Section 1 – Exploring the issues

1 What makes people healthy and what makes them ill?

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The factors contributing to health and, conversely ill-health are multiple and complex and the subject of much earnest debate among policy-makers, practitioners and academic researchers. But there is now sufficient evidence and agreement to be able to assert with reasonable confidence that promoting good and sustainable health requires particular actions both on the part of individuals and of various bodies and groups engaged in a range of activities and providing a range of services. Occupying a pivotal role among these agencies are local authorities whose contribution to improving health and tackling health inequalities is considerable. Yet, for various reasons and with some important exceptions, local authorities as a whole have not seen their health-enhancing role as uppermost in their thinking or central to their core business. This mindset is changing but, as we enter challenging and difficult territory as far as future public spending goes, it needs to change more quickly.

This chapter examines the social determinants of health and why they remain important. It also explores the puzzle that, despite governments expressing a real desire to tackle these, their efforts are generally disappointing and not up to the task. Too often they end up as lifestyle interventions that target individuals and their health problems whether it is obesity, the effects of alcohol misuse, or growing stress and mental ill-health. Such problems have been termed 'wicked problems' because of their complexity and intractability and because they demand new approaches in respect of tackling them. This chapter then examines the critical role local authorities have in impacting upon these social determinants which goes far beyond their traditional concern with health and safety and environmental health, important though these functions are and will remain. But there is a great deal more that local government can, and must, do if we are serious about tackling health inequalities and improving the health status of our most disadvantaged communities.

The social determinants of health

There is probably no better or persuasive analysis of the contemporary state of affairs in regard to the social determinants of health and health equity than the final report of the World Health Organisation's Commission on Social Determinants of Health. Chaired by Professor Sir Michael Marmot, the Commission's final report was published in mid-2008 (WHO, 2008). The Commission's remit was to gather the evidence on what can be done to promote health equity, and to foster a global movement to achieve it. The Commission adopted a holistic view of the social determinants of health. Essentially, it argued, poor health is the result of the unequal distribution of power, income, goods, and services. It commented on the widespread 'unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns, or cities' – all of which diminished 'the chances of leading a flourishing life'.

The Commission went on to make it clear that there was nothing immutable about these developments – such health-damaging experiences are not an unavoidable 'natural' phenomenon. Rather, they are 'the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics'. In addressing this heady cocktail of factors and remedying the deficiencies identified, national and local governments have a major leading role.

A major misconception that hampers progress is the belief that anything to do with health and ill-health is surely the business of the health sector and, primarily, the NHS. Certainly, the health sector has a vital role to play in tackling the maldistribution of services and access to them (the so-called 'inverse care law') as this is one of the social determinants of health. But the key drivers that account for people's poor health in large part lie, as the Commission points out, in the 'conditions in which people are born, grow, live, work, and age'. Action on poor and unequal

living conditions must involve a range of organisations, including local government, and policies and programmes must embrace all sectors of society and not just the health sector. We know, for instance, that where people live has a major impact on their health. Commonsense alone tells us that healthy places result in healthy people. We know, too, that fair employment and decent working conditions are major contributors to health and well-being. And the evidence testifying to the importance of early years development and education, through initiatives like Sure Start, while not complete, is good enough in terms of pointing to where investment might be made. In each of these areas, local government has a key role to play. It often does play it – though not always for reasons to do with improving health and well-being.

Despite what seems like an endless stream of well-researched descriptions and analyses of the problem, and eloquent and well-intentioned statements of the need to tackle the social determinants of health, successful political action has been less impressive. On this score, the most recent Department of Health review of progress in England over the 10 years since 1998 makes rather depressing reading (Department of Health, 2009). It insists that much has been achieved over this period but there is no disguising the underlying message that though health overall has improved for everyone, including the poor and disadvantaged groups, the gap between these groups and the rest of the population has remained. Indeed, the report states, 'the gap is no narrower than when the targets were first set'. Other evidence suggests that the gap may be widening and with the future economic prospects looking bleak, there are serious worries that the position could deteriorate further. It is an issue the Marmot review, established by ministers at the end of 2008 to consider post-2010 strategy for tackling health inequalities in England, is well aware of, as it prepares its final report for submission to the Secretary of State for Health by the end of the year.

But whatever the commitment to social justice and tackling the social determinants of health enshrined in successive policy statements, the default position has been the need for individuals to take more responsibility for maintaining their health, enabled by government and others through the provision of advice and information to inform healthier choices. The phenomenon has been termed 'lifestyle drift'. It is not so much that such a focus is wrong as that it is, by itself in isolation, insufficient to address the deep-seated and persistent inequalities which exist. Looking ahead, the report highlights that progress against the social determinants of health will be crucial to a long-term, sustainable reduction in health inequalities. Effective action on health inequalities demands action in a wide range of policy areas but in particular on education, employment, transport and the environment. Unless the policy responses in these and other areas are aligned, they have the potential to widen, unintentionally, the health gap.

A key reason for poor progress may be the absence of a strong evidence base in respect of evaluations of wider public health interventions and in particular those policies which affect the social determinants of health and health inequalities. A recent report from the Public Health Research Consortium reviewing evidence from systematic reviews concludes that there is 'some suggestive evidence that certain categories of intervention may impact positively on inequalities, in particular interventions on the fields of housing and employment, though further evidence is needed' (Bambra et al, 2009). Despite gaps in the evidence base, the review pointed out that the most important determinants of health and health inequalities are the wider, 'upstream' determinants. This raises the possibility that government policies in sectors other than health, including housing, education, transport and employment offer real opportunities to improve health and reduce the health gap. In each of these areas, local government has a critical role although one that often requires working in partnership with others since the issues are too complex for any single organisation to resolve. Such issues are often known as 'wicked problems'.

The dilemma of 'wicked problems'

Wicked problems are those which are difficult to define, which straddle many organisations and professions, and for which there are no clear, simple or even known solutions. The problems are complex, multi-causal and multi-dimensional and require action at all levels by numerous bodies and agencies. An excellent in-depth analysis of such an issue in the context of obesity is provided by the Government Office for Science's Foresight report (Butland et al., 2007). It concludes that by 2050 around two-thirds of the population will be obese and that this will put considerable strain on health and other budgets. There is an urgent need to tackle the problem, but it requires engagement and action on the part of all sections of society. Because the causes of obesity are complex, encompassing biology and behaviour, the report says the responsibility for such a state of affairs cannot be pinned on individuals and their lifestyles. It asserts that we have created an 'obesogenic environment' that requires action from government and communities at various levels. 'A bold whole systems approach is critical' and one that requires integrated policies and actions on the part of a range of stakeholders, including local government. Obesity

is not an isolated case and has much in common with other public health challenges.

But like other such challenges, and as noted in the previous section, it is very easy to slip from a concern with the social determinants of health to a narrow focus on individual lifestyle. Regardless of the intentions of government, either national or local, to move 'upstream' and focus on the structural and social determinants of health, interventions all too often end up as small-scale projects or initiatives aimed at changing individual lifestyle behaviour and, in the process, failing to tackle the underlying health determinants on the scale needed to make a sustained impact at a population level. The ban on smoking in public places is a good example of an upstream intervention designed to tackle the problem on the scale required. Initial assessments of its impact suggest it has done more to improve people's health at a stroke and reduce hospital inpatient admissions than any number of local smoking cessation interventions. This is not to decry the useful work often achieved through such measures, but to recognise that, on their own, their impact on the problem is likely to remain marginal. Obesity is another case in point whereby action that tackles the manufacturing and marketing of certain foods needs to go hand in hand with measures which try to help people eat sensibly and exercise appropriately.

The contribution of local government to good health

Traditionally, local government has played a crucial role in public health through its work on sewers and sanitation, food hygiene and environmental health. Such concerns figured prominently in the 'golden age' of public health in the 19th century when huge gains in health were made as a result of bold action on the part of key individuals like epidemiologist, John Snow, and William Duncan, the first Director of Public Health to be appointed in Liverpool. Local government was at the forefront of many of these gains. But with the advent of the NHS and the transfer of much public health activity from local government to the NHS in 1974, local government has often taken a back seat when it comes to improving health and well-being. Anything to do with health has been the preserve of the NHS. But, as we have seen, the contemporary challenges posed by the so-called 'diseases of comfort' require action of a different kind and achieved through other means. These actions rage from cycle routes and vehicle speed limits to anti-smoking measures, leisure services and so on. The NHS has a limited role to play in these areas while local government has a major one. This is recognised by the LGA's Health Commission when it states:

'local authority staff across a wide range of activities – education, transport, planning, leisure, housing, environmental health and social care – have a key role to play in the partnership approach to public health'. (LGA, 2008).

It goes on to point out that 'addressing the problems of relatively poor health among deprived sections of society clearly has a local dimension'.

The Local Government Act 2000 gave local authorities the power to promote social, economic and environmental well-being, thereby placing a renewed emphasis on the role of public health in local government. In recognition of the important and growing role of local government in improving health and well-being, there has been a move since 2006 to appoint directors of public health who are jointly accountable to both the NHS and to local government and who work across the two agencies. While a welcome move, little is known about how such posts are impacting on health. Such posts are challenging in terms of the demands made upon them and the skills required to discharge them effectively (Hunter (ed), 2008). Not all local authorities have favoured such a single post on the grounds that the job is too big and complex for just one person to undertake. Birmingham City Council and Sheffield City Council, for example, have opted to appoint their own health directors to work alongside the DPH located in the NHS. Whatever the preferred arrangement, those leading public health in local government work closely with the local authority director of adult social services and director of children's services whose responsibilities also have a significant health dimension.

Whereas general support for local government's public health role has remained, until recently, rather weak and tentative, this is no longer the case. The Faculty of Public Health (FPH), UK Public Health Association (UKPHA), NHS Confederation and other important advocates for health acknowledge unequivocally that in tackling the wider determinants of health and reducing health inequalities the role of local government is fundamental. It has available to it far more scope and power than the local NHS to promote healthy environments, job opportunities and stable communities. As the president of the FPH put it: "[Local government] can join-up housing, transport, schools, community safety and environment to improve the community's health and well-being". Links can then be made to the health sector through LSPs and LAAs. In a paper calling for a renewed political commitment to health as a public and not just an individual good, the LGA, UKPHA and NHS Confederation stated that local government has the capacity to tackle public health in the

following ways:

- as an employer
- through the services it commissions and delivers
- through its regulatory powers
- through community leadership
- through its well-being power.

The paper considers that this 'vital role' has been 'both obscured and undermined by the policy fragmentation which has separated policy on healthcare from the wide range of policies determining the conditions in which health can be sustained' (LGA, UKPHA, NHS Confederation, 2004). Since 2004, there has been a more explicit recognition of local government's important role in this area which allows local authorities the opportunity to take a lead.

Some functions within local government are more aware of their health role than others. Obviously, those working in environmental health have always been aware of the contribution they are able to make to improved health. But other departments, such as those concerned with urban planning and place-shaping, are perhaps less aware, although the situation is beginning to change. There is growing awareness that sustainable healthy communities require good urban planning and a commitment to what has been termed 'liveability' for healthy communities.

There are other sound reasons for regarding the wider public health and assault on health inequalities as being key functions for local government. A problem with much public health thinking and practice, especially those aspects rooted in a medical model of illness and disease, is that they focus on deficits rather than assets. Many, though not all, public health practitioners, especially those with medical backgrounds, have tended to place an emphasis on identifying the problems and needs of populations that require professional resources and high levels of dependence on health care and other services. In addition, much of the evidence base in pubic health remains dominated by a biomedical approach to understanding 'what works'. It therefore results in policy developments that in turn focus on the failure of individuals and local communities to avoid disease rather than their potential to create and sustain health. Deficit models have their place but the danger is that, coupled with the powerful vested interests of those who subscribe to and actively promote such views, they effectively dominate policy discussions to the neglect of asset models that have more to do with maintaining health.

The target regime operating in the English NHS over the past decade or so has reinforced this bias. For example, in order to meet the looming 2010 target for narrowing the life expectancy gap in England by 10 per cent, there has been considerable effort and investment in secondary prevention, with effort focused on pharmacological interventions, notably statins prescribing among those aged in their fifties and sixties, and other measures to reduce deaths from the big killers such as stroke and cancer. There is, of course, a place for measures of this sort targeted on groups who have been overlooked or neglected in the past. Indeed many areas, notably Sheffield but elsewhere too, have made impressive inroads into tackling health inequalities as a consequence of such means. But these measures focus on treating symptoms rather than getting to grips with underlying causes and can hardly be regarded as evidence of good public health.

The focus on individuals has also been reinforced by a shift since the publication of the national strategy, *Choosing Health: making healthier choices* in 2004 from upstream to downstream action with a stress on personal responsibility and promoting individual behavioural approaches. This renewed focus on individuals also chimes with a biomedical downstream approach. Ideally, a more balanced policy response is required and it is in achieving this that local government has an especially critical role to play. An asset model such as that discussed by John Ashton in Chapter 9 would take as its starting point the need to identify and build on the positive features of individuals and communities, utilising such capacities and capabilities as exist to further empower them.

At the risk of being over-simplistic, the NHS deals with the negative outcomes of people's health experience (it is, after all, a sickness service) whereas local government eschews 'quick fixes' and looks for positive patterns of health in respect of strengthening those social bonds and ties that go far in sustaining health, even in the face of disadvantage. Assets can operate not just at the level of the individual but, importantly from a local government perspective, at the level of the group, neighbourhood, community and population. These assets can be social, financial, physical, environmental, educational, employment-related and so on. Conceived of in these ways, they relate directly to the social determinants of health discussed at the start of the chapter. Worth recalling, too, are the recommendations of the Acheson inquiry into the inequalities of health published in 1998. Of the 39 recommendations put forward, only 3 directly concerned the NHS or were within its power to influence directly. This rather makes the point that, when it comes to the wider health agenda, the NHS has a somewhat limited role.

Conclusion

Health inequalities between the least well-off and the better-off are growing in the UK despite the government's commitment to tackling them. Part of the mismatch between the policy goal and the reality in practice is a failure, for numerous reasons, to get a proper grip on the social determinants of health. Tackling health inequalities through the NHS and secondary prevention, though important and necessary, will not in themselves be sufficient to narrow the health gap. Rebalancing health policy to accord a higher priority to the wider public health requires local government, as well as national government, to assume a greater responsibility for enhancing the health status of their communities. Much good work has already been achieved, or is in hand. Some of this has been documented by the IDeA's healthy communities initiative. But there remains a concern that local government has a great deal more to contribute to the health agenda than has yet been realised. Paradoxically, the gloomy economic outlook from 2011 also brings with it hope for a step change in how local government regards its role in improving health and well-being. As Barack Obama's Chief-of-Staff, Rahm Emanuel put it: 'Let's not waste a good crisis'.

References and further reading

Bambra C, Gibson M, Petticrew M, et al (2009) *Tackling the Wider Social Determinants of Health and Health Inequalities: evidence from systematic reviews*. York: Public Health Research Consortium.

Butland B, Jebb S, Kopelman P et al (2007) *Tackling Obesities: Future Choices – Project Report*. London: Government Office for Science.

Department of Health (2009) *Tackling Health Inequalities: 10 years on*. London: Department of Health.

Hunter DJ (ed) (2008) *Perspectives on Joint Director of Public Health Appointments*, London: IdeA.

LGA, UKPHA, NHS Confederation (2004) *Releasing the Potential for the Public's Health*. London: NHS Confederation, LGA, UKPHA.

World Health Organization (2008) *Closing the Gap in a Generation: Health equity through action on the social determinants of health*. Geneva: WHO.