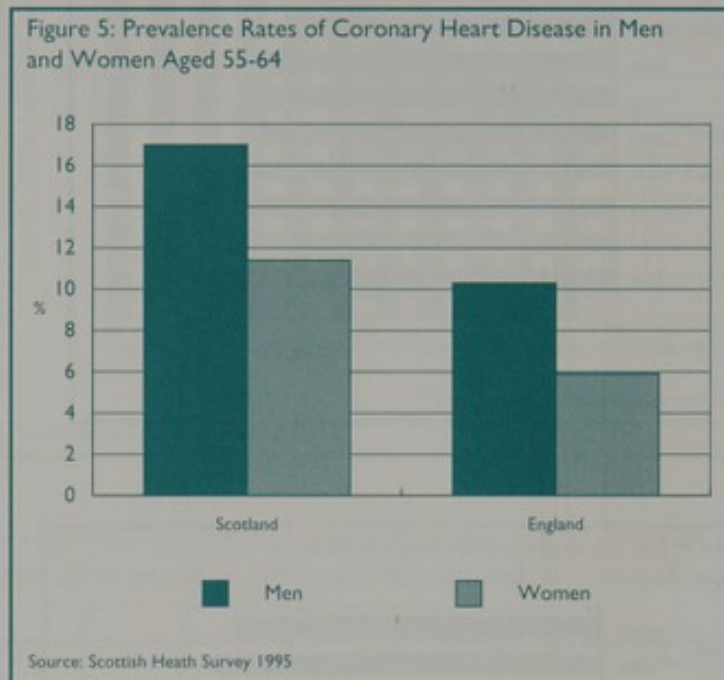
Figure 4: Life Expectancy of Women at Birth



11. Scottish mortality rates from CHD and cancer also compare unfavourably with this group of countries. Taking the genders separately:

- Scotland has the highest mortality rate from CHD for men and the second highest for women.
- women in Scotland have the highest mortality rates from cancer, while men in Scotland have the second highest rate.

The recent *Scottish Health Survey*<sup>3</sup> compared the self-reported prevalence rates of CHD in Scotland and in England (Figure 5). The proportions of Scottish men and women with a history of CHD are much higher than in England. Almost 1 in 6 men aged 55-64 in Scotland have a history of CHD compared with just over 1 in 10 in England. The prevalence of CHD among women aged 55-64 in Scotland is almost double the rate for women in this age group in England.



### *Mental Health*

12. Mental health, alongside cardiovascular disease (coronary heart disease and stroke) and cancer, is a top priority for the NHS in Scotland. Although there is no evidence to suggest that mental illness occurs more frequently in Scotland than in other industrialised countries, it is one of the most common forms of ill-health. In any year, about one-quarter of the population will experience some mental distress. Most of these will see their general practitioner at some point, but only a half will receive treatment explicitly for mental health problems. Ninety per cent of those treated suffer from depression or anxiety. Only 1 in 10 people with a mental health problem will be referred to the specialist mental illness services. Therefore, the general practitioner and his primary care team are the main providers of care. At least 1 in 10 of the 16 million consultations with GPs each year involves a mental health problem.

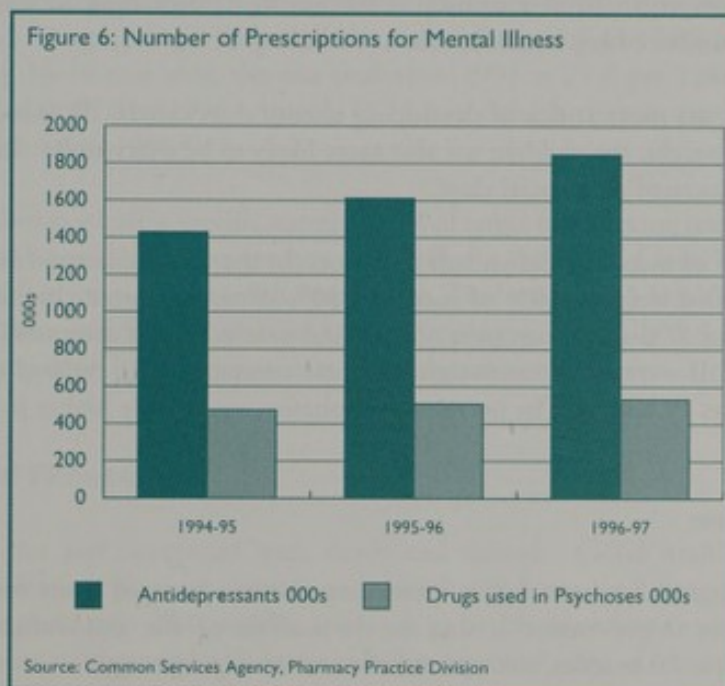
13. There is no evidence available about longer term trends in the incidence of mental illness in the population. The number of first admissions to mental illness hospitals and psychiatric units has remained relatively stable at around 9-10,000 patients a year, though these statistics should be treated with some caution since they do not necessarily reflect trends in the underlying incidence of mental health problems. The suicide rate among men and women aged 15-29 almost doubled during the 1980s, but has fallen since 1993. Although suicide rates in Scotland have been higher than in England, they are lower than in other Northern European countries.

14. Women who experience domestic violence are more likely to have poor health, depression, addictions, difficulties in pregnancy and to attempt suicide; and it has serious effects on children.



15. Children who are living in poverty, or experiencing parental separation or divorce, are at high risk of ill-health. So too are adults who are undergoing divorce or separation, who are unemployed or who are carers of highly dependent people.

16. Prescribing rates for patients with mental illness have risen sharply in recent years (Figure 6). The number of prescriptions for antidepressants increased from 1,429,000 in 1994-95 to 1,848,000 in 1996-97, a rise of almost 30% in the space of 2 years. Over the same period, the number of prescriptions issued for antipsychotic drugs rose by 12%. Again, these trends in prescribing do not necessarily reflect changes in the underlying incidence of mental illness in the community, but they illustrate the significant and growing pressures that treatment for mental illness imposes on the Health Service. It is known that not everyone with a mental health problem can access the treatment they need, often because of the effect it has on their capacity to seek help. As people's needs are uncovered, so the pressures on services will increase.



17. As with health more generally, (see paragraph 32) mental illness is only one side of the coin. Mental well-being is vitally important in enabling us to fulfil positive, productive and rewarding roles in society and enhancing quality of life.

### *Dental and Oral Health*

18. Scotland's poor record of dental health led to dental and oral health being established as a health priority in 1991. One of the main targets set for the year 2000 was that 60% of 5 year old school entrants should have no cavities, fillings or extractions. In the late 1980s the figure was 42.3%,<sup>4</sup> and there has been no significant change since then. It seems very unlikely, therefore, that the target of 60% by the year 2000 will be achieved.

19. The second target set in 1991 was that, by the year 2000, less than 10% of 45-54 year olds should be without their own teeth. There has been a significant improvement in this area: the proportion of this age group without their own teeth has fallen from 33% in 1988 to 17% in 1995. However, recent data<sup>3</sup> suggest that the reduction may have levelled out and there is some doubt as to whether the target will be achieved.

20. Dental decay, the main cause of which is excessive use of refined sugar in food and drinks, is most pronounced among disadvantaged groups. The United Kingdom diet is high in sugar with an average consumption of over 140 grams per day (28 teaspoons). Reviews suggest that the Scottish diet has an even higher sugar content. Over 60% of 3 year-olds in disadvantaged areas of Scotland have dental decay.

21. An increasing incidence in oral cancer in recent times, especially in younger age groups, reminds us of the need to address aspects of oral health other than dental.

### *Obesity*

22. There is growing concern about the rising prevalence of overweight and obese people in Scotland. This is not a problem unique to Scotland but one which is seen throughout the developed world. Obesity is now regarded as a medical condition in its own right as well as a marker of increased risk for a number of key health problems including CHD.<sup>5</sup>

23. Certain people are more at risk of developing obesity than others. In families where one or both parents are overweight, the children are also more likely to be overweight. Risk of overweight and obesity is also associated with social class.

24. More than half of men and almost half of women in the recent *Scottish Health Survey*<sup>3</sup> were above the recommended weight: 40% of men and 30% of women were classified as overweight while 16% of men and 17% of women were obese. And nearly 26% of men and 27.1% of women in social classes I and II were either overweight or obese compared with 33% of men and 43% of women in social classes IV and V. The prevalence of obesity was slightly higher in Scotland than in England.

### *Communicable Diseases*

25. Substantial progress has been made in reducing the incidence of many forms of infectious disease. Much of this improvement is due to the success of the immunisation programmes established, for example for measles, mumps, rubella and whooping cough.

26. The annual number of food poisoning notifications in Scotland has doubled over the last 10 years. There has been an especially sharp rise in the number of reported cases of E coli 0157, and a serious outbreak towards the end of 1996 resulted in the death of 20 people.

27. HIV infection and AIDS have not resulted in the escalating epidemic anticipated in the mid-1980s. This is, in part, a tribute to the scope and effectiveness of public health measures, including health education, over the last decade. Nonetheless, there has been no evidence of any overall decrease in the number of new infections since 1988. A cumulative total of 2,725 people in Scotland were known to have become HIV infected by the end of 1997: of these, 1,011 are known to have died, many at a young age.

28. Statistics<sup>6</sup> suggest that other sexually transmitted diseases are now on the increase among young men and increasing sharply among young women.

### *Accidents and Safety*

29. In younger age groups, accidents are an important cause of death. In 1996 they accounted for 25% of deaths in boys, and 13% of deaths in girls, under 15 years of age.<sup>7</sup> Almost half (43%)



of deaths of young men aged between 15 and 34 years were attributed to accidents or suicide. Between 1983 and 1994 deaths from accidents in Scotland fell by 32%. This fall affected mainly the over 65 age group with little decrease in the death rate at younger ages. Over the same period, hospital admissions following accidents increased by 16%. Significant death rates were recorded from accidents in each of the main categories: work, leisure and sporting activities, road traffic and in the home. For example, in 1996-97, half a million working days were lost in Scotland as a result of accidents at work. The highest hospital admission rates were for work, leisure and sport-related accidents, followed by home and road traffic accidents. Increasingly, the focus is widening out from accidents to safety, with attention to aspects of quality of life in communities, including issues relating to crime against people and property.

### *Teenage Pregnancies*

30. The rate of teenage pregnancies rose between 1986 and 1991 - from 44.4 to 50.5 per 1,000 women in the 13-19 age group. Although the rate fell to 43.1 in 1996, it remains a cause for concern. Among 16-19 year olds, the rate peaked in 1991 at 77.8 per 1,000 females in this age group and declined to 69.6 by 1996. Among 13-15 year olds, the rate increased from 7.5 per 1,000 females in 1986 to 9.6 in 1996.<sup>8</sup>

31. Scotland does not have a specific current national target for reducing teenage pregnancies. The general policy has been that targets are best set locally in the light of local circumstances. Local targets have, therefore, been set at Health Board level. Twelve of the 15 Health Boards have set local targets to reduce the number of pregnancies amongst teenagers. Typically they are expressed in terms of a percentage reduction in conception rates for teenagers or a reduction in the number of teenage abortions.

### **Well-being and Fitness**

32. Health is not just concerned with death and disease. Good health can, and must, be promoted by increasing physical, mental and social well-being and fitness while tackling and preventing health problems. This positive approach to health must be an essential component of a health improvement strategy, and will equip us better for every stage of life.

### **Inequalities in Health**

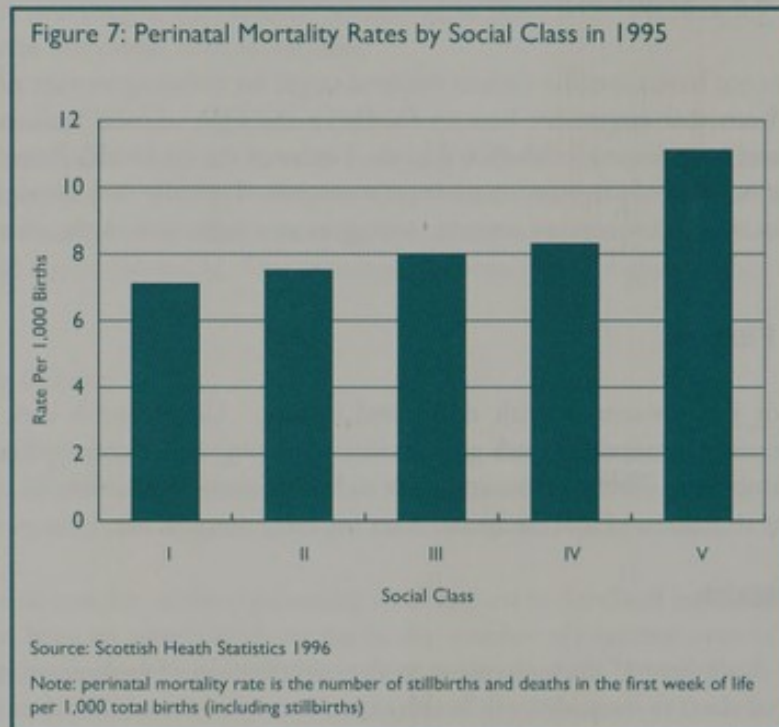
33. In 1980, *the Black Report*<sup>9</sup> drew attention to the contribution of socio-economic inequalities (as indicated by social class) to inequalities in health experience within the UK. More affluent people of both sexes and at all ages experienced less illness and premature death than the disadvantaged groups. A class gradient was observed for most causes of death, including stillbirth, accidents, cancers, respiratory disease and cardiovascular disease. Available data indicated a similar pattern with regard to chronic illness. Possible explanations for the relationship between health and inequality were considered, based on artefact, natural and social selection, culture or behaviour and economic and socio-structural factors. The report stated that there was no single or simple explanation, but stressed the importance of material conditions of life.

34. Further studies<sup>10</sup> have confirmed the findings of *the Black Report*. These show not only that disadvantaged groups, whether in urban or rural environments or determined by ethnicity or gender, experience more chronic incapacitating illness at an earlier age, but also that socio-economic determinants of adult health, with particular regard to CHD, may date from very early life, including before birth.

35. Over the last twenty years or so, the gap in death rates between the most and least affluent categories has widened and a King's Fund publication in 1995<sup>11</sup> states that, in Britain, death rates were 2-3 times higher among disadvantaged social groups than among the more affluent, and the disadvantaged were likely to die about 8 years earlier.

36. Illness shows a similar link to deprivation. It has been calculated that, in Lothian during 1995, 460 premature deaths would have been avoided if the entire population had shared the mortality experience of the most affluent. Similarly, more than £8m would have been saved if the overall rate of emergency hospital admissions had been as low as that of the most affluent. The differences between affluent and disadvantaged groups in Lothian in terms of premature deaths rates, rates of emergency hospital admissions and numbers of mental health outpatient referrals are all increasing over time.

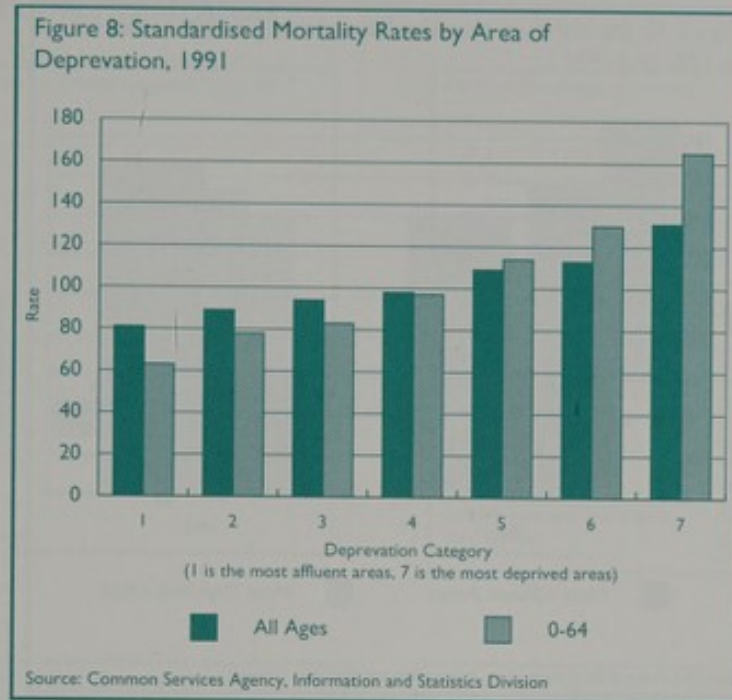
37. The major inequalities in the health of different socio-economic groups within the Scottish population begin even before birth. Figure 7 shows the perinatal mortality rate among different social classes in 1995. The perinatal mortality rate in social class V is 11.1 per 1000 compared with 7.1 in social class I.



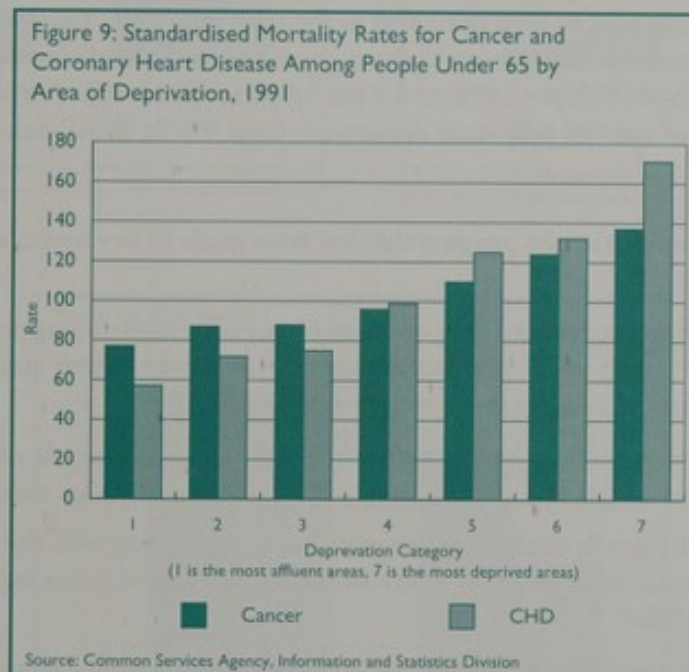
38. Children in the more deprived socio-economic groups are also more likely to be born prematurely and to have low birthweight. These factors are associated with greater likelihood of illness during childhood and adult life.

39. A number of studies has found that mortality rates are significantly higher among more deprived socio-economic groups. Figure 8 shows standardised mortality rates by the deprivation category of the area of residence. The all ages mortality rate shows a marked relationship with deprivation: in the most deprived areas, mortality rates are some 60% higher than in the most affluent areas. The relationship between deprivation and mortality is even stronger among people under 65. Mortality in this age group provides a crude proxy for general health. In 1991 the mortality rate among people under 65 in the most deprived areas was more than double the rate in the most affluent areas.

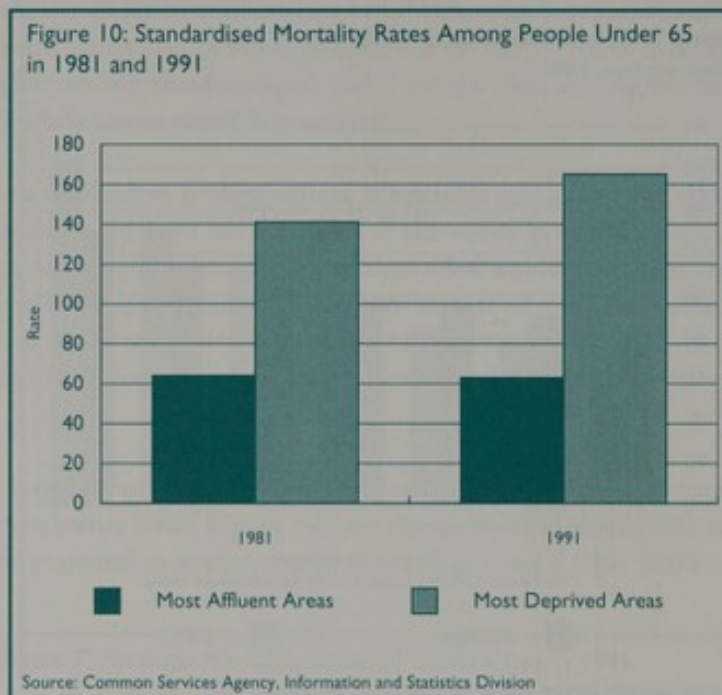




40. Similar results are found when death rates from specific diseases are compared by deprivation category (Figure 9). Mortality rates from CHD and cancer among people under 65 are much higher in areas of deprivation than in relatively affluent areas. And certain ethnic groups have a higher than average incidence of CHD and hypertension.



41. The gap in health between people living in the most affluent and the most deprived areas has widened during the 1980s (Figure 10).



In 1981, the standardised mortality rate in the most deprived areas was 120% above the rate in the most affluent areas. By 1991, this difference had increased to 162%.

42. Recent figures<sup>12</sup> show that, in Scotland, teenage pregnancy rates are closely related to social deprivation categories, with the pregnancy rate for 13-19 year olds ranging from 17.2 per 1,000 girls in the least deprived categories to 68.6 per 1,000 in the most deprived. Young women living in the most deprived areas are considerably more likely to choose to continue their pregnancies than those living in the least deprived (47.0 per 1,000 to 4.9 per 1,000 at age 13-19). A study of 3,000 women showed a wide range of rates of post-natal depression, from 8% in social class I to 33% in social class V.

43. Figures 11-15 summarise the progress that has been made in key health areas since the mid-1980s.

*Figure 11:* significant reductions have occurred in mortality rates among people under 65 from coronary heart disease and, to a lesser extent, from cancer. There has also been a slight reduction in this age group in the mortality rate from stroke.

*Figure 12:* modest reductions have occurred in the percentage of people who smoke in the age ranges 12-24 and 25-64, though the targets set for the year 2000 are unlikely to be achieved.

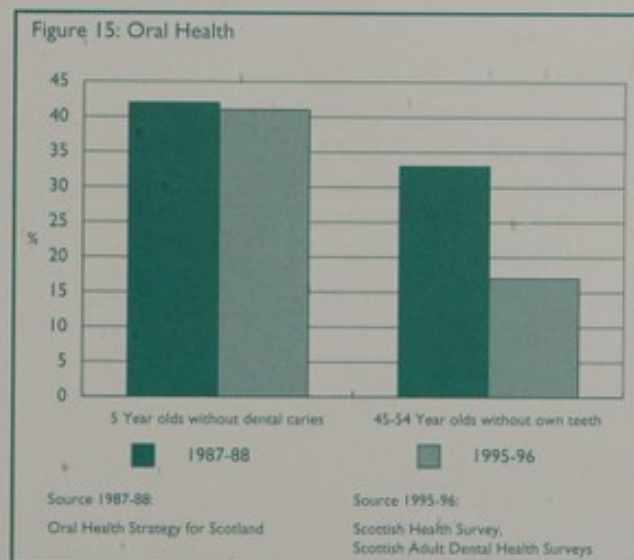
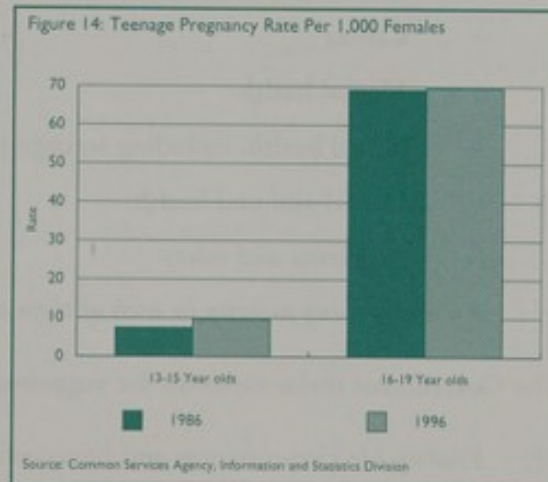
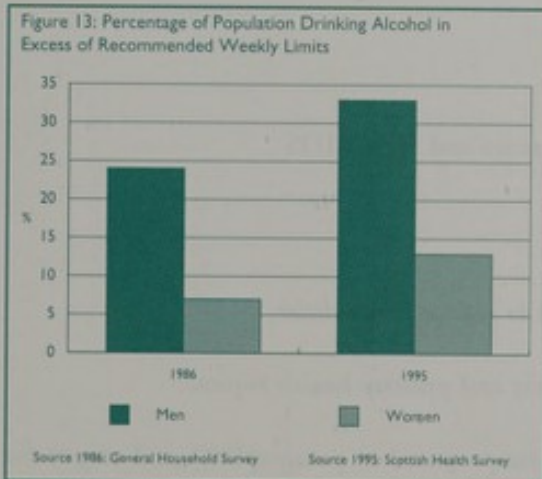
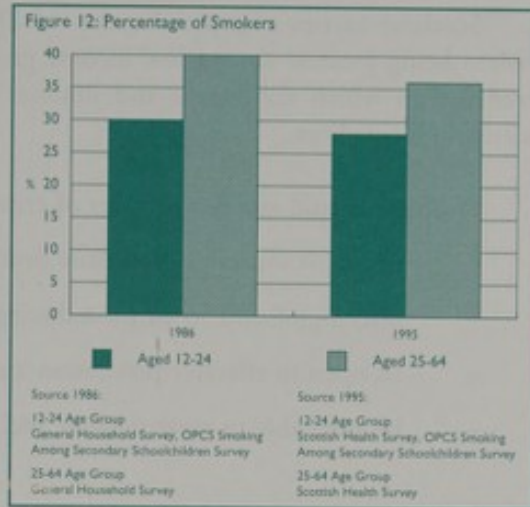
*Figure 13:* the changes in alcohol consumption are disappointing with the percentages of both men and women drinking in excess of the weekly recommended limits increasing significantly since the mid-1980s.

*Figure 14:* the teenage pregnancy rate (per 1,000 females) increased from 7.5 in 1986 to 9.6 in 1996 among girls aged 13-15.

*Figure 15:* while there has been a significant reduction in the proportion of 45-54 year olds without their own teeth, there has been little change in the percentage of 5 year olds without cavities, fillings or extractions and it is very unlikely that the target set for the year 2000 will be achieved.



## Progress in Priority Health Areas



## Priority Health Topics

44. Scotland carries a greater burden of ill-health than other developed countries, with the problem being greatest among low income groups. The quest to lighten that burden starts with agreement on which conditions and illnesses to tackle most urgently, including action on the underlying inequalities.


45. Priorities should satisfy a number of criteria. They should:

- be major causes of premature death or avoidable ill-health;
- offer significant scope for reducing overall health inequalities;
- be open to effective prevention and/or positive health promotion; and
- be amenable to measurement and monitoring.

46. Using these criteria, the following priority health topics are proposed:

- CHD and stroke
- Cancer
- Mental health
- Sexual health, including teenage pregnancies and HIV/AIDS
- Dental and oral health
- Accidents and safety

*An overarching priority in each of these areas is to reduce inequalities.*

 The Government invite views on the suggested criteria and priority health topics.

47. Priority life circumstances and lifestyle factors are proposed in paragraph 81 and targets for priority health outcomes and lifestyle factors are discussed in paragraphs 198-212.

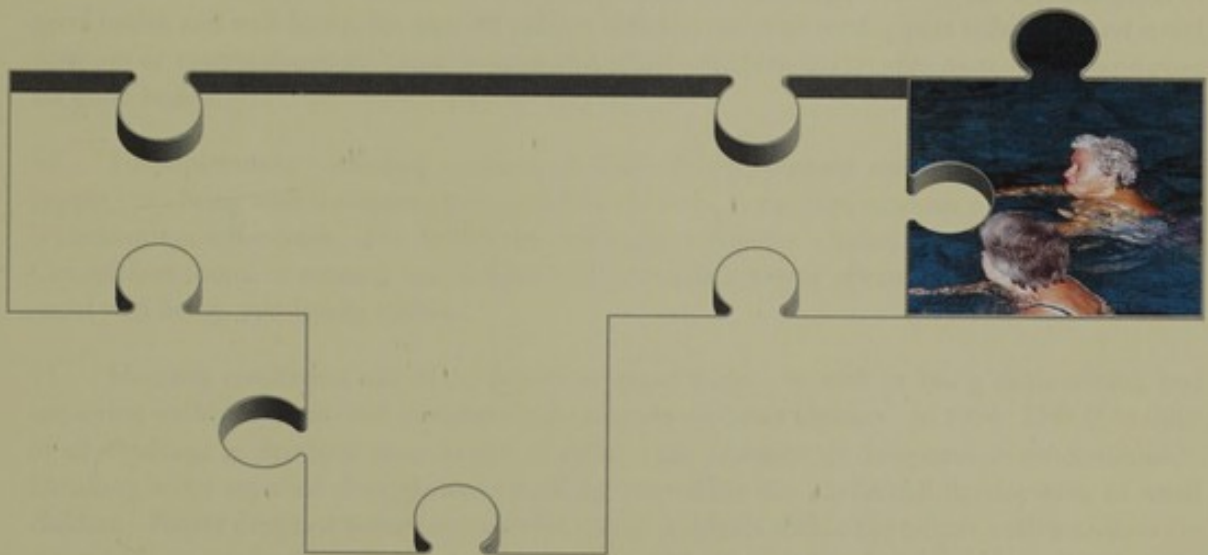
Differences in lifestyle do not fully account for inequalities in health. Disadvantaged life circumstances, although being a major barrier on

the path to better health, are not the only barrier. A

*“Differences in lifestyle do not fully account for inequalities in health. Disadvantaged life circumstances, although having a major bearing on lifestyle, have in themselves, a harmful effect on health.”*



### Chapter Three Influences on Scotland's Health



Differences in lifestyle do not fully account for inequalities in health. Disadvantaged life circumstances, although having a major bearing on



health and well-being.

## Chapter Three Influences on Scotland's Health

48. Many different factors account for Scotland's relatively poor health record and for the large inequalities in health that exist in Scotland. Lifestyle factors have been shown to be associated with a range of diseases. These aspects of our behaviour are strongly linked to underlying social and economic circumstances. Prominent among these are poverty, unemployment, and inadequate housing. Environmental factors, like pollution and access to health services and amenities, also bear on health.

### Life Circumstances

49. The circumstances in which we live closely affect our risk of poor health and our prospects of good health and well-being. So, too, do culture, fashion, the mass media, peer influences and social isolation or marginalisation. Good general education - not just health education - is a foundation for good health.

50. Unemployment - standing currently at some 6% in Scotland and involving over 147,000 people - can bring with it despair, poverty and resentment. It develops a culture of hopelessness, and it undermines self-esteem. The knowledge and means to choose a balanced diet are often lacking. Consolation found in tobacco and alcohol misuse has detrimental effects on physical, mental and social well-being, and family income.

51. Housing conditions can affect health in many ways. As well as being demoralising and impairing well-being, cold and dampness can worsen respiratory illnesses. In 1996, 25% (534,000) of all dwellings in Scotland were judged to suffer from problems of dampness or condensation.<sup>13</sup> Drinking water supplied through lead plumbing may affect the intellectual development of small children. Poorly designed houses increase the risk of accidents within the home: such accidents are a major cause of death or injury among children and the elderly. Local problems of naturally recurring radon gas at high levels, if not addressed, can substantially increase the risk of lung cancer. Where there are problems, their impact will generally be greatest for those who spend most time at home. There are, of course, other risks for those who are homeless.

52. A clean, well maintained environment, free from pollutants and dereliction, helps safeguard physical and mental health. Local amenities, including parks and recreational facilities, are also important. Not only do they improve the environment and support well-being, but they increase the incentive to take physical exercise, which, in turn, contributes to better health. Conversely, a lack of local amenities encourages recourse to other pursuits such as smoking, alcohol misuse and drug taking.

53. Areas of multiple deprivation pose a particular threat to health. The combined problems of low incomes, unemployment, poor housing, a degraded environment, and high levels of crime impose an additional burden of ill-health on many families. Each of these problems can, in isolation, affect our risk of poor health, but this combination of social ills can place extreme stress on communities, families and individuals.



54. Regeneration of these areas is required to transform the housing stock, improve the environment, provide training and employment, tackle crime, bring new amenities, and build a sustainable community infrastructure. The Government are determined to take action to regenerate our most deprived urban communities. At the same time, the Government recognise that disadvantage can also be found in rural areas, where local solutions can address inequalities on similar concerted lines.

55. A safe and healthy workplace is important. For people who work, the working environment is a significant influence on their health. For many, going to work is a positive part of their lives, and it helps them stay healthy. But we need to make sure that work does not injure people or make them ill, and that they leave work at the end of the day at least as healthy as when they arrived.

56. The Government are concerned about the impact of social exclusion on health. There are growing numbers of people who lack the means - material and otherwise - to participate in mainstream economic, social, cultural and political life in Scotland. Long-term unemployment, poor housing, homelessness, poverty and low educational achievement can all contribute to ill-health. Some health problems may also contribute to social exclusion. Some people may face stigma and prejudice as a consequence of a particular health problem, such as mental illness or HIV/AIDS. Some may face practical barriers to opportunity through disability. And high levels of long-term illness can suppress economic activity and employment in many communities.

57. An important aspect of people's life circumstances is the extent to which a wide range of services and facilities is easily reachable, affordable and user-friendly. Health services, including health centres, health visitors, and pharmacies, are not only about treating illness: they promote and support health. Adequate shopping facilities are also important so that people, especially in deprived and remote communities, can have easy access to purchase the foods which are necessary for a balanced diet. So are safe and accessible places for taking exercise. A good transport system brings such provision within the reach of all, while reducing pollution and accidents.

## **Lifestyle**

### *Smoking*

58. Tobacco smoking is the most important preventable cause of disease and premature death in Scotland. Each year smoking accounts for more than 10,000 deaths - approximately one in 6 of all deaths - and the cost to NHS hospitals in Scotland of treating smoking-related disease is around £87 million each year. Lung cancer causes the death of more men, and women, in Scotland than any other form of cancer, and Scottish death rates from lung cancer are among the highest in the world. Smoking is a major risk factor for CHD and is also implicated in chronic bronchitis, high blood pressure, stroke, peripheral vascular disease, a number of types of cancer and osteoporosis. Women who smoke are less likely to conceive and more likely to lose their babies before or soon after birth. Children of smokers are more likely to be of small stature and to develop respiratory infections, while more than 25% of the risk of sudden infant death syndrome is attributable to maternal smoking. There is increasing awareness of the dangers of passive smoking in relation to lung cancer, asthma and respiratory infection. Since 1982 there has been little decrease in the number of children smoking, particularly among girls. Sadly, smoking will kill many of today's teenagers in their later years.

Table 2: Percentage of Secondary Schoolchildren (aged 12-15) Smoking Regularly or Occasionally Scotland 1982-1994 (Source: OPCS)

	<i>Boys</i>	<i>Girls</i>
1982	23	24
1984	24	26
1986	14	20
1990	19	20
1992	16	21
1994	19	23

59. Apart from the direct effects of smoking on health, thousands of fires are caused each year by carelessness with cigarettes or other smokers' materials, some with fatal consequences. Of the 88 deaths resulting from fires in dwellings in 1996/97, 39 resulted from fires so caused, as did 731 injuries.<sup>14</sup>

60. The recent *Scottish Health Survey*<sup>3</sup> suggests that limited progress has been made in reducing the level of smoking among adults aged 25-64. The proportion of people in this age group who smoke has fallen from 40% in 1986 to 36% in 1995. But it seems unlikely that the target of reducing the level of smoking in this age group to 32% by the year 2000 will be achieved. Other surveys indicate that no significant progress has been made in reducing smoking levels in the 12-24 age group.

### *Eating for Health*

61. The link between diet and health is well established. *The James Report*<sup>15</sup> on Scotland's diet, published in 1993, confirmed unequivocally the very poor balance of our diet and its highly damaging impact on the population's health. In short, the average Scottish diet is deficient in certain vitamins and fibre and contains too much saturated fat, sugar and salt. Children's diets are particularly bad with many never eating fruit and vegetables and some eating almost exclusively crisps, chips, snack foods, sweets and fizzy drinks. The rate of breastfeeding by Scottish women is very low despite the well-known benefits of breast milk, which provides children with a healthy start to life by reducing the risk of certain potentially serious illnesses in infancy and childhood. The *Scottish Health Survey*<sup>3</sup> found that, among the adult population:

- 28% eat fresh fruit once a week or less
- 20% eat cooked green vegetables once a week or less
- 34% eat cooked root vegetables once a week or less.

62. Such is the extent of our poor diet that it ranks second to smoking as the cause of Scotland's high mortality rate from CHD, stroke and cancer (evidence suggests that our diet influences the incidence of almost one-third of cancers in men and nearly half of those in women); is directly responsible for much of our poor dental health, particularly among children; and contributes to our comparatively poor life expectancy. Unless the Scottish people change their present diet, they are likely, despite advances in healthcare, to continue to have a high rate of mortality and disability from CHD, stroke and cancer and a lower life expectancy than most other western countries.

63. Improving diet has to be at the heart of improvements in Scotland's health. We want to encourage and enable the Scottish people to adopt a better and healthier **balance** in their diet. This means much more fruit and vegetables, bread, cereals, potatoes, rice, pasta and fish, especially oil rich fish; and much less of foods containing high levels of fat, salt and sugar. Lifelong food preferences are established at an early age; and so the eating habits of young children are an important start.



64. Most Scots are aware of the beneficial impact of a balanced diet on the quality of health and well-being. The task is to help each of us to act on that information. Dietary targets for the year 2005 have been set, therefore, and a *Diet Action Plan: Eating for Health*,<sup>16</sup> was published in 1996. The Plan, for action over a 10 year period, provides a coherent framework for tackling our dietary shortcomings. It examines the changes required in the diet of the population in general and of particular groups, notably pregnant women and children, and those in deprived communities to whom low income and unavailability of healthy food choices present particular barriers to achieving a balanced diet. It identifies ways in which the various interests in a position to influence what we eat can contribute to helping people choose, and enjoy, a healthy diet.

65. With the support of Government funds of £1m, implementation of the Plan is now underway across the spectrum of interests. The Scottish Community Diet Project, led by a national project manager to co-ordinate dietary strategy and develop initiatives in deprived communities, has already awarded £60,000 to fund innovative diet projects in these communities. Constructive discussions with the major food retailers have explored ways of increasing the contribution they can make to improving Scotland's diet as a whole and within deprived communities. A Scottish Healthy Choices award scheme is open to all catering interests in Scotland. A healthy eating leaflet has been issued to all Scottish households. A short practical cooking skills course for schoolchildren is being developed. Many initiatives, particularly within communities, are also being taken forward at local level.

### *Physical Activity*

66. Physical activity can help protect against heart disease, strokes and a number of other health problems and promote physical, social and mental well-being and fitness. It also helps prevent obesity. Around one-third of all CHD and one-quarter of all strokes could be avoided if regular physical activity was undertaken by all, while programmes of physical activity can reduce mortality after a heart attack by 20%. Exercise taken in Scotland falls well short of the levels regarded as beneficial to good health. A key recent development has been the identification of the benefits of regular **moderate** activity, not just vigorous exercise. This is true for all age groups, and regular activity, continued into older age, has been shown to prevent falls and diseases such as osteoporosis as well as improving mental health. Of those interviewed in the *Scottish Health Survey*,<sup>3</sup> 53% of men and 62% of women acknowledged that they did not get sufficient regular exercise, while 23% of men and 26% of women undertook no moderate or physical activity in an average week. Low levels of physical activity in children in Scotland are a cause for concern.

### *Alcohol Misuse*

67. Over 90% of the adult population drink alcohol. It can be a part of a healthy lifestyle if taken in moderation and at the right time and place, and, indeed, there is evidence of physical health benefits of regular moderate alcohol consumption for men over 40 and women after the menopause. Both excessive consumption over long periods and heavy spasmodic drinking cause damage to health, accidents, and anti-social behaviour. The costs of alcohol misuse in personal, social and economic terms are great, and are all too often hidden or unheeded.

68. Some 8% of men and 1% of women in Scotland - about 200,000 people - are drinking at levels which are definitely harmful. The *1994 General Household Survey*<sup>17</sup> showed alcohol consumption levels in Scotland to be broadly similar to those in other parts of the UK. There has been a greater tendency, however, towards binge drinking in Scotland and this may be the most significant variation in the patterns of alcohol consumption in the UK. Misuse of alcohol is a major



risk factor associated with disease, homelessness, unemployment, criminality, mental breakdown, domestic violence and child abuse. Many working days are lost each year due to alcohol misuse. Heavy drinking contributes to high blood pressure; increases the chances of stroke; and is linked to cancer of the throat and mouth. A quarter of the men and a tenth of the women admitted to general hospitals will be problem drinkers.

69. There has been a steady increase in deaths attributable to alcohol. According to the Office for National Statistics, there has been a small increase in the 1990s in the proportion of children in Scotland aged 12-15 who drink alcohol at all (from 59% in 1990 to 64% in 1996). However, there has been a more marked increase in the amount consumed by those who drink. The average number of units a week drunk by children of this age has more than doubled - from 0.8 units in 1990 to 1.9 units in 1996. Alcopops, which were first introduced into the market in 1995, accounted for about 18% of all alcohol consumed by this age group in 1996. Consumption by women has increased in the last two decades. Their smaller average physical size means that a given amount of alcohol may cause more damage to women than men.

70. The target set for alcohol consumption was to reduce the 1986 figures for men drinking more than 21 units per week and for women drinking more than 14 units per week by 20% by the year 2000. The heavier the drinking above this level, the greater the hazard to physical and mental health. Findings from the *Scottish Health Survey*<sup>3</sup> are that 33% of men and 13% of women drank more than these recommended levels. This indicates an increase compared with the 1986 levels of 24% and 7% respectively. To be effective, preventative policies have to focus on the moderately heavy drinkers as well as those at the extreme end of the range.

71. The Government are fully committed to tackling alcohol misuse on a broad front. Alcohol development officers have been appointed throughout Scotland, co-ordinating action at local level. The licensing framework in Scotland works well and can react to particular problems, for example, licensing boards are required to refuse late night extensions unless satisfied of their community benefit. Regulation has recently been strengthened. Local authorities can now have recourse to byelaws prohibiting the consumption of alcohol in designated public areas. Under Scots law, it is already an offence for adults to buy alcohol for supply to children and recent legislation allows the police to confiscate alcohol from under 18s who are drinking in public.

72. The Government have made clear that, if their current measures to bolster the action taken by the drinks industry towards better self-regulation do not bear fruit, they will take further action which could include legislation in areas which have traditionally been left to self-regulation. The Government have also made very clear their determination to tackle alcohol misuse by young people - which can lead not only to crime but also to under-achievement, poor health and poor employment prospects.

73. A high proportion of adult fatalities from fire in dwellings (where the cause of fire was carelessness with smokers' materials, pans left on cookers, or misuse of electrical apparatus, for example) has been linked with excessive intake of alcohol.

### *Drug Misuse*

74. All the indicators show that drug misuse continues to grow in Scotland. Surveys of young people regularly show half or more reporting that they have taken an illicit drug at some time in their lives. In surveys<sup>18</sup> about 1 in 4 young people acknowledge having taken drugs within the preceding 12 months, and figures for drug misuse in young age groups - for example those pupils starting

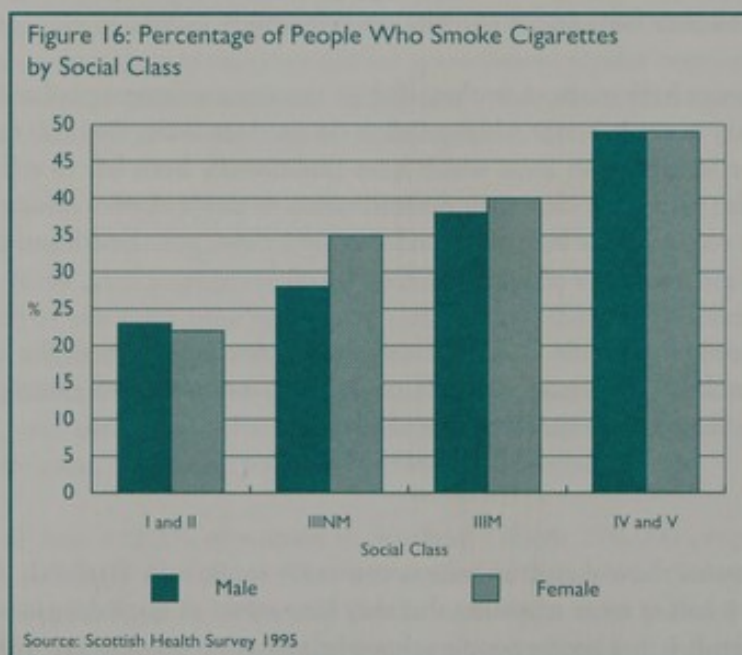
secondary school - are of especial concern. While these figures also remind us that drug taking is not part of the day-to-day lives of most Scots, the upward trends dispel complacency. With growing concern about the medium to long-term effects of drugs taken freely in dance settings, mixing of hard and recreational drugs, and drugs and driving, a sustained effort is needed to stop drug misuse acquiring the malign grip of tobacco and alcohol in Scotland. Early adolescent solvent abuse continues to be associated with a significant risk of brain damage and accidental death.

75. The figures for those with a serious drug problem reported to the Scottish Drug Misuse Database show that heroin-users increased significantly during 1996/97. Comparing these figures with those for other parts of the UK provides evidence that Scotland is one of the worst areas for heroin misuse. A similar pattern emerges in the illicit misuse of certain prescription drugs, together with injecting and "polydrug" misuse. Drug-related deaths in Scotland rose from 251 in 1995 to 267 in 1996, following a steeper rise from 151 in 1992. There is a damaging link between injecting drug use and the spread of HIV/AIDS and hepatitis B and C. The most serious harm from drug misuse is concentrated in areas of deprivation.

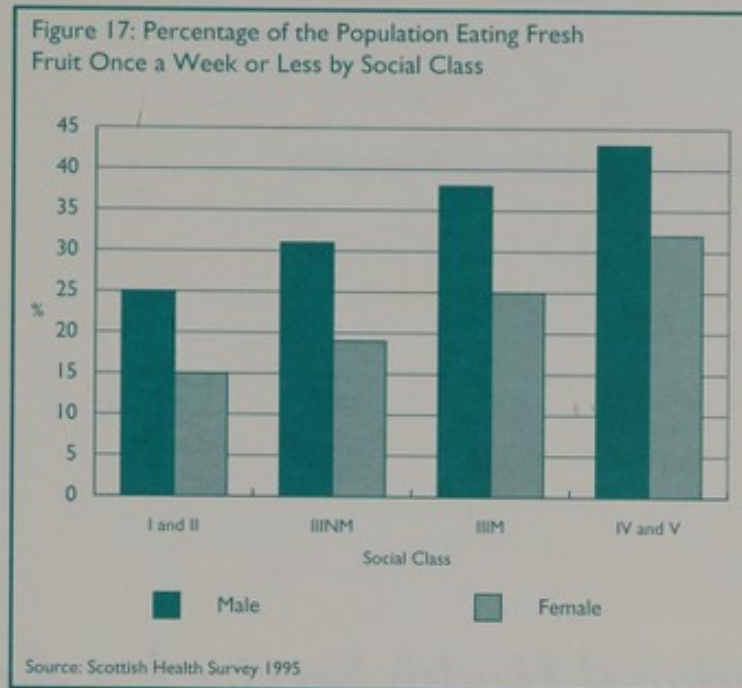
76. Drug misuse and crime are closely linked. Some police forces operate on the basis that 50-70% of crime is drug related. It can take many forms, from petty thefts and burglaries, to fund drug purchase, through anti-social behaviour induced by drug taking to intimidation and violence spawned by drug dealing. An ongoing study suggests that around 2.5 million crimes may be committed annually in Glasgow by heroin injectors. Substantial costs fall on local communities, public services and industry.

## Inequalities

77. Just as there are inequalities in **health**, so there are marked differences in **lifestyle** between socio-economic groups, geographical location and other groupings. For example, levels of smoking are closely associated with social class (Figure 16). Less than a quarter of men and women in social classes I and II smoke cigarettes, but in social classes IV and V the percentage of smokers among both men and women is almost 50%.







78. Diet is also closely associated with social class. Thus the percentage of people who eat fresh fruit only once a week or less is significantly higher in social classes IV and V than in social classes I and II (Figure 17).

79. Differences in lifestyle do not fully account for inequalities in health. Disadvantaged life circumstances, although having a major bearing on lifestyle, have in themselves, a harmful effect on health. Low income or poorly located housing can affect access to a range of health promoting venues and facilities. There is evidence that the availability of general medical care tends to vary inversely with health need in the population served.

80. In order to take stock of current knowledge on inequalities in health and to identify the best areas on which to concentrate efforts, the Government have established an independent inquiry under Sir Donald Acheson, the former Chief Medical Officer in England, into inequalities in health, drawing on international experience. Together with responses to this Green Paper, Sir Donald's report will help inform the development of our health strategy.

### Priorities

81. The effects of life circumstances and lifestyle on health are readily apparent, well documented and have been accepted by the Government. Tackling them is important in health terms, and, more broadly, in support of social cohesion and community safety. We propose that the priorities should be:

- Life circumstances, such as deprivation
- Smoking
- Eating for health
- Physical activity
- Alcohol and drug misuse

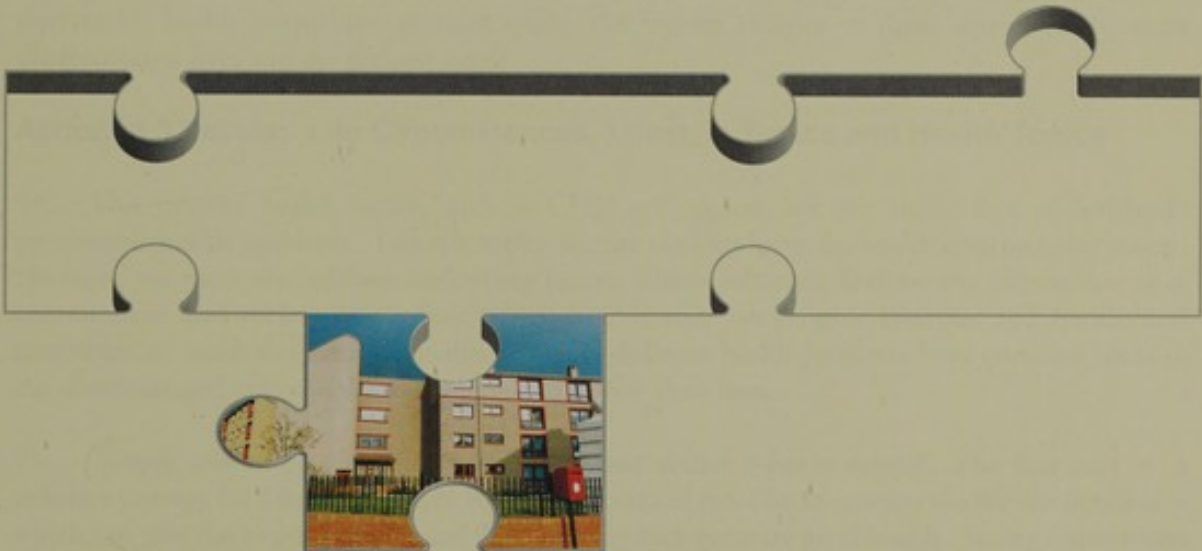
*In identifying a range of priorities, an overarching objective must be to reduce inequalities.*

Views are invited on the priorities proposed.

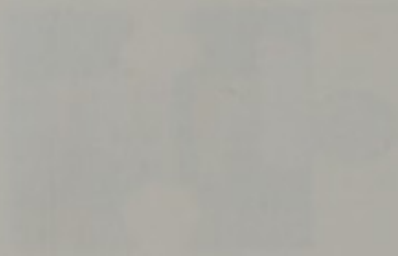


*“The National Health Service has the lead role in forming strong partnerships with local authorities, voluntary organisations and the private sector which are essential for success.”*

Chapter Four The Government's Approach



The National Health Service has the lead  
in providing a comprehensive range of  
health care services to the population  
and the private sector which are essential  
for the well-being of the nation.





## Chapter Four The Government's Approach

### Purpose

82. This chapter builds from previous chapters a framework within which the action outlined in the remainder of this document might be pursued.

83. Our goal is a healthier Scotland, with less ill-health and higher levels of well-being and fitness across the nation and social spectrum. The Government view as unacceptable the inequalities in health which exist in Scotland. The challenge lies in reducing avoidable differences in health opportunities and experiences across socio-economic groups, and geographical localities. The strategy for a healthier Scotland must be a strategy for the whole population, but must at the same time tackle health inequalities through giving the highest priority to those who have the most disadvantaged lives and the greatest needs.

### Action at 3 Levels: Life Circumstances, Lifestyle Topics and Health Topics

84. Our priority health topics, such as CHD and cancer, are the visible face of Scotland's preventable health problems. Lifestyle topics are the obvious focus for health improvement action. However, we must also address underlying factors which influence health - the circumstances in communities and society as a whole which bear heavily on people's lifestyles and health, and contribute so much to health inequalities. Many different health problems have common roots in the disadvantaged circumstances in which people live their lives.

85. *Simply addressing disease and lifestyle cannot deliver what is needed.* The first part of a cohesive strategy for a healthier, more equitable, Scotland must be to counter the life circumstances which can give rise to poor health, and foster those which generate good health. Strong foundations must be put in place. These include a job, a home, a good education and an attractive environment.

86. A key task is to help strengthen communities in need, promoting a sense of belonging, hope, self-esteem and confidence. This is fundamental to the well-being of families and individuals and their capacity to act on health education messages, taking fuller responsibility for safeguarding their own - and other people's - health. Communities, families, groups and individuals need help to have more influence over their day-to-day lives and destinies, and to play their part as citizens and family members in looking after each other and building a better, more caring, more cohesive and healthier society. This is not just, or primarily, for health agencies to pursue, but will provide common cause with those working to prevent crime and social exclusion, and to improve children's lives and education.

87. Action at this, **first**, level will not generally come under specific headings such as CHD, cancer, stroke, mental health, smoking, or even be labelled 'health'. But it does hold the potential for a major, long-term and sustainable impact across a spectrum of health and lifestyle topics, on health inequalities, on related issues such as crime, on mental and social well-being, and on quality of life.

88. The Government will build on these foundations by ensuring that communities, families and individuals have the specific support and help they need in relation to particular lifestyle priorities, such as smoking, healthy eating and drug misuse.

89. **Lifestyle topics** are the **second** level, calling for strong and supportive health education, underpinned by appropriate policies including regulation.

90. At the **third** action level - **health topics** - we must bring home to everyone the importance and **preventability** of Scotland's major causes of illness and death, and help people who have already developed particular health problems to reduce the risk that they will worsen or recur.

### FERGUSLIE COMMUNITY HEALTH PROJECT

From the outset, this project has been community-led and over the years the number of people who feel not only part of, but also ownership of, the project has steadily grown. The relationship between the project and the Ferguslie Park Partnership has always been a strong and reciprocal one, with the role of the community in identifying and tackling health and social issues being recognised as crucial. Initiatives are wide ranging and include a drop-in centre; support groups; an information project on the health and well-being of the elderly; a school pupil-led evening to discuss relationships; projects on the prevention of teenage pregnancies and drugs and alcohol misuse; and training courses on matters such as stress management, welfare rights and health, and health in the community.

### CRAIGMILLAR COMMUNITY HEALTH PROJECT

The project provides a meeting place for local people to discuss health concerns. It seeks to involve local people in efforts to address health inequalities at community and individual level. Current activities include a drop-in centre; training courses and workshops on health themes; support groups; counselling; complementary therapies; stress management and relaxation. Facilities include a creche.

## Action Dimensions

91. A range of measures is required, including: policies addressing life circumstances as well as specific lifestyle and health topics; broad-based strategies for the development and strengthening of communities; the provision of high quality, accessible services and facilities for the prevention of ill-health and the promotion of good health; and health education which influences culture, provides information, gives encouragement and helps people to acquire the skills needed to act on the advice given.

## Arenas for Action

92. The Government are committed to ensuring that the people of Scotland have the benefit of healthy influences and access to health promoting resources wherever they live, learn, work, spend leisure time and seek help. To this end, it is important to encourage the continued development of health promoting strategies, policies, facilities and education in arenas such as the Health Service, schools and other educational institutions, the workplace and a range of other community settings, formal and informal. We need frameworks for a health promoting Health Service, the health promoting workplace, health promoting communities and so on, building on the pioneering concept of the health promoting school. This work needs to be supported and encouraged by giving health issues a high profile in the mass media.



## Life Stages

93. Promoting health is a challenge at all stages of life, from first life (indeed, before conception and during pregnancy) to old age. The challenge is to young and old people alike, the community in which they live, and the organisations and policymakers who support them. Different stages in people's lives bring different priorities and require different approaches. Much of the health promotion effort must continue to involve people in the middle years of life, but young people and people in later life have particular needs. Effective early intervention for children in high risk groups can yield great benefits later on. Personal responsibility must also be stressed. A matter of pressing concern is risk-taking behaviour among young people, manifest in smoking, drug and alcohol misuse and hazardous sexual behaviour. We must be ever more creative in our search for ways of bringing these problems to their attention, while listening to their views.

94. It will not be enough to treat the various life stages in isolation. The opportunity for the generations to learn from each other and to help each other should not be forgotten. Adults have important parts to play in helping young people to healthier habits, and old people need to have the benefit of respect and care from the younger generations. In recent years, evidence has been accumulating of links between particular aspects of parenting and a range of unhealthy and antisocial behaviours among young people. This is not to say that parents alone are responsible for young people's problems. Rather it points to a need to explore carefully what can be done to identify the circumstances which will enable parents to give their children the best start in life and support in their formative years.

## Partnerships for Health

95. The task of building a healthier Scotland is not for the Health Service alone. The National Health Service has the lead role in forming strong partnerships with local authorities, voluntary organisations and the private sector which are essential for success. Partnerships must reach out to their local communities and involve the public in their activities. The Scottish Office is committed to setting a good example by ensuring that there is adequate co-ordination across all its Departments and with other Government agencies which operate in Scotland, including the Health and Safety Executive, in the interests of better health and that policies, strategies and initiatives are sensitive to people's needs and circumstances.



Views are invited on the various aspects of the Government's suggested approach, including the 3 level strategy envisaged, ie life circumstances, lifestyle topics, and health topics through prevention of illness and premature death.



*“There is no quick fix. Changing habits acquired through many generations will need a cultural shift which will not be achieved at the touch of a switch.”*

*“The Government will drive forward its policies for revitalising Scotland’s economy and environment, creating the climate in which good health can flourish.”*

*“Local authorities wield a significant influence on health right across the range of their functions. Maximising their potential to improve health must be fundamental to any strategy.”*

*“Good health is everyone’s business.”*

## Chapter Five Roles, Responsibilities and Action



There is no such thing as a free lunch. Changing habits  
and the way we think will need  
a cultural shift which will not be achieved in  
the short run.

The Government will have to invest in  
[illegible] and [illegible] programs  
to [illegible] the [illegible]

Good health is a [illegible] important  
ingredient in [illegible] the [illegible] of  
[illegible] [illegible] [illegible] [illegible] potential to  
[illegible] [illegible] [illegible] [illegible] in any  
[illegible]


Good health is everyone's business.



## Chapter Five Roles, Responsibilities and Action

96. Health regeneration calls for personal investment in our own health: improved living conditions; and supporting infrastructure and services. Mental and physical well-being will improve, as we rebuild in deprived communities access to the opportunities people elsewhere take for granted. There is no quick fix. Changing habits acquired through many generations will need a cultural shift which will not be achieved at the touch of a switch. But we can ease and quicken change. The right mix of measures - economic, social, environmental and behavioural - will deliver not just better health but many other social gains.

97. Scotland's problems are pressing but not unique. We need to learn from other countries that have overcome similar problems and now have better health.

 Views are welcome on actions taken elsewhere, which have led to health improvement, and which can be made to work in Scotland.

98. Health measures need to be coherent, with each agency aware of its joint and separate roles, and each potential health setting 'wired up' for health improvement, in a structured way. This chapter sets out our proposals for co-ordinated action to realise maximum health gain.

### THE PUBLIC

99. Any strategy for health improvement must have at its heart the recognition that it is "the public's health" and the public's own responsibility. Countless steps can help shape our own future health, and combine to shape the nation's health. But we can also influence and affect others - the move to smoking-free settings and reductions in drinking and driving are examples of how change takes off, as more and more Scots subscribe.

100. As individuals with responsibilities, we have a right to expect healthy choices to be made easier choices, particularly in communities where access and choice are constrained by poverty. And we have a right to protection from industrial wastes and pollution, to a clean environment and safe clean water. The public should have the chance to help identify the key health issues affecting them and the action needed to promote health. Central government, working with other public and private sector bodies, have a responsibility to support healthy choices with accurate and credible information, strong leadership and the creation of a strategic framework within which the NHS, local authorities and other partners can work to deliver improved health.

### CENTRAL GOVERNMENT


#### Policy Co-ordination

101. The Government have a particular responsibility to ensure that all their policies are brought together in a coherent way so that the potential for health gain is achieved. It must also set the tone

for economic and social prosperity, leading to job creation, better education, a cleaner environment and so on. The Scottish Office, with its wide-ranging economic, social and environmental remit, is well placed to promote this integrated approach to health. Devolution will enhance its capacity to marshal and target its policies and resources in a way which best reflects Scotland's health needs.

102. Health will be a key consideration in policy formulation across the spectrum of Scottish Office responsibilities and Scottish Office Ministers will ensure that health considerations are given due prominence in developing and taking forward initiatives within their respective portfolios. The Scottish Office Minister for Health, in collaboration with his Ministerial colleagues, will drive and oversee the work of the interdepartmental group of senior officials which will ensure co-ordination across The Scottish Office to improve Scotland's health.

103. The Government propose that this task should be facilitated by means of **health impact assessments**, which will identify and evaluate the health implications of relevant new central government policies and initiatives. The Public Health Policy Unit in The Scottish Office Department of Health will have the responsibility for this work within The Scottish Office. The emphasis will be on identifying a small number of significant policies which clearly affect health and on considering how best health gain can be maximised or, conversely, adverse effects on health avoided.

 Views are invited on the proposal that health impact assessments should be carried out on evolving national policies. What guidance would be helpful both to identify the policy areas which would benefit most from such an approach and to assist in the undertaking of such assessments?

### **Strengthening Communities**

104. In seeking to foster community cohesion and reduce social exclusion it is important that community-based approaches to promoting health across a broad front are put on a sustainable footing, with local action underpinned and enabled by policy and strategy at higher levels.

105. Community involvement is a key component of our area regeneration policy. Sustainable regeneration requires community support, involvement and ownership. The local community is a full partner in all our regeneration partnerships. The New Life Partnerships all have community support structures to facilitate community participation in the partnership process, and there is much valuable experience which can be learnt from them.

106. The Government are looking at new ways of meeting the needs of communities. With COSLA, we have established a working group on community planning, to consider how to develop the role of local authorities in working together with other bodies to plan for and meet the needs of their communities. The group will also identify best practice in existing council partnerships in planning, providing for, and promoting the economic, social and environmental well-being of the communities they serve.

107. The Government are committed to tackling social exclusion. In Scotland, this will be taken forward at central Government level by Lord Sewel and The Scottish Office Social Exclusion Network. The Government are keen to take on board views about how best social exclusion is to be tackled and a consultation exercise is being undertaken.

108. In addition, the Government suggest setting up an expert working group, chaired by The Scottish Office Minister for Health, charged with drawing up a strategic framework for concerted action to promote health at community levels with a particular focus on, but not limited to, deprived communities. This would include any necessary national structures or mechanisms for



stimulating and supporting local action. The working group would critically appraise available evidence on links between community factors and health and on the effectiveness of various approaches to strengthening communities, taking account of the emerging findings from the enquiry under Sir Donald Acheson, the work to tackle social exclusion and ongoing activities in community planning, community development and area regeneration. As part of its work, the working group could identify large-scale ground-breaking projects at community level, which, in a concerted way, focus on pressing and stubborn local problems, for example, coronary heart disease.

Views would be welcomed on this proposal and specifically on the composition of any such working group.

### Other Action on Life Circumstances

109. The Government will also drive forward its policies for revitalising Scotland's economy and environment, creating the climate in which good health can flourish. These include:

#### *Employment*

- through the continued deployment of the energies and powers of the Enterprise Networks in Scotland to create employment, provide training and improve the environment, and with the availability of direct help for industrial development, such as the Regional Selective Assistance Scheme, much can be done to reduce unemployment, attack the problems of social exclusion and promote economic activity.
- the introduction of the National Minimum Wage to encourage industry to compete on the quality of goods and services they produce rather than solely on low costs based on low rates of pay. With an adequate income, people will be able to afford to choose a more healthy lifestyle.
- increasing the ability of young people to get into work as a result of the impact of the Government's New Deal initiative. The New Deal for 18-24 year olds was launched in the Tayside Pathfinder area on 5 January 1998 and arrangements for implementing the programme in the rest of Scotland from the beginning of April are well advanced. The New Deal for those aged 25 and over is due to commence in June. The New Deal for lone parents, currently being piloted in the Clyde Valley, will be expanded nationwide from October. The New Deal for people with a disability or long-term illness has recently been launched and bids have been invited to help deliver the programme's aims.

#### *Environment*

110. A clean environment is a key health determinant. We will continue to take action to improve the quality of our environment. Sustainable development is the main element of the Government's manifesto commitment to place the environment at the heart of policy making. It requires the pursuit of economic growth and social progress, which respects the environment. Our sustainable development strategy is, therefore, a key contributor to the drive to improve public health in Scotland.

111. Action will be taken to improve the environment in which we live and work. Key areas include:



- the Government have set local authorities four key priorities for **housing** investment. These are: housing in the worst physical condition (below the tolerable standard); condensation and dampness; homelessness; and care in the community. Already we have made available an additional £15.5 million of new money in this financial year, and over £50 million extra for 1998-99. All of our housing priorities have a direct relevance to health. We attach importance to improving energy efficiency and extra resources are being provided this year and next to improve the energy efficiency of housing stock. The Rough Sleepers Initiative, with a budget of £16 million over the 3 years to 1999-2000, supports partnership projects at local level to help those sleeping rough.
- **transport** is influential on health in a number of ways. Access to health services, shopping centres and recreational facilities is made easier. This is particularly important for isolated rural and deprived communities. Pollution, too, can be addressed by policies which reduce the need to travel and dependency on cars, especially in urban centres; and greater provision for cyclists and pedestrians contributes both to a cleaner, safer environment and to improved health through increased physical activity. The Government intend to publish in Spring 1998 a White Paper on Integrated Transport in Scotland, which will take account of the health dimension in these key policy areas. In addition, the Government have set up a National Transport Forum for Scotland. This brings together the major transport operators, decision-makers and influences to provide advice to Ministers and encourage greater co-ordination between the various forms of transport. Health and environmental interests are represented on the Forum.
- **air quality** is high on our agenda. *The Report by the Committee on the Medical Effects of Air Pollutants: Quantification of the Effects of Air Pollution on Health in the United Kingdom*,<sup>19</sup> confirmed the links between air pollution and effects on health. The Report concluded that each year significant numbers of vulnerable people are admitted to hospital or have their deaths hastened because of the effects of air pollution.
- *The Government's National Air Quality Strategy*<sup>20</sup> was implemented in December 1997. It establishes health-based standards and objectives for 8 individual pollutants to be met by 2005. The Strategy sets out a new system of local air quality management under Part IV of the Environment Act 1995. Local authorities now have a duty to assess and review their air quality and to identify pollution hot-spots where national policies alone will not deliver the statutory targets. In these cases, local authorities must declare an Air Quality Management Area and develop an Action Plan to tackle the problem. In addition, the Government announced last July an accelerated review of the Strategy in order to consider the scientific basis of the objectives set in the Strategy, and the range of policy options which will help deliver them. The review findings will be announced later in 1998. Last November, the Government launched a new system for informing the public about air quality. This followed extensive consultation to take account both of the concerns that the existing system was misleading in terms of the descriptions of effects on health, and also to ensure consistency with the standards in the Strategy.
- good quality **water** from both public and private supplies is essential to good health. Although risks from drinking water are small compared with other "life" hazards, it is important that this basic requirement for health is adequately protected. The Government are urging Scottish water authorities to accelerate their investment both in treatment works and in pipes under the ground. The Government are determined that Scottish water should always meet the very highest standards.

- during the last 20 years, the UK water industry has made steady progress in the understanding of lead in drinking water and has moved towards compliance with a lead standard more stringent than elsewhere in Europe. The replacement of all lead communication pipes by water authorities is likely to become mandatory following the introduction of a tighter standard for lead in the revised EU Drinking Water Directive. The Directive excludes the replacement of lead plumbing in domestic properties. However, in recognition of the work involved, the EU have allowed water authorities 15 years to meet the new standard.
- a **safe and healthy working environment** is an important determinant of the health of the workforce. The Health and Safety Commission and Executive are working on a national occupational health strategy and expect to issue a consultation paper during 1998. This strategy will complement and contribute to the strategy for a healthier Scotland.

112. Many of these environmental factors are raised in the *National Environmental Health Action Plan*,<sup>21</sup> published in July 1996 and drawn up under the auspices of the World Health Organisation. The Government intend to review the Plan ahead of the next WHO Ministerial Conference on Environment and Health to be held in London in 1999.

#### *Area Regeneration*

113. Area regeneration has a key contribution to make to improving health. It tackles the social, economic and environmental problems of multiple deprivation. And it embodies the concerted approach the Government seek to foster.

114. Area regeneration policy is based upon a long-term, strategic approach. It is founded on a partnership approach with all key local and national agencies working together, in conjunction with the local community. This has been developed within the four pilot 'New Life for Urban Scotland' Partnerships (Castlemilk, Ferguslie Park, Wester Hailes and Whitfield) and is now being developed within the Programme for Partnership framework. The New Life Partnerships have achieved a high impact in relation to housing, crime, education and employment. In recent years, the Partnerships have begun to tackle health issues more directly by drawing up health strategies, and seeking to tackle lifestyle factors such as smoking.

115. Programme for Partnership now supports twelve Priority Partnership Areas (PPAs) with a 10-year lifespan. Eleven Regeneration Programme areas have also been designated. Health Boards are members of the Partnerships in each area. Each Partnership is required to establish baseline data on health indicators, and to set targets for health gain. This will allow us to monitor the impact of the regeneration process on health in some of our most deprived communities.

116. Regeneration partnerships offer significant opportunities for health gain. There are opportunities for the new PPAs to make use of their block Urban Programme allocations to develop innovative but appropriate local solutions to health issues, and if necessary to fund pilot or developmental work. The PPAs have access to large sums of Urban Programme Funding (ranging in 1998/99 from £760,000 to £3.4m.)

117. The PPAs, existing Urban Partnerships, and Regeneration Programme areas offer scope for the development of work to tackle health inequalities. Partnership areas could bring 'added value' to initiatives being developed on a nation-wide basis. For example, a 'healthy living centre' developed within a PPA might achieve increased impact as a consequence of additional investment in



complementary local services. Health Boards, which have become active in Partnership areas, have discovered that the Partnership process facilitates consultation with local agencies and the local community on service development. There are significant opportunities within Partnership areas to develop innovative approaches to health and health promotion which recognise the circumstances of local people, and to monitor their impact and outcome. For example, Argyll and Clyde Health Board are running a pilot service in the Inverclyde Partnership, through the secondment of a Health Implementation Officer into the Partnership team. The outcomes of this work will be reported to The Scottish Office as part of their formal management agreement. If successful, this pilot could be considered as a model for future reporting arrangements. But there is scope for other models to be tried.



Views are invited on how health improvement can be further integrated into the work of the PPAs and Partnerships.

### *Healthy Living Centres*

118. The Government's White Paper on the National Lottery, *The People's Lottery*,<sup>22</sup> set out our plans for a core network of healthy living centres, funded from Lottery proceeds. This initiative has great potential to improve health. It will be of particular value in deprived communities, and under the criteria we are assembling, preference will be given to projects which target areas and groups with the worst health. Projects may be small or large and there is no set blueprint. There will be scope to be bold and imaginative in utilising what will be substantial sums of money from the New Opportunities Fund to improve our health. Any initiative which has the prospect of improving health in the community will be within bounds.

### *The Scottish Prison Service*

119. The Scottish Prison Service (SPS) is responsible for the primary healthcare of prisoners. Prisoners are more likely to be disadvantaged across the range of factors which determine health. The Government recognise fully the pivotal role which prisons can play in improving the health of the prison population both within the prison setting and beyond. The time in prison offers the opportunity to look not only at direct offending behaviour but also at the associated factors which may have contributed to crime, including drugs, and the ability to function independently in society on return to the community.

120. The Government will, therefore, expect the SPS to help offenders address their offending behaviour, to provide appropriate education, training and counselling opportunities and to continue to work with APEX and other organisations to seek to increase the employment prospects for prisoners on release. In addition, the SPS will continue to ensure that healthcare provided in prisons is in line with Government policies on health and best practice in the community. Within this context, it will work within the WHO healthy prisons initiative. In pursuit of this, Inverness Prison, in collaboration with Highland Health Board, is developing a "healthy prison" project concentrating on the issues of alcohol, diet and co-ordination of care on release. A study has also been put in hand under the Scottish Needs Assessment Programme to review the opportunities for health promotion in prisons in key areas such as coronary heart disease, diet, smoking and exercise.

## **Lifestyle Topics**

### *Smoking*


121. To combat smoking and make inroads into the associated toll of ill-health and premature death, the Government will publish a separate White Paper on tobacco, setting out its overall control strategy, with proposals for action at all levels - international to the individual. That White Paper



will consider the steps to be taken forward towards a ban on tobacco advertising alongside a range of comprehensive and integrated supporting measures.

### **COUNTRYWIDE: ASH (Scotland) Community Initiatives**

ASH Scotland, through their Women, Low Income and Smoking Project, have set up a database of community based projects and are funding two waves of community initiatives. The first wave has just been completed with evaluation now under way. The second wave of funded projects came on stream in June 1997. A variety of approaches are being used ranging from health and fitness sessions to magazine production. And peer education projects are a potential way forward, training local women how to run initiatives themselves and how to train other women.


 The Government's smoking strategy will shortly be set out in a White Paper. Views are invited meantime on how best to develop strategies for those most at risk from tobacco: young people and those living on low income.

#### *Alcohol Misuse*

122. A strategic review of alcohol issues will start with an evaluation of the structure for tackling alcohol misuse in Scotland. A recent national alcohol symposium has identified areas where action might best be targeted. These include greater involvement of young people themselves in prevention and promotion; learning and teaching about good practice; changing perceptions about excessive drinking; and improved co-operation and co-ordination. Because alcohol is so widely and pleasurable used, the general public is largely ignorant of the cost of alcohol misuse to society. A change in attitudes to underage and heavy drinking is essential.

### **COUNTRYWIDE: Teenwise Alcohol Project (TAP)**

The Government have been funding initiatives aimed directly at tackling underage drinking and reducing crime - notably the Teenwise Alcohol Project, which is police-led. Measures, which are being piloted in half a dozen locations, include the targeting of illegal sales of alcohol and increasing awareness of the underage drinking problem within communities. The Project is now being evaluated and the results will be disseminated.

 The Government, in developing an alcohol policy for Scotland, would welcome views on key areas for action. Specific proposals are invited on how best to bring about a change in the culture and to reduce excessive drinking, learning from successful approaches with drink driving.

#### *Drug Misuse*

123. Realism about the scale of the challenge ahead and the timescale for results is essential, but the Government believe that we can hit hard on serious harm to health from illicit drugs and the drugs trade, with the right mix of policies and support. In shaping the future attack on drug misuse we will build on those parts of the existing strategy that work best. Much of this work has been supported by all the main political parties in Scotland for many years. A good example is the Drugs



Task Force report of 1994 - *Drugs In Scotland: Meeting the Challenge*,<sup>23</sup> a robust framework for the current action against drug misuse, which has commanded a great deal of support in the field. Drugs Action Teams, an innovation from the Task Force report, have had an important leading role.

124. Another significant element in the fight against drug misuse in Scotland in recent times has been the Scotland Against Drugs Campaign. Our Manifesto for Scotland said that we would step up and refocus the Campaign initiatives at the community level. On taking office we moved quickly to affirm the continuation of the previous Government's financial support for the Campaign, while indicating that we would look carefully at what should happen after March 1998, in the context of the best way forward for wider consideration of drugs prevention initiatives in Scotland.

125. Some important foundations for future work have been laid. The management of drug misuse has been strengthened through new national objectives, issuing guidance on drug misuse services and introducing a new information strategy. Improving research will be our next target. Understanding is needed of the jigsaw of separate components of the problem and what the effects of environment, personal factors and drug availability are.


126. Drug misuse cannot be dealt with in isolation. Not all drug misuse problems are caused by social disadvantage: it occurs across all levels of society. But its hardest impact is in deprived areas, in terms of health and community safety.


#### **LANARKSHIRE: Community Athletics 2000 project**

The Community Athletics 2000 project in North Lanarkshire is a real partnership between the local communities and the public and private sectors. This project, funded under the Scottish Drugs Challenge Fund, has enabled members of local communities to become involved in sporting activities and encouraged parents to take ownership of a practical solution to the social problems they and their children face on a daily basis.

127. There are complex issues in targeting misuse in areas that are trying to dispel a poor image and make new economic starts. But the infrastructure available through the Partnerships that have now been established in many of Scotland's most deprived areas offers considerable scope for action on drug misuse.

128. Government, agencies and individual drug workers can do a great deal, but young people, parents, the media, business and individuals representing their communities also need to be engaged. Dynamic alliances to complement existing activities by statutory and voluntary agencies are particularly important for drug misuse, because of its volatile nature, links to crime and widespread lack of knowledge among adults in general and parents in particular.

 Views are invited on how to broaden the scope for action in tackling drug misuse, so that both health and community safety issues can be addressed, particularly in areas of high use. How can the interest and support of the wider community, including business and the media, best be captured and made use of? How can community organisations best work with the agencies who specialise in drug misuse? What should be the outcomes sought, and how can they be measured?

 Views are also sought on how far preventive work, aimed at young people, should target tobacco, alcohol and illegal drugs together, separately, or largely through broader lifestyle approaches and the wider health determinants.




### *Eating for Health*

129. The Government will press home strongly the *Scottish Diet Action Plan*,<sup>16</sup> and work with other interests to secure dietary improvement, including an increase in the rate of breastfeeding and the prevention and management of overweight and obesity. The pace of action and change will necessarily vary from sector to sector given the diverse range of interests involved and the extent to which they already have in play their own initiatives to encourage healthier eating. But the Government will monitor progress closely through mechanisms that include the *Scottish Health Survey*,<sup>3</sup> and see that the Plan's implementation is facilitated and maintained.

130. Labelling is important in helping consumers choose healthier food products. Discussions in the EU Commission are well advanced in introducing more rigorous requirements for food products labelling. Regulations for Quantitative Ingredients Description (QUID) will make it compulsory for the label to state clearly the percentage of ingredients in certain foods.

131. Food safety is of the essence. The Food Standards Agency, which we propose to set up, with wide-ranging powers and remit, will do much to restore public confidence in the food we eat. The Government's proposals are set out in the White Paper, *Food Standards Agency: A Force for Change*.<sup>24</sup>

 Views are invited on further measures which can be taken to secure dietary improvement in Scotland.

### *Physical Activity*

132. Sport can be a healthy, enjoyable and beneficial pursuit for people of all ages, and can foster social development and a sense of personal achievement. Within its overall policy of "sport for all", the Government are committed to raising participation levels, particularly among our young people, through the provision of sporting opportunities and accessible, good quality and cost-effective sports facilities.

133. The Scottish Sports Council (SSC) is the Government's advisory body for sport in Scotland. The Council works in partnership with a range of other bodies involved in sport and sports development, including local authorities who are the main providers of sports opportunities and facilities in Scotland. The SSC's current priorities are youth sport and the development of sporting excellence. Good habits in sport and physical activity developed at an early age can last a lifetime, and the Council has developed a national youth sport strategy for Scotland comprising 5 key elements - physical activity, school sport, club sport, coaching and equality of access. The programme's mission is "to bring sport into the lives of all our young people": firstly, through the provision of opportunities to encourage and facilitate participation; and secondly, through the development of pathways to encourage more young people to remain involved in sport throughout their lives. The SSC is currently developing action plans to implement the component parts of the strategy.

134. The SSC is also the Distributing Body for the Lottery Sports Fund in Scotland. To the end of October, the Council has awarded over £46m to 376 capital projects, thereby enhancing the infrastructure of sports facilities throughout the country.

135. Work is under way to help develop sporting talent. National success in sport not only adds to national pride, but provides a great incentive and encouragement to others, and particularly to our young people, to take up sport. But it is not just about elite performers: it is important to allow all Scots to develop their sporting talents and skills, whatever their level of ability.



136. The Government are particularly keen to improve the provision of sport in schools, within the curriculum and as part of extended curricular activities. It has asked the Scottish Sports Council to produce a package of measures designed to help sport in schools, drawing on the resources of the National Lottery. The package will include plans to extend the current school sport co-ordinator pilot schemes into a national structure with a co-ordinator in every secondary school in Scotland. The co-ordinator will be a teacher working in the school, who will be freed from normal duties one day a week, to organise sports activities within the school. The co-ordinator will also take steps to develop links both with local primary schools and with sports clubs within the community more generally.

137. Physical activity is in everyday living, not just through sport. Encouraging provision of accessible sports and exercise facilities, cycling and walking to school and work, and other measures to promote safer communities and wider amenities including open spaces and the countryside will support active living. Healthy living centres should make a strong impact on local provision.

Views are invited on ways in which physical activity can be further stimulated in Scotland.

### Health Topics

138. Other issues are important in improving and safeguarding health.

#### *Dental and Oral Health*

139. Action is needed to address our poor dental health record, which is particularly bad in children in deprived communities. Individual action such as regular brushing and flossing, attending for regular dental checks and reducing consumption of sugar can help prevent decay and gum disease. Health Service actions such as encouraging early registration with a dental practice, ideally before the first teeth erupt and dental hygiene advice can also help. But these measures are least likely to reach those who need them most, that is the children of the deprived communities who currently suffer such an unacceptable record of dental decay.

140. The evidence shows that fluoridation to the optimum level of one part in a million can substantially reduce the amount of decay in children from similar backgrounds and areas. Decay in one part of England where water was fluoridated more than halved between 1986 and 1995, while a comparable area without fluoridation saw little change.

141. At present, in terms of the Water (Fluoridation) Act 1985, as amended, the final decision on fluoridation rests with the water authority, taking into account recommendations from the local Health Board or Boards, which are made following local advertisement of the proposals and consultation with the relevant local authorities and the Scottish Water and Sewerage Customers Council.

142. The Government acknowledge the differing views on the issue of water fluoridation and are concerned to explore ways of bridging the gap between those who are opposed to any fluoridation of the water supply and those who believe that only in this way can the children most at risk be protected against the damaging effects of tooth decay.

The Government would therefore welcome ideas - including any views on possible changes to the legislation - on how best to test public opinion in particular localities, but take the view that fluoridation offers an important simple method of protecting the population from tooth decay and would be particularly beneficial among children in Scotland where dental health is still very poor.

### *Teenage Pregnancies*

143. A good deal of work has been done aimed at reducing the numbers of teenage pregnancies. This includes a report by the Scottish Needs Assessment Programme (SNAP) in 1995<sup>25</sup> which was issued to the NHS and offers guidance about family planning services and advice which can be made available to younger people. It highlights the importance of addressing the wider issues of teenage sexuality and inter-personal relationships to secure a fall in the rate of pregnancies. The need for co-operation between the agencies providing advice and services is also stressed.

144. The Scottish Office provides financial support for voluntary bodies in the family planning field, either towards specific projects or as core funding to meet central administration costs. The bodies given support include the Family Planning Association, the Brook Clinic and the Natural Family Planning Group. Sex education is provided in Scottish schools as part of a comprehensive programme of health and social education which considers a number of issues relating to moral choices and healthy living.

145. The key areas identified as impacting on teenage pregnancy are social and economic factors, particularly deprivation, education (and not just on sexual health), access to contraceptive services, information about services and confidentiality.

146. Current policies touch on most or all of these issues. But given that there is little central monitoring or co-ordinating of policies in this area, it is difficult to measure success or failure. The one crude measure available is to look at Health Board targets for reducing teenage pregnancies against the latest statistics of pregnancy rates. Most Health Boards have set targets to reduce teenage pregnancies by significant percentages - usually around 25% - by the year 2000. However, as can be seen from Figure 14, progress in reducing pregnancy rates has been limited. There is clearly a need to review the policy.



Views are invited on how best the question of teenage pregnancy should be tackled. Would a national strategy be desirable, on which local strategies could be based? If so, does the SNAP strategy form a good basis on which we can build? What elements should a national strategy contain? Would a national strategy best be developed by a national group of relevant interests?

### *Mental Health*

147. Mental health care must be based on an individualised assessment of needs. This is the philosophy underpinning the *Framework for Mental Health Services in Scotland*<sup>26</sup> launched in September 1997 to which Health Boards, NHS Trusts and partner agencies are working. The Scottish Needs Assessment Programme has also recently produced a portfolio of reports in the mental health field. It covers particular clinical areas - dementia, schizophrenia and suicidal behaviour - but also topics which locate mental health in a wider context. These include public health and mental health gain, mental health in the workplace, and domestic violence. The detailed agenda which they provide gives a clear focus for collaborative action.

148. Action can be taken to help protect people who are vulnerable to mental health problems due to poor social environments or severe adverse life-events. This can include, for example, high quality pre-school education and support visits for new parents, and school-based interventions and parental training programmes in relation to children showing behavioural problems. Mental health problems in children of separating parents can be reduced by providing focused psychological therapy. The stress often experienced by long-term carers can be lessened by respite care and some forms of psycho-social support. **Particular attention thus needs to be paid to improving the scope for good**



mental health. The NHS will continue to develop and implement local strategies for mental health in collaboration with social work, housing and other planning partners, targeting those most at risk.

### *Domestic Violence*

149. Domestic violence exacts a heavy toll on the physical, psychological and emotional health of women and children. The Government has acted to make clear that domestic violence is unacceptable, for instance by an award-winning advertising campaign in 1995-96. In 1995, Greater Glasgow Health Board, supported by funding from the Health Education Board for Scotland, embarked on a demonstration project, focusing on the role of primary health care and inter-agency working in Castlemilk in tackling the problem of domestic violence. The resultant model strategy was published in September 1997. This, together with the SNAP Report on *Domestic Violence*,<sup>27</sup> and the forthcoming research report commissioned by The Scottish Office on services to victims of domestic violence, will help inform the development of the strategic, intersectoral approach which is required to tackle this harrowing problem.

### *Accidents and Safety*

150. Good progress has been made in reducing the incidence and severity of road accidents in particular, and the Health and Safety Executive continues to work with employers, trades unions and others towards improving safety and health at work. Following the issue of a consultation document in 1996, the Government have recently announced their intention to set new road safety targets for the period up to 2010. There is ample scope for further improvement, especially in regard to safety in the home, where the young and the old are particularly vulnerable.



To help develop its approach to accident prevention, the Government would welcome views on measures which could most usefully be taken.

### *Communicable Diseases*

151. Good progress has been made, particularly through childhood immunisation programmes, in minimising the threat of diseases such as poliomyelitis and whooping cough, which afflicted earlier generations.

**The Government will ensure that such programmes are maintained and, where possible, enhanced in the light of scientific and medical advances.**

152. Major public health challenges still remain, however. More international travel has heightened the risk of serious infections being contracted abroad and brought back to Scotland, including tuberculosis which is resurgent in many parts of the world. The recent serious outbreaks of infection from the bacterium *E coli* 0157 have emphasised the fact that we cannot afford to relax our defences against infectious disease. The Scottish Centre for Infection and Environmental Health will continue to play a key role in this area, including monitoring to provide early warning of the emergence or re-emergence of infectious diseases.

The Government propose to review existing public health legislation in Scotland to assess whether additional legislative measures are needed to protect the public health. Current practice is rooted in the Public Health (Scotland) Act 1897. This has served us well for a century but the time is opportune to review its provisions. A consultation document will be issued in due course seeking views on possible changes.




153. The overall total of reported HIV infections each year between 1990 and 1996 has averaged 156 (the peak was 314 in 1986) and there can be little doubt that the major health promotion initiatives over the last decade, including the introduction of needle and syringe exchanges for drug misusers, have contributed greatly to controlling the spread of HIV in the population. However, while in recent years infections reported among intravenous drugs users have declined, numbers among gay men and heterosexuals have been slowly increasing. Health promotion efforts need to be maintained and reinvigorated, especially as a new cohort of young people become sexually active each year.

The Government will continue to make resources available to fund prevention activity, recognising the wider dimensions of sexual health and linking appropriately with work on drug misuse.


## LOCAL AUTHORITIES

154. Local authorities wield a significant influence on health right across the range of their functions. Maximising their potential to improve health must be fundamental to any strategy. Environmental health, housing, economic and community development, social work, education, police, transport, planning, sports, leisure and recreational facilities can all contribute substantially to a prosperous, safer community, in which good physical and mental health can flourish. They also have the lead role in area regeneration. As in the case of national policy development, it is important that strategies and policies at local level should take health considerations into account.

 The Government seek views on the suggestion, that Health Boards' Directors of Public Health (DsPH) should assist in preparing health impact assessments in relation to key relevant local policy proposals and initiatives.

155. The Government hope that local authorities will increasingly seek to skew resources and the siting of amenities towards areas of greatest need where the levels of health are worst. As service providers they have a key role in ensuring that health is promoted among those they serve; and, as employers, they have a duty to promote health within their own workforces.

156. The DPH is well placed to give a perspective on how the policies and actions of Health Boards and local authorities can be brought together to ensure best health advantage.

 The Government believe that the DPH should be fully integrated into the policy development and decision-making processes at local level. This could include co-option or appointment to relevant council committees, for example, social work or education, as appropriate. The Government would welcome views on this suggestion.

157. The close working relationship between the Government and COSLA will foster the contribution local authorities can make to health improvement.



To help develop the local government input, the Government propose, subject to further discussions with the Convention, to fund for a specified period a public health post in COSLA. The postholder's task would be to draw up, in close consultation with local government, good practice guidance and other advice bearing on health improvement for the benefit of local authorities. Views are invited on how local authorities can best contribute to health improvement.

## THE NATIONAL HEALTH SERVICE IN SCOTLAND

158. The prime aim of the NHS in Scotland is to improve the health of the people of Scotland. This has been a consistent theme of the annual Priorities and Planning Guidance issued to the Service, and it applies to every part of the NHS and to every aspect of its work.

159. Health Boards have responsibility for protecting and improving the health of their resident populations. In this role, they work in partnership with other parts of the NHS, with local authorities and with other local organisations. With their wide expertise and knowledge of local health needs, Boards are ideally placed to help other organisations to target services, funds and personnel where there is greatest need. Boards have an important role as leaders of local health alliances to improve health and in ensuring that health is high on the agenda of other partnerships in which they are involved.

160. The ending of the NHS internal market means that all parts of the NHS are now working together to identify and address health needs. The key mechanism for achieving this is the annual Health Improvement Programme (HIP) for each Health Board area, the first of which are currently in preparation. Boards lead this process but they are working closely with NHS Trusts and GPs in drawing up HIPs and will involve local authorities and other organisations. The 5-year rolling nature of HIPs will balance the need to focus on specific action to be taken in each year and recognition that improvement in health will take time. HIPs will cover all aspects of NHS activity, in which key components are service developments and health promotion designed to achieve health gain and tackle inequalities. They will thus be the vehicles for making a major and sustained impact on the health problems of every part of Scotland.

161. The new Primary Care Trusts, announced in *Designed to Care*,<sup>1</sup> responsible for primary health care and community services, will have a key role in improving health. GP practice plans should also show how they will contribute to the implementation of the HIPs. There will be monitoring each year of the implementation of Programmes and Health Boards will be required to demonstrate that they have implemented their Programmes and met any targets set.

162. Health Boards will be expected to target health improving action and resources to help people living in deprived areas and others with special needs. Health promotion specialists based in Boards, Trusts or in locality teams, have the expertise to develop initiatives aimed at tackling health inequalities and to train those working with disadvantaged communities. Community involvement and development, advocacy and working in partnerships are essential ways in which health promotion specialists seek to enable people to help themselves and their communities towards better health. Specialist involvement at the strategic level in Boards and in the development of health promotion strategies, involving Health Boards and their partners in local authorities, voluntary organisations, the business community and elsewhere, demonstrates that health promotion is integral to all areas of Boards' agendas. Health promotion departments work to evolve and develop effective programmes to improve the health of all the population in their areas.

163. The primary care role in improving health is clearly vital. Perhaps more than any other area of health care, health promotion is dependent for its success on giving individuals real control of

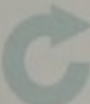


their own choices, rather than imposing choices on them. The one to one, face to face consultations which are typical of primary care interventions offer an ideal opportunity not only to put the message across, but to discuss it with individuals and help them to decide how to respond. Although, therefore, it is valuable to identify health promotion separately to raise its profile, long-term success also depends on its integration into the day-to-day working of members of the primary health care team.

164. The type of health promotion activity which is appropriate depends on the context. Most people's initial contact point with the NHS is a primary care professional - whether that be a dentist, a pharmacist, a GP, a school or practice nurse or a community nurse or health visitor. Evidence suggests, for example, that GPs see 67% of their registered patients in any one year, with the figures rising to 90% over 2 years and 95% over 5 years. A GP can tackle healthy living issues in the context of a routine consultation. As well as general advice on good health, GPs can focus on the prevention of certain specific diseases and problems: it is important to see that preventive role as a vital contributor to public health. Health visitors have the potential to support vulnerable individuals and deprived communities.

165. Dentists also have an important role in improving health, given that oral ill health is a major public health problem in Scotland. They provide advice and educational materials, especially to children, to help them maintain good dental hygiene and to encourage them towards a healthy, low-sugar diet.

166. Pharmacists provide a range of services to the public and have a direct impact on public health. Community pharmacists see most adults and many children regularly - a recent survey<sup>28</sup> concluded that 94% of the population visited a pharmacy at least once a year. The wide distribution of pharmacies means that professional information and advice are available in diverse communities on UK and local health initiatives, the avoidance of further illness, safer sexual practices, drug and medicine safety, smoking cessation, healthy eating, exercise, sun safety, the management of chronic conditions and alcohol consumption. Community pharmacists also contribute to local groups tackling the misuse of drugs.

 The roles of these professionals in relation to health promotion can be, and should be, developed. We would welcome views, in particular, on how health visitors can fulfil their potential in improving Scotland's health.

167. Beyond the national screening programmes there are opportunities for the primary care professions to undertake opportunistic screening, for example, for high blood pressure and for depression. It is also possible to identify those at particular risk by, for example, action to establish genetic risk factors.

168. In all these areas the Government seek to build on recent trends, taking support and services into the community through primary care rather than expecting people to come into an institutional setting. On a pilot basis this principle has been extended to take health promotion and risk awareness into people's homes. Evidence suggests that volunteers taking part in such intensive programmes benefit without (in most cases) receiving any additional medication. Much excellent work is also done in schools and the Government are keen to develop a stronger focus on making it easy for individuals to access services. Libraries, shopping centres and schools are among possible locations which could be used more and to greater effect.

169. More broadly, while each health professional has his or her own particular skills the most effective work is often done by bringing professionals together in new ways. The Government



believe that to deliver integrated health services - including health promotion - there should be increasing stress on the breaking down of boundaries between health professionals to provide a seamless service. *Designed to Care*<sup>1</sup> deals in more detail with ways of promoting greater structural integration across the whole range of primary care.

170. Nowhere is all this more important than in areas of deprivation. Reducing health inequalities by effective frontline delivery of the full range of health services - including health promotion - in areas of deprivation is a key priority for the next few years. The Government have already taken steps to broaden the range of potential contracts for GPs, in particular under the Primary Care Act Pilots, offering new salaried options which can be used to bridge current gaps in practice provision. Building on this, the Government are considering a mapping exercise to identify systematically areas disadvantaged in terms of service provision so that new initiatives can be focused there.

171. In addition to strengthening the role of health professionals in advising patients, there is also a clear need for the Health Service to adopt a wide range of policies which establish it as a health promoting institution, promoting positive health and well-being within hospitals and health centres and thereby setting an example to the organisations in the community at large. The network of Health Promoting Hospitals is expanding and HEBS are working with Health Service colleagues on a framework for the Health Promoting Health Service. This will develop a common framework for health promotion which can be used by commissioners, providers and practitioners across all Health Service settings to ensure that health promotion is an integral and sustainable part of health care, service delivery and organisational development. The new Project 2000 training of nurses, which focuses much more on their health promoting role, contributes to the greater effort towards prevention and health promotion which the Government expect from all sectors of the Health Service.



Views are invited on how best the contribution of the Health Service to health improvement can be maximised. The Service itself is invited, in particular, to

- respond to this Green Paper with ideas and proposals which reflect their knowledge and experience
- lead by example, taking every opportunity to promote health to patients, staff and the community they serve
- assist local agencies in auditing their policies for their impact on health
- support local community initiatives
- bring together the local agencies, whether in a lead or support role, for health gain.

#### *Directors of Public Health*

172. Directors of Public Health and their colleagues in public health medicine, as an integral part of each Health Board, have a key role in supporting their Boards and the NHS generally in fulfilling their corporate responsibilities for improving health. The DPH also serves as Designated Medical Officer (DMO) of the local authorities within the Board area and thus is a valuable bridge between Health Boards and councils across the broad spectrum of their activities which impinge upon health.

173. At local level, the DsPH and their teams can play a major role in the development and delivery of the comprehensive programme of action, which will be required to tackle multiple deprivation and associated health problems, especially in the Urban Partnership areas. As already stated, in order to maximise the health gain potential of local policies, it is envisaged that DsPH, in their capacity as DMO, can assist health impact assessments by local agencies on policies most likely to impinge



on health. In their Health Board role, the DsPH, with strategic specialist health promotion advice, can help Boards fulfil their responsibility for planning and coordinating activity which increases health gain. The many facets of this role include assessing health needs, assigning priorities and helping to ensure that the NHS provides a health promoting environment for both its users and its employees.

174. The Scottish DPH Group, which brings together DsPH from every part of Scotland, is well placed to share the outcome of initiatives and experience in their areas of tackling public health issues, especially in relation to health inequalities. The Government propose that the Group should be invited to produce a periodic report of effective good practice for the benefit of councils and Health Boards.

175. The Chief Medical Officer has periodic meetings with DsPH, allowing opportunity for a two-way exchange of information. It is proposed that this arrangement should be strengthened to enhance knowledge about emerging public health problems and issues and to assist in the development of measures to improve the public health. The Government also believe it would be useful to strengthen the practice of regular reports by DsPH about the health of their populations.

Views are invited on the foregoing and on how the DPH's role might be further enhanced.

### HEALTH EDUCATION BOARD FOR SCOTLAND

176. The Health Education Board for Scotland (HEBS) is the lead organisation for health education in Scotland. The Government believe that the Board's *Strategic Plan for 1997 to 2002*<sup>29</sup> has a key part to play in the wider strategy for a healthier Scotland. The Plan is available from the Board and on HEBSWeb.\*

177. Through its general public programme, HEBS will have a key responsibility for high-profile health education initiatives in priority health and lifestyle topics. The strategic campaign on Scotland's 'Big 3', which draws together CHD, cancer and stroke and related lifestyle factors, is important. So too is the developing campaign to encourage healthy decision-making among young people, with its interlinking action on smoking, drug misuse, alcohol misuse and sexual health.

178. Complementary to this high-profile work will be HEBS's lead role in encouraging and enabling health promotion commitment, capabilities, strategies and action in the NHS, schools, the workplace and communities as a whole, and in the voluntary sector. The Government intend to enable HEBS to extend its involvement in this regard through a new programme centred on further and higher education institutions.

179. There is a need also to continue to develop health promoting schools in Scotland. Local councils are well placed to implement this concept. The nature of the educational experience young people have in schools is closely related to the extent to which schools can nurture and support the pupils' emotional, social and physical health needs. There is evidence from research in Scotland that when young people have conflict at home but feel good about their school, they are less likely than other vulnerable young people to be involved in health-damaging activities.

180. The Government, therefore, believe strongly that the health promoting school movement, which had its origins in the health sector, should become fully integrated into current initiatives in the education sector. It is proposed, therefore, that HEBS, in conjunction with COSLA and the Scottish Consultative Council on the Curriculum, consider establishing a specialist unit, to further develop health education and health promotion in schools. Such a development would

\* <http://www.hebs.scot.nhs.uk>

provide both the curricular aspects of health education and have an impact on the wider life of schools and the school/community interface.

Views are invited on this proposal.

181. HEBS also will further develop its role in education and training to increase the expertise of the many professionals and agencies which have parts to play in health promotion. It will continue to harness information technology for health promotion.

182. More widely, the rapid advances in information technology, such as *NHSnet* (the NHS telecommunications network), and *HEBSWeb* will increasingly enable health and health education and promotion information and resources to be accessed on line by the public in a range of settings, for example at home, at work, in schools, in hospitals and GP surgeries and clinics.

Views are invited on ways to optimise the benefits to health of the increasing availability of information technology within the community.

### SMOKELINE

HEBS has undertaken a wide range of carefully targeted initiatives within an overall long-term strategy. For example, the education of young people and adults about the serious health implications of smoking has been, and remains, a key priority. One of the Board's most successful contributions has been a free telephone helpline, *Smokeline* which has received some 400,000 genuine calls since its inception in 1992. An increasing number of calls have come from under 16s who take up the habit during adolescence and are influenced to do so by many factors including peer pressure, parental smoking behaviour and advertising. Encouragingly, a comprehensive evaluation has demonstrated that the *Smokeline* campaign has been highly effective in helping adults to quit.

183. HEBS will also develop the evidence base for health promotion, devise properly targeted initiatives across Scotland, and evaluate and promote good practice. Due emphasis will be placed on research concerned with reducing health inequalities, which may flow from the Acheson Inquiry, identifying factors which generate good health, developing intermediate community indicators and assessing the impact of interventions on inequalities. While serving the population as a whole, HEBS will be expected to give high priority to tackling inequalities through ascertaining and addressing the circumstances of groups and communities with the greatest needs.

184. The Government fully support the Board's emphasis on stepping up its strategic leadership role and collaborative working. Health Boards will remain vitally important partners, and a new working relationship with COSLA is being developed, to complement and facilitate alliances between Health Boards and local authorities.

Views are invited on the role of HEBS particularly in relation to the tackling of health inequalities; on new initiatives which it should undertake; on how its partnerships with other key agencies might be strengthened; and on how its work in various arenas might be developed further.

### OTHER PLAYERS

185. Clearly, then, the contribution of all in the public sector is crucial to health improvement. But the private and voluntary sectors have also a vital part to play. Some of the players are identified below, but the Government are conscious that the list is not exhaustive. Good health is everyone's business.



### *Industry and Commerce*


186. Industrial and commercial policies, practices and products can have major effects on health, beneficial or harmful, and these can go unrecognised. Businesses are encouraged to consider the possible health consequences of their decisions and actions and to make choices which are as health promoting as possible.

187. There are also clear links between employment and health. Having a secure, rewarding job, in addition to providing the wherewithal to live, can do much to provide the social support and motivation so vital to good mental health. Conversely, poorly paid, unsafe jobs can undermine the potential for good health.

188. Employers and trades unions have a particular interest in developing the health of workforces both to increase the well-being of employees and to reduce sick absences so that output is maintained or increased. The dissemination of health promoting messages for employees and the provision of facilities to enhance fitness are key measures in this respect. For example, employers can help address alcohol misuse by having enlightened policies for the workplace, focusing on education, early detection of problems, and opportunities for help in changing drinking habits. Businesses can also contribute to community development and regeneration through the creation of jobs, and, by attention to pollution-reducing measures, help create a better local environment.

189. As a prerequisite to maintaining and improving health at work, employers, employees, trades unions, staff associations and employer organisations should demonstrate a fundamental commitment to implementing good health and safety at work policies and procedures.

190. The *Scotland's Health at Work* award scheme was launched in 1996. By meeting set criteria, companies and organisations can achieve three levels of award and, in so doing, gain prestige for themselves and, importantly, encourage health enhancing practices in their workplaces. The Government wish to encourage all workplaces to work towards achieving the award standards.

 Views are invited on how health can best be promoted through industry and commerce and in the workplace.

### *The Voluntary Sector*

191. The voluntary sector has its own distinctive part to play in improving health, often providing services in a way the public sector cannot. The value of voluntary agencies working in partnership with statutory bodies has been recognised in Scotland for many years.

192. The strengths of voluntary agencies are most visible in the work undertaken to support client groups concerned about, or affected by, particular health-related issues. They are also well placed to speak on behalf of client groups about the needs that specific population groups have, to identify policy and service requirements, and encourage community participation in decision-making processes. **It is the Government's intention to stimulate a thriving and innovative voluntary sector.**

193. Healthy Living Centres (see paragraph 118) will also provide major opportunities for voluntary organisations to apply for support funding for innovative projects.

194. Voluntary organisations are often built around single topics or client groups. This is right and understandable. There is also a need, however, to ensure that adequate co-ordination and integration of effort are achieved against the background of priorities set out in this Green Paper.



Views are invited on how the voluntary sector can further develop its contribution to health improvement in Scotland.

195. The key actions by the key interests for improving Scotland's health are summarised in Table 3.

Table 3: Key Actions By Key Interests

<i>National Level</i>	<i>Local Level</i>	<i>The Public</i>
<u>Government and other national interests</u>	<u>Local interests and communities</u>	
Provide leadership and strategic framework which can deliver integrated and holistic approach to improving health.	Fulfil their potential to contribute to improving health.	Take note of the information provided on improving health.
Ensure that policies focusing on health are founded on sound evidence-based information.	Provide leadership and direction in the implementation of local health improvement strategies to tackle the root causes of ill-health.	Take action to make the recommended changes in lifestyle behaviours which will benefit health.
Tackle the root causes of ill-health, both physical and mental.	Work collaboratively to secure the improved health of local communities, including within the workplace and schools.	Encourage these changes within the family and more widely.
Encourage participation of local, voluntary and private sectors in action to improve health.	Ensure the services provided meet the needs of the communities they serve.	Discourage young people from practices harmful to health.
Ensure that all interests, including the public, with an influence on health have available to them the information necessary for better health.		Communicate and co-operate with all interests in a position to help improve health.
Ensure NHS contribution to improving health is maximised.		Take all available educational training and employment opportunities which have potential to lead to better health.
Ensure rigorous mechanisms in place to monitor progress towards improved health.		

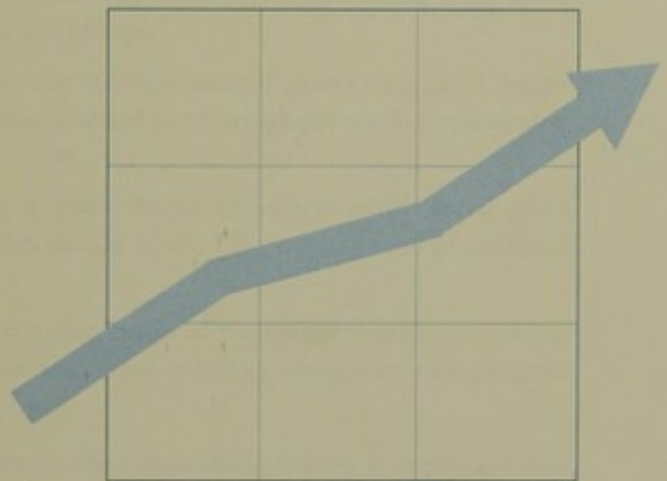
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"Target market" is used to refer to the  
segment and credibility, and to  
be "owned" by all concerned.



*“Targets must be seen to have  
relevance and credibility, and to  
be “owned” by all concerned.”*

## Chapter Six Indicators, Targets, Monitoring and Research



Chapter 10: The Role of the State in Economic Development

The role of the state in economic development is a complex and controversial issue. This chapter explores the various ways in which governments have intervened in the economy, from the provision of infrastructure to the implementation of industrial policies. It also discusses the challenges of state-led development and the role of the private sector.





## Chapter Six Indicators, Targets, Monitoring and Research

### Indicators and Targets

196. Yardsticks are necessary if we are to measure progress towards the health improvements we seek. Emphasis in the past has been on targets in relation to health outcomes and underlying behaviours. The downside of this approach is that it deflects attention from markers of progress towards tackling the circumstances which affect health and lifestyle and fails to recognise the wider environmental influences on individuals, families, groups and communities.

197. The guidance on Intermediate Indicators for Health Alliances, sent to Health Boards last year, identified specific operational indicators for measuring and monitoring the health-related impacts of alliances using a health gain model based on a range of health determinants. This is a useful approach that can be used to measure health gain in a variety of situations. The Government have identified the following key principles for guiding the identification of indicators and targets for the future:

- there should be a core set of indicators and targets which is as small as is consistent with gaining an adequate overview of progress with the strategy;
- the core set should reflect, as appropriate, challenges and objectives relating to reducing inequalities in health, and to particular age groups;
- indicators and targets should relate to the strategic aim of promoting good health through enhancing well-being and fitness, and not just through preventing or lessening ill-health;
- indicators of progress towards putting in place the circumstances which create good health and those which generate ill-health should be set. They ought not to be confined to lifestyle or health outcomes; and
- health outcome targets should relate to major causes of premature death or avoidable ill-health, they should offer significant scope for reducing inequality and progress should be readily measurable.

198. In considering the need for indicators and targets, the Government believe it important that these should be kept to the minimum necessary for the proper assessment of improvement in Scotland's health. Too many indicators and targets diffuse effort and resources. Against that background and based on the foregoing criteria and earlier discussion in this document, the Government suggest that health outcome targets should be drawn from the following priority health topics:

- CHD and stroke
- Cancer
- Teenage pregnancies
- Dental and oral health
- Accidents

199. National targets would be set but, within them, targets bearing on, for example, socio-economic class or geographical location could also be set in order to trace progress in addressing inequalities. Local targets, taking a lead from those chosen at national level, could also be set. Targets must be seen to have relevance and credibility, and to be "owned" by all concerned.

The Government, before finally setting targets, would accordingly welcome views (a) on the priority health topics suggested, (b) on the targets which might be set, and (c) on the period which should be covered.

200. In the light of comments received, the Government propose to establish an expert group which will give advice on the targets to be set.

201. The Government also propose to set targets in relation to the priority lifestyle topics, namely:

- Smoking
- Alcohol misuse
- Eating for health
- Physical activity.

#### *Smoking*

202. Targets to reduce the levels of smoking by the year 2000 already exist. The 1992 publication *Scotland's Health - A Challenge to Us All*<sup>2</sup> aims for a 30% reduction in the number of smokers aged 12-24 years to 21% and a 20% reduction amongst those aged 25-65 years to 32%. The recent *Scottish Health Survey*,<sup>3</sup> which sampled adults in the 16-64 age group, recorded 34% of men and 36% of women as current smokers.

The Government would welcome views on smoking targets. For example, should the present targets be modified? If so, by how much and by when? Is there a need for specific targets for young people and those living on low incomes? Should there be a target directed either at pregnant women or at women of childbearing age?

#### *Alcohol*

203. In 1991, *Health Education in Scotland: A National Policy Statement*,<sup>30</sup> set a national target of achieving a reduction of 20% by the year 2000 in the number of Scots drinking above the recommended sensible levels of 21 units a week for men and 14 for women.

204. This target of 19% for men and 6% for women has not been reached and is unlikely to be by the year 2000. The *Scottish Health Survey*<sup>3</sup> shows that a substantial proportion of the population - 33% of men and 13% of women - is drinking in excess of the target limits, and the proportion doing so has increased sharply among both men and women since 1986. Given the large increase in excessive drinking in recent years and the widespread pattern of excessive drinking across social classes and across different regions within Scotland, the potential for reducing excessive alcohol consumption may be limited. This conclusion is supported by HEBS health survey findings, published in 1996, which show a motivation indicator (those drinkers aged 16-74 who want to or intend to cut down on their drinking) of only 6% for men and 4% for women. The main motivational barrier cited to moderating drinking was finding it difficult to cut down or stop when friends were drinking. The same survey showed that only 22% of heavy drinkers were taking action to change their behaviour: 49% were not even considering taking such action.



The Government would welcome views on whether the current target for alcohol should be maintained and, if not, specific suggestions for alternative population indicators for alcohol misuse.

205. The most recent guidance on alcohol consumption<sup>31</sup> emphasised daily rather than weekly drinking levels. The recommendations are that regular drinking of 4 or more units a day for men, and 3 or more units a day for women is likely to result in increasing health risk.

The Government would welcome views on this latest guidance, against the background of the previous weekly levels.

206. Underage drinking is being viewed as a significant problem in its own right. The inclusion in future of young people's alcohol consumption in the *Scottish Health Survey*<sup>3</sup> will be of considerable benefit in this regard.

Views would be welcome on setting a new target or indicator for underage drinking.

### *Eating for Health*

207. Given that the current dietary targets were set as recently as 1994, are for the year 2005 and are closely related to the *Scottish Diet Action Plan*,<sup>16</sup> which the Government propose to keep as a framework for dietary improvement, there is merit in retaining the current targets.

Views would, however, be welcome.

### *Physical Activity*

208. No formal national targets have as yet been set by the Government for physical activity.

Views would be welcome on whether targets in this area are desirable and, if so, what they might be.

209. Again, the Government would propose to refer the comments received to the expert group to inform their consideration of appropriate targets.

The Government would be grateful if responses could cover the possibility of targets relating to inequalities being set.

210. The expert group will also consider whether indicators and targets relating to life circumstances should be set.

Views are invited on whether these are needed and, if so, what they might be.

211. Mental health, drug misuse and HIV/AIDS are among the suggested priorities. It is notoriously difficult to set meaningful national targets in these areas.

Views are invited, therefore, on whether targets should be set and, if so, what these might be.



212. Scotland already has health targets set in 1991 and 1992 in *Health Education in Scotland*<sup>30</sup> and *Scotland's Health: A Challenge to Us All*.<sup>2</sup> The year end for these is 2000. One possibility would be to keep the targets in play until they end in 2000, alongside any further targets that may emerge in response to this Green Paper.

Views would be welcome.

## Monitoring

213. Progress towards the targets has to be monitored and evaluated rigorously. The *Scottish Health Survey*<sup>3</sup> will chart progress. The main focus of the Survey is on a range of diseases and conditions, including coronary heart disease, stroke, dental health and obesity and lifestyle risk behaviours such as diet, smoking, alcohol consumption and physical activity. It is now being extended to collect data on children's health and, for the first time, comprehensive information on asthma incidence. In addition, the Information and Statistics Division of the NHS collates a wealth of further information, including coverage of cancer mortality. And Health Boards will be continuing to monitor progress towards local targets. Collectively, these data will enable regular and comprehensive reviews of progress to be undertaken which will further inform our policies for improving Scotland's health.

## Research

214. This Green Paper addresses the challenge of improving people's health. A parallel challenge is to learn how to use resources most effectively to make these improvements. A programme of research and evaluation should accompany any public health strategy.

215. While there are a range of indicators which measure health and inequalities, a research programme should begin by building on the work of the Acheson Inquiry and selecting the most accurate measures which identify important health problems and influences. It should identify how to take effective measures to narrow inequality, both in the field of health policy and in ways which make the necessary changes happen.

216. The research programme must look beyond health and disease, just as this Green Paper identifies a range of social and economic changes which are necessary to deliver improved health. And, just as we identify major challenges ahead, we should also select accurate indicators of success.

217. Much useful research is already taking place in Scotland and further afield towards improving public health. Within The Scottish Office, the Clinical Resource and Audit Group concentrates on the contribution of the Health Service to the delivery of high standards of care, while the Chief Scientist Office addresses important public health research questions which range outside the arena of treatment. The Chief Scientist Office is currently revising its Research Strategy for consultation and is considering whether new areas require attention. These organisations will review the contributions of current research work, and consider whether new areas require attention.

218. The priorities in research might include the following:

- efficient and effective ways of assessing the health impact of central and local Government policies;
- how best to make, and measure the success of, alliances which feature health improvement among their aims including the value of the intermediate indicators;
- important factors in rural disadvantage and valid ways of measurement;
- identifying success factors in staying healthy, as well as learning more about why people become ill;
- success factors in building strong communities which, in their turn, improve the health of local people;
- selecting key indicators for health determinants outwith the health sphere but which impact on health and well-being (eg housing); and
- further improving the ways in which we evaluate health education and promotion action.

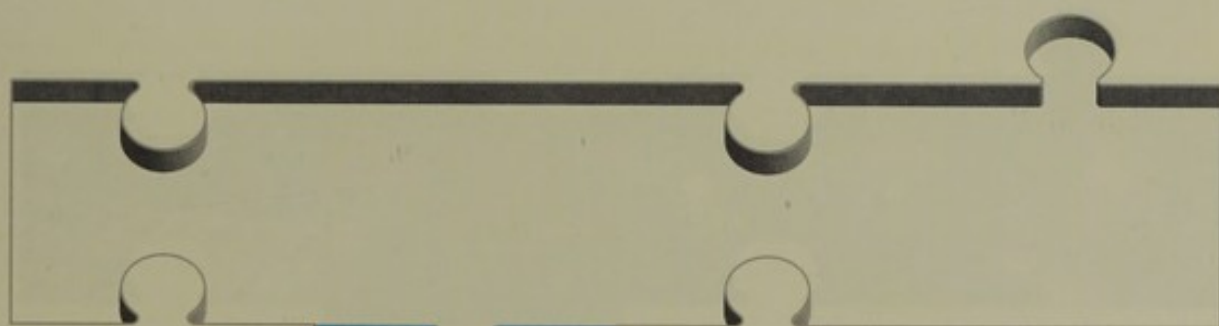


Views are invited on the priorities which might be set for a research programme to improve Scotland's health.





## Chapter Seven Conclusion





## Chapter Seven Conclusion

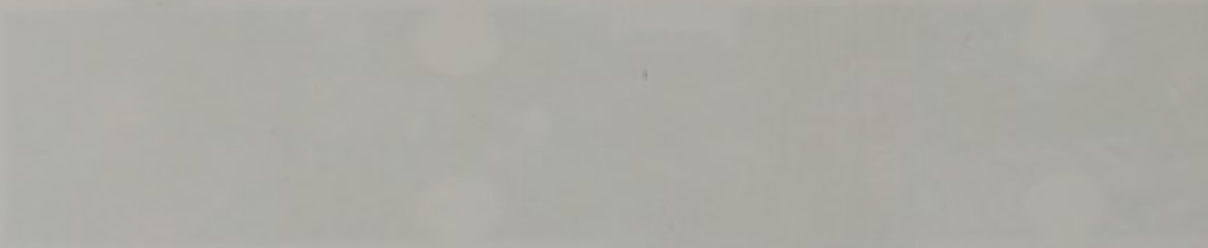
219. We have an unprecedented opportunity to make Scotland healthier. This Green Paper sets out ways in which this can be achieved. But we will only succeed if we work closely together - from central government to each of us as individuals.





Chapter 10: Introduction

The first part of the chapter discusses the importance of the study and the objectives of the research. It also outlines the structure of the book and the chapters that follow.



## References

1. Designed to Care: Renewing the National Health Service in Scotland, Cm 3811, 1997, The Stationery Office, ISBN 0-10-138112-3.
2. Scotland's Health: A Challenge to Us All, HMSO, 1992, ISBN 0-11-494218-8.
3. Scottish Health Survey 1995, TSO 1997, ISBN 0-11-495847-5.
4. Scottish Health Boards Dental Epidemiological Programme 1987-94.
5. Obesity in Scotland - Integrating Prevention with Weight Management - Scottish Intercollegiate Guidelines Network Pilot Edition 1996, Royal College of Physicians, Edinburgh, ISBN 1-899893-35-0.
6. Sexually Transmitted Diseases, 1996 Health in Scotland, Report of the Chief Medical Officer on the state of Scotland's health for the year ended 31 March 1996, TSO, ISBN 0-11-495846-7.
7. Annual Report of the Registrar General for Scotland 1996, TSO, ISBN 1-874454-47-8.
8. Common Services Agency: Information and Statistics Division (Teenage Pregnancies).
9. Inequalities in Health: The Black Report, Penguin 1982, ISBN 0-14-022-4203.
10. (i) Deprivation and Health in Scotland, Carstairs V. and Morris R., Aberdeen University Press 1981
- (ii) Socio Economic Variations in Scotland's Health - A Review, Macintyre S., Health Bulletin S2.6 1994.
11. Tackling Inequalities in Health - An Agenda for Action, ISBN 1-85717-088-1.
12. Common Services Agency: Information and Statistics Division.
13. Scottish House Condition Survey 1996, Scottish Homes.
14. The Report of the Chief Inspector of Fire Services for Scotland 1996/97, The Scottish Office Home Department, TSO, ISBN 0-10-137882-3.
15. The Scottish Diet, HMSO 1993, ISBN 0-7480-0797-0.
16. Eating for Health - A Diet Action Plan for Scotland, HMSO 1996, ISBN 0-7480-3138-3.

17. General Household Survey 1994, HMSO, ISBN 0-11-69116672.
18. Scottish Crime Survey 1996, ISBN 0-748-66038-0.
19. The Report by the Committee on the Medical Effects of Air Pollutants, Quantification of the Effects of Air Pollution on Health in the UK, ISBN 0-11-322102-9.
20. National Air Quality Strategy, ISBN 1-10-135872-5.
21. National Environmental Health Action Plan, ISBN 0-10-133232-7.
22. The People's Lottery, Department for Culture, Media and Sport, ISBN 0-10-13709-2.
23. Drugs in Scotland: Meeting the Challenge, Report of Ministerial Drugs Task Force, HMSO, ISBN 0-11-495277-9.
24. Food Standards Agency: A Force for Change, ISBN 0-10-138302-9.
25. Scottish Needs Assessment Programme, Teenage Pregnancy in Scotland, Scottish Forum for Public Health Medicine, Glasgow.
26. Framework for Mental Health Services in Scotland, TSO, No J13702 9/97
27. Scottish Needs Assessment Programme, Domestic Violence in Scotland, Scottish Forum for Public Health Medicine, Glasgow.
28. Community Pharmacy, The Choice is Yours, The Royal Pharmaceutical Society: BMRB International 1996.
29. Health Education Board for Scotland Strategic Plan 1997-2002.
30. Health Education in Scotland: A National Policy Statement 1991, ISBN 0-748003975.
31. Sensible Drinking - A Report of an Interdepartmental Working Group - December 1995, Department of Health.



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