

HEALTH STRATEGY FOR LONDON

1. Introduction

Our Healthier Nation, the Health Strategy for England will shortly be published. England was the first country in Europe to produce a strategy on Improving Health. From the green paper on Our Healthier Nation¹ and from the changes to other government policies both within and outside the health sector we have seen that there is a new focus on health, improving health and addressing the determinants of health and inequalities. This has been emphasised by the present government appointing a Minister for Public Health, and by the recognition that these issues can only be tackled by joint action at both national and local levels. Improving health and reducing inequalities is not only being addressed as a priority by health professionals and the NHS but is clearly a priority for all public services. There is increasing ministerial commitment to “joining up” locally, regionally and nationally, as evidenced by the Cabinet Office Performance and Innovation Unit work in this area and the recent White Paper “Modernising Government”². This is translating into real action, such as the New Deal for Communities Pathfinders programme focusing on 17 estates – 4 in London – includes health as one of its four key outcomes. In London a Health Authority Chief Executive is the accountable officer for a significant Single Regeneration Budget (SRB) in King’s Cross – and was the first in the country.

The World Health Organisation defines Health as a state of complete physical and mental well-being and not merely the absence of disease or infirmity.

Within this context, London’s population faces many health and social issues and the need for a strategic framework for improving health has come from shared discussions with partners and the desire to improve health and tackle inequalities. The Modernisation plan for the NHS in London³ has identified the development of a Health Strategy for London.

This paper outlines:

- The opportunity that exists to develop a Health Strategy for London
- The aims and benefits of the strategy
- The major health issues in London, including inequalities
- The main determinants of health and how they impact on peoples lives, health and well-being
- How the issues can only be addressed by joint working, at various levels
- The considerable work that is already underway
- How success can be measured in order to know that a difference is being made
- Some of the ways in which the issues can be addressed
- Who needs to be involved
- What a health strategy for London might cover
- What the priorities might be for the future

2. The Opportunity

The issues of tackling exclusion, marginalisation and meeting the population needs – particularly linguistically, culturally and religiously in London, are such that the NHS alone cannot address them nor can they be addressed only at either local, regional or national level. Action will need to be taken at all levels. The new London Regional Office of the NHS Executive (LRO), instigated in January 1999, provides a new coherent, co-ordinated and consistent NHS region for London and hence enables a renewed focus on tackling the root causes of exclusion, inequality and ill-health. Similarly the opportunity is there for LRO to work more coherently with other London-wide bodies and with the collective NHS community across London. The development of the GLA and of a mayor for London in 2000 also affords an opportunity for the health and social welfare issues of Londoners to be addressed strategically.

The London Regional Office has a unique opportunity to facilitate a strategic approach to these issues and to work in partnership with other bodies including the Association of London Government (ALG), Government Office for London (GOL), Social Services Inspectorate (SSI) and the King’s Fund (KF), as well as local health authorities and local authorities, to develop a strategic framework for improving the public’s health and well-being in London.

3. The Aims

The overall objective of a Health Strategy for London is to improve the health and quality of life of Londoners. More specifically the immediate aims are:

- To develop a pragmatic vision for improved health for Londoners, which is outcome orientated
- To identify priorities and specific targets, including reducing inequalities and addressing the needs of diverse minority ethnic communities
- To identify indicators and measures of success, both in the short and longer term
- To identify specific action to be undertaken by a variety of stakeholders, at various levels, to ensure a co-ordinated action plan, including partnership working
- To build on the considerable work which is already underway, at local and other levels
- To add value by a London-wide focus on health issues
- To raise awareness of health issues amongst the public in London, and of the complex actions needed to address them

4. The Benefits

Improving the health and well-being of London requires action across sectors and at all different levels – as the paper shows. In such a complex system the vision and direction of travel at different levels and across sectors needs to be coherent. The London Health Strategy is one part of this, in the context of the national government policy agenda that is stressing joining up across government – for example Modernising Government White Paper² and Our Healthier Nation¹ which is expected to be published as a White Paper soon. The local context is becoming increasingly joined up through Health Improvement Programmes, Community Plans and others, as well as a number of interlocking area-based initiatives, such as Single Regeneration Budget Health Action Zones, Education Action Zones and Employment Action Zones.

Given the identity of London and the opportunity that exists now to “join up” across the capital the Health Strategy for London will provide part of the London context. (See section 8 later).

5. Health Baselines

London is the largest city in the UK with a population of over 7 million people. There are also nearly 1 million daily commuters and over 20 million tourists visit London each year.

London’s population is characterised by high levels of deprivation, social exclusion, homelessness and the presence of many varied ethnic communities. It is an area of extreme contrasts, with pockets of great deprivation next door to those of great affluence, but even in the more affluent areas there are people living in great poverty. London shows a wide range of health indicators from the very good to the very bad. . Moreover the health divide between the most affluent and the deprived communities in the capital grew during the 1980’s.^{4, 5}

As elsewhere the major causes of death in London are coronary heart disease, stroke, lung cancer and breast cancer. Deaths from these diseases before the age of 65 are considered avoidable by timely and appropriate intervention. However in some boroughs the chances of dying before 65 are 50% higher than in others⁴. There is a downward trend in most of these death rates but the trends in the most deprived parts of London are less fast than is seen nationally and in some cases rates are rising. Relative mortality (Standardised Mortality Ratio (SMR) <75) in the most deprived wards in London has got worse over the past ten to fifteen years whilst SMR in the least deprived has improved slightly⁶. Hence there is a widening gap.

Infant mortality is particularly high in some parts of London and poverty and disadvantage particularly affect children. Acheson identified that the major area where work is needed is to address children’s health and early development. There is evidence that this will be the key factor for future generations. Accidents including road traffic accidents are also particularly important in young people⁴.

HIV/AIDS is striking in London as being the major cause of death for young men aged 15-40^{4, 7}. London has almost half the cases reported in the UK. Other sexual health issues are likewise major issues in London including sexually transmitted disease and teenage pregnancies. For example the number of new cases of gonorrhoea seen in GUM clinics in 1996 was nearly double the number seen in the rest of England, and inner city areas such as Lambeth, Southwark and Lewisham and East London are experiencing teenage conception rates which are amongst the highest in England^{4, 7}.

Mental health, drug misuse and addiction including alcohol similarly are major health issues in London and are higher in the capital than elsewhere. Similarly factors associated with these such as unemployment and deprivation are more acute.

Infectious diseases are a major health problem in London, exacerbated by international travel, ethnic origin and deprivation. The main disease of concern is tuberculosis⁸, with some parts of the capital having notifications six times higher than national averages but there are also cases of malaria and food poisoning and hospital acquired infections are also issues. Vaccine preventable infectious diseases in childhood, such as measles and rubella are also of concern and immunisation rates are low in inner London with areas such as Lambeth, Southwark and Lewisham having rates ten percentage points below the national target of 95%^{4,9}.

London has a large and diverse ethnic minority population. In some boroughs it is now estimated that 50% of the population are minority ethnic groups. In five of the health authorities, ethnic minority groups constitute a quarter or more of their populations. Some common conditions such as stroke, CHD and diabetes are more prevalent in certain ethnic groups, whilst there are also some specific diseases, such as sickle cell and thalassaemia which are linked to ethnicity^{4,5}. London has been a common arrival destination for refugees and immigrants. In addition to specific conditions and diseases which are more prevalent in certain minority ethnic communities, there is also evidence that there is poorer access to health and other public services compared with other groups in the population. Some ethnic groups suffer from living in poor accommodation and experiencing significantly higher levels of unemployment.

KEY HEALTH ISSUES IN LONDON :

- Deprivation, social exclusion, homelessness
- Varied ethnic communities
- Contrasts : deprivation and affluence juxtaposed
- Coronary heart disease and stroke
- Lung and breast cancer
- Infant mortality
- Sexual health – including HIV/AIDs and teenage pregnancy
- Infectious diseases – including TB
- Mental health, drug misuse and addiction
- Inequalities in health and huge ranges and growing divide

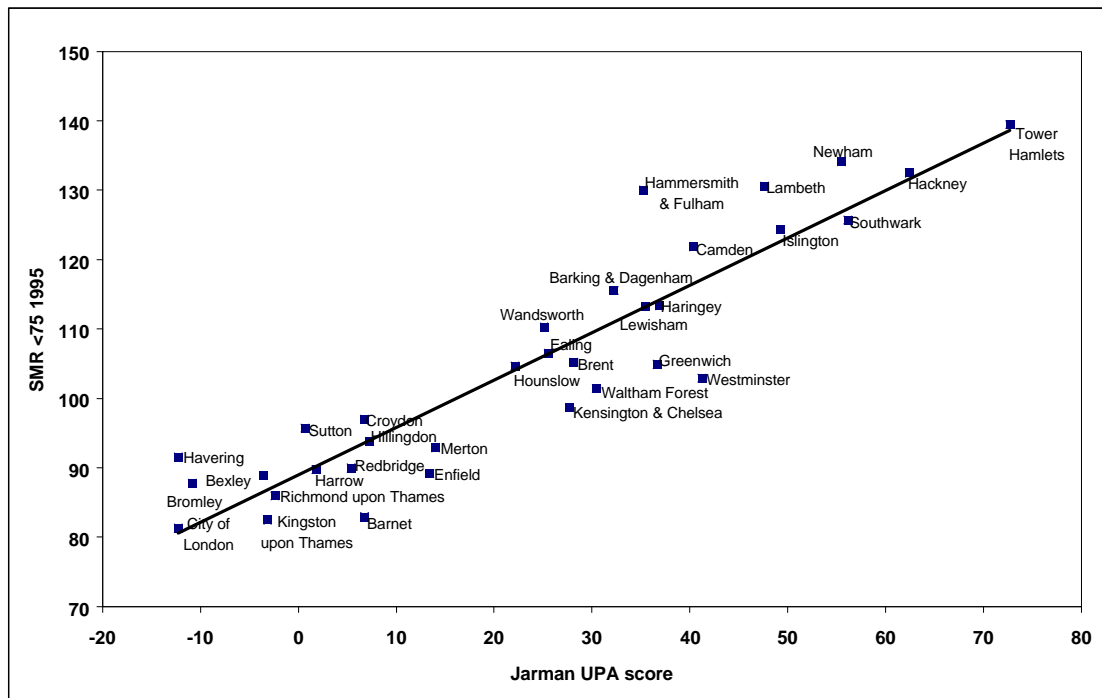
(See Table 1)

6. Inequalities

The publication in November 1998 of the report of the Independent Inquiry into Inequalities in Health (chaired by Sir Donald Acheson)¹⁰, has drawn attention to inequalities and their effect on health and to the actions needed to address them. Inequalities are the variations seen in measures of health, such as life expectancy, causes of death, risk of death from particular diseases and accidents. Inequalities are markers to look more closely and examine why the variations exist and what can be done to change them. Whilst general health indicators, such as SMR, indicate that the SE of England and London are not the most unhealthy places to live compared with the north of England, nevertheless London, and particularly inner London has indicators showing poor levels of health and that these are not improving as fast as elsewhere. The range of inequalities is also most striking in London with some indicators for premature mortality extending from 20% below to 35% above national averages⁶. It is unlikely that a totally uniform situation will ever be achieved, but it is worrying that for some inequalities the gap is widening. Life is getting worse for the people who are already badly off whilst getting better for those who are already well off. For example, one in three children were living in poverty in 1993/4 compared with one in ten in 1979. The three agendas – biomedical, environmental and social – that make up public health are all involved if inequalities are to be addressed, and this can only be achieved by multisectoral action^{6,10}. A further example of inequalities is in oral health. Levels of tooth decay are lowest in the most affluent areas and highest in the least affluent parts of the capital.

Fig 1 shows the differences in death rates related to deprivation across London boroughs.

Fig 1 - Differences in SMR related to deprivation across London Boroughs



7. Determinants of Health

A range of factors affects people's health :

- Health Services : Health services are important in prolonging survival and so improving health and the quality of life *after* serious illness strikes. The London Modernisation Plan³ includes development of London-wide "service strategies" to ensure the quality and access to health services in key areas including mental health, coronary heart disease, cancer, emergency services and people with learning disabilities. Work is already in hand on these "service strategies", with the NHS taking the lead to develop arrangements with other partners to improve the delivery and outcomes of health in these key areas across London.
- Other Factors : However, the social and economic conditions that affect whether and how people *become* ill are more important for improving health and health gains in the population over the longer term. It is these "other factors" that are the primary focus of this Health Strategy for London.

The relationship between health and health service strategies is described later (section 13).

Dahlgren and Whitehead's¹¹ diagram shows 'layers of influence' on an individual's health (Figure 2). The diagram depicts individual people in the centre with concentric semi-circles indicating the various sequential influences on people's health.

In the central circle are individual people. Fixed factors - people's age, sex and constitutional factors such as genetic make-up influence people's health. It is obvious that with increasing age, there is an increased risk of illness such as coronary heart disease, stroke and degenerative and disabling diseases such as osteo-arthritis. It is a sine qua non that there is some ill health only associated with women, such as breast and cervical cancer and others only associated with men, such as prostate disease. However there are also higher risks of CHD in men which for example accounts for one third of all deaths in men under 65 and one fifth of all deaths in women under 65. Genetic make-up also influences health, most directly in the specific genetic diseases such as sickle cell or cystic fibrosis, but also in genetic associations with particular types of breast cancer, diabetes, obesity or CHD.

In the first outer layer - individual lifestyle factors are a major influence on health. The most obvious example here is smoking, which increases risks of lung cancer, heart attacks and strokes, and chest problems. Half of all who continue to smoke for most of their lives die of the habit¹². It is estimated to account for nearly a fifth of all deaths each year - 120,000 lives in the United Kingdom. Similarly, individual lifestyles in relation to what people eat and drink also affect their health, as does how much

exercise they take, research suggests that a third of all cancers are the result of a poor diet. Whether there is a balanced diet or one high in fats and sugars will impact on health. Those who take regular exercise or whose work is physically demanding are more likely to be fit and hence reduce the risk of coronary heart disease, as well as reducing obesity, reducing the risk of diabetes and improving the blood cholesterol profile. Day to day exercise may be dependent on availability of transport.

The next layer, social and community networks, are now known to be critically important to an individual's well being and to their mental health. Increasingly there is evidence of people's social support helping them with such skills as parenting and hence having an effect not only on the individual but also on the next generation¹⁰. Community support through social networks is protective to people's health and high levels of trust and density of group are associated with reduced mortality^{13, 14}. Social exclusion has a major impact on people's lives, their health and on premature death^{15, 16}. Community networks decrease due to increased mobility. The working distance from home and reducing links with increasing traffic eventually mean more people have less social contact and more live alone. Mobility in London is very high.

Living and working conditions, the next layer, constitute some of the major factors in relation to both immediate and long-term health of individuals. In the UK, basic rights such as water and sanitation are generally taken for granted. In London, the major issues about health pertaining to water concern potential risks of contamination such as cryptosporidium leading to gastro-intestinal problems, or to a rise in gastro-intestinal infections if the water supply is cut off. However, there are still issues about sanitation and health in London with 1.5% of residents in households with shared basic amenities, nearly 100,000 persons. Also in multi-occupied housing, sharing kitchen and bathroom facilities and overcrowding can lead to food contamination and food poisoning.

The effects of housing on health are exemplified in terms of overcrowding, so increasing the risks of spread of infectious diseases, such as TB⁸ and other respiratory diseases¹⁷. Cold housing, without central heating, can lead to increased winter illnesses, such as hypothermia in the elderly, chest infections and have been identified as a major cause of winter pressures on health services. At the last census over a million people in London were in households without central heating. Physical fabric and noise are also factors connecting housing and health.

Agriculture and food production, may not on first sight be thought to be critically important to London's health. However food supply is very important. The type of food people eat is very dependent on its availability and accessibility, which in turn is dependent on food production and hence costs. Cheaper food should be more accessible to lower income families. However, frequently this is not the case in that cheaper food may be more readily available in supermarkets, which are often in outer suburbs. This has led to the idea of 'food deserts' where the poorer estates have less good food available locally and so those who can least afford it have limited choice and more expensive food. Those without transport are unable to avail themselves of cheaper supermarket foods. This in turn leads to those who can least afford it eating poorer diets, without fresh fruit and vegetables and often higher in salt and sugar as in prepared foods. Skills are also needed in preparing fresh food such as vegetables^{18, 19}.

One of the most critical predictors of health is education. Whilst education specifically about health - for example knowing about healthy lifestyles and food etc, and how to keep healthy, may be important - of much more importance is basic general education. A better education enables people to get jobs and to develop themselves, thence to have a reasonable income. This is the major predictor of improved health. Adult literacy and further education for those who missed out on basic education earlier, are both important. Children concentrate and learn better if they are not hungry. The introduction of breakfast clubs to ensure children eat breakfast is a clear recognition of the link and of the need to improve nutrition.

Likewise, improved education leads to improved employment. The connection between these and hence leading to better jobs and higher incomes, and the association between income and improved health is irrefutable. There is a clear gradient relating poorer health with poorer income and better health with higher incomes^{19, 20}. Unemployment and poverty are key factors in poor health^{21, 22}.

The work environment is also critical to health. This is obvious in relation to some work-related illnesses, such as asbestosis. However, stress in the work environment as well as elsewhere and other work environment factors also have been shown to have major impact on health^{23, 24}. More recently, the amount of control individuals have over organising their own work has been shown to be significantly related to health²⁵.

The outer layer is general socio-economic, cultural and environmental conditions. These are now recognised to be some of the major factors affecting both individuals' and communities' health. There is a growing body of research which demonstrates the strong connections between socio-economic status and health. Poverty is a multidimensional phenomenon defined in both economic and social terms, it is part of the ecosystem health. Sustainable economic development is crucial if poverty is to be fundamentally addressed.

Environmental conditions may include the physical environment such as air pollution, both outdoors and indoors, which may be associated with susceptibility to asthma and other respiratory conditions. We also see an increase in cot deaths associated with parental smoking and the indoor environment. The environment itself will be affected by traffic and road congestion in London and these may also lead to accidents. Londoner's already recognise the importance of these influences on health²⁶. The links therefore between environment, sustainability, social capital and health²⁷ may be encapsulated in several of the outer layers. Two other factors in the environment are relevant – noise and safety or fear of crime. The latter can lead to social isolation if elderly people living alone are fearful to go out.

The built environment, not only housing but also other buildings and urban design, are now known to have impact on people's health. Many of the worst estates are now being addressed, not only from the physical housing and building perspective but also in terms of social regeneration, building social capital and community development as these are recognised as critically inter-linked, and to have a major impact on people's health and quality of life²⁷. We are increasingly seeing examples of these through the SRB bids, for example in Sutton and in the Health Action Zones particularly where these interface with other initiatives such as Education Action Zones.

The complexity of these interfaces and of the interactions of many levels on each other is clear. The population in London already understand that the environment, employment and lifestyle are important factors for Health, as was shown by the King's Fund/Evening Standard poll²⁶. The improvement of health and quality of life is therefore complex.

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| <ul style="list-style-type: none">● Key determinants of health:● Individual factors● Lifestyle, including food and addiction (smoking, alcohol, substance misuse)● Exercise and transport● Effects of early development● Social support● Social exclusion● Stress, including at work● Unemployment and poverty● Social and economic circumstances |
|---|

The green paper on Our Healthier Nation¹, recognised different levels of working to improve health. It identified that action would need to be taken at government level and between government departments, we have already seen the start of some of this “joined up government” in such initiatives as ‘Sure Start’ and ‘Healthy Living Centres’. Much of the partnership work is already taking place at the local level, particularly between Health and Local Authorities, and this will increasingly be embodied in Health Improvement Programmes (HImps) and Joint Investment Plans (JIPs), and through the Drug Action Teams (DATs), etc. Partnership is also taking place at London-wide (Regional) levels. This is clearly exemplified by the joint action between NHS Executive, London Regional Office working collaboratively with Government Office of London, Social Services Inspectorate, Association of London Government, King's Fund, Health of Londoner's project, Metropolitan Police Service, London Housing Corporation. Similarly action needs to be taken at a neighbourhood or community level. This is particularly important in London where we see the juxtaposition of very poor areas next to the extremely affluent. Focusing in at the specific local level and empowering that particular community to develop itself will be what is required to achieve change. To action this requires not only commitment to community development but also that the public sector changes the ways it works to enable and encourage meaningful community engagement, innovation and initiative. Power will need to be devolved to the community.

OHN also identified that some factors are within the responsibility of the individual and an approach adopting a ‘contract’ for action was outlined.

The following case study exemplifies the issues that affect individuals and that need to be addressed :-

CASE STUDY :

Mandy aged 16

- Truanted and dropped out of school, so no GCSEs or educational qualifications
- Low self esteem
- Smokes as all peers do
- Teenage pregnancy
- Housed in 'sink' estate, 14th floor tower block, lift frequently broken, it is cold and damp
- Isolated with her baby
- Health visitor and midwife encourage to breast feed but any experiences she has and peer pressure is to bottle feed
- Little or no social support
- Poor parenting skills and no 'informal' support to turn to such as mother or grandmother to help with baby
- Local shops have poor quality "packaged" foods which are expensive and no local cheap fruit or vegetables (food desert)
- Nearest supermarket two miles away
- There is no transport and she cannot walk it with baby, Robbie
- She does not have experience of cooking or skills to cook vegetables even if she could get them
- Poor (expensive) high in fat, sugar and salt diet for herself and Robbie
- As Robbie grows up he has little or no play space, the playground is frequently vandalised and used by drug users, so Mandy does not want him to play there
- Robbie is more likely to have an accident in the home, and/or in the street as play areas inadequate
- Housing block has many 'vacant' flats – these tend to be used by drug users and dealers
- Neighbourhood area is vandalised and much graffiti and mother and child stay indoors and become more isolated and depressed
- Neighbourhood school has poor record of educational attainment so child does not develop educational skills
- Robbie is bright but is not stimulated at school. Starts to truant AND SO ON
- Mandy has no educational qualifications
- There are limited jobs in the area
- She cannot get a job – or she can only get a very low paid job
- She stays at home and becomes socially isolated
- Continues to smoke
- Little opportunity to meet others and make long term relationship – may make poor short term Relationship for 'company'
- Mandy has another baby, Sam, but her partner, who is not supportive leaves
- Whilst looking after children, in stressful circumstances and worrying about their well-being in poor local neighbourhood, Mandy is unable to think about her own education in order to get a decent job
- Children are subject to petty crime and drugs and alcohol 'atmosphere' as 'the norm' and Vulnerable to smoking at young age and 'experimenting' with glue sniffing/drug taking to relieve Boredom
- Mandy copes but continues somewhat isolated, continues to smoke, little support, and she starts to use alcohol as support
- As her use of alcohol increases she increasingly does not cope with the children and gets irritated

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The need for co-ordinated multisectoral action to break such a downward spiral is apparent.

8. Addressing the Issues at Various Levels

The vast majority of actions to improve health and wellbeing and reduce inequalities across London are at a very local level. The local authorities and health authorities are key and much of the work will be through collation of the substantial work already undertaken through HImPs.

Action at various levels and by various parties working in partnership will however be needed, for a successful health strategy. These levels are:

- Governmental
- London-wide
- Local (HA and Borough based)
- Neighbourhood and community
- Individual

For any of the factors that influence health there will be action at more than one level.

The intention of a health strategy for London is not to say that everything needs to be done only at a London-wide level.

London-wide action can be instrumental in a variety of ways:

- Action needed to effect change where the issues are broader than 'local' and can only be tackled effectively on a London-wide basis. Examples here may be air pollution, traffic and transport issues and water fluoridation.
- Working with London-wide partners to ensure that the partnership action at local level is enabled and encouraged. Over time the development of common measures of success which apply to more than one sector will be important.
- Building on the work at local level to share examples of good practice or to encourage other parts of London to adopt similar methodologies without 'reinventing the wheel'.
- Co-ordinating the work across London such that there is more focus on the issue and a co-ordinated approach may lead to more effective delivery.
- For some issues action may be needed both London wide and locally. For examples to address smoking effectively, both London wide action (for example on advertising) may be appropriate, some co-ordination of effort at local level would add value (for example learning from the initial smoking cessation work in four HAZ's), whilst local action with schools, etc will need to continue. Similarly for TB, there is need for some London-wide action, such as a register, but also the local pattern of service needs to be better co-ordinated within the health sector and with other partners, which may be achieved more effectively by joint working on a pan-London basis.

The coverage of the London Health Strategy will seek to identify areas where London-wide action may significantly improve health and how this may be achieved. This will require the strategy to have a number of dimensions to it:

- Identification of conditions, diseases and services that can be improved by London-wide action;
- Identification and agreement of methodologies, processes and ways of joined up working to improve health. For example, the consideration of the impact on health and on health inequalities of policies and strategies in London;
- Agreement of information and baseline indicators on health; and
- Building the research and evidence base for improving health in London.

9. Considerable Work is Already Being Undertaken

There is a unique opportunity to consolidate relevant work and knowledge and to develop a coherent overall strategic framework for improving the health of Londoners.

This must be 'bottom up' and build on the considerable good work already being undertaken at a local level. Much of this will be embodied in HImPs (Health Improvement Programmes) which have been developed by Health Authorities in partnership with their local partners. However there will also be more specific initiatives undertaken locally within both the statutory sectors and voluntary and private sectors which may not have formed part of the HIMP process during its first year. Similarly the various zone initiatives, including Health and Education Action Zones have identified major action to improve health. Learning from these experiences across London will be an important part of the health strategy. Also at local level there is considerable action and expertise through health promotion departments and local authorities through agenda 21 and other initiatives as well as their mainstream functions such as housing, education and environmental health, etc.

The aim of the health strategy for London is not to undervalue this work but to work on a London wide basis, where appropriate to compliment it and add further value. This will be through the various levels of actions outlined above (section 8).

Work has already been undertaken at a London-wide level:

- The Health of Londoner's Project was started in 1994/5 funded by the Regional Directors of Public Health in the two (then) Regional Health Authorities, North and South Thames, each of which had half of London within their boundaries. The HOL has produced a series of reports on specific issues related to health in London. These include Child Health in London, Housing and Health, Transport in London, Contraception and Abortion, London Health and Lifestyles, and they will shortly be publishing a report on Refugees and Asylum Seekers. 'The Health of Londoners' report² published in 1998 gives a comprehensive picture of the determinants of health and of their impact on London's health and well-being.
- The King's Fund with the Evening Standard undertook a poll asking Londoners what they thought about the underlying causes of health and the health of London, and what should be done about it. It showed that Londoners know about the determinants of health and that the environment, work and employment and lifestyle issues all affect their health
- Work has already started on a pan-London basis on a variety of specific topics. These include Smoking, Tuberculosis (TB), HIV/AIDs, Healthy Living Centres, Prison health and a workshop is planned in June on Environment and Health in London, as part of the Healthy Planet Forum in parallel with the WHO Third Ministerial Conference on Environment and Health in Europe – Action in Partnership.
- Mechanisms are in place to work in partnership across London Regional Office, Social Care Region and GOL on issues that interface, such as HImPs, HAZ, SRB, NDC and are being developed for Employment Action Zones, Education Action Zones, the New Deal and Gateway initiatives.
- There is also joint work with many other London bodies, such as Metropolitan Police Service and Inner London Probation Service on issues such as drugs, mental health, crime prevention, youth offending, domestic violence, etc.
- The research community within London is substantial. Much of the research may be relevant to London and some will be specifically based on the populations within London. Part of the strategy will be to ensure that this evidence is built into the thinking and informs the action as appropriate. Following the 'Towards a Health Strategy for London' conference, work will be commissioned on specific topics from the research community, to inform the development of the strategy.
- Inequalities in health are a major issue in London. There are two aspects to this, inequalities in the determinants of health (as outlined above) and inequalities in access to health and other services. Whilst these are not mutually exclusive differing action and approaches are needed to address them. Initial workshops have taken place with senior health service managers and a broader group of people, particularly from local authorities, have been identified.
- The ALG has set up a commission on Race Health and Social Exclusion. The commission has recently started to take evidence and will be undertaking the work over the course of the next year. The panel is intersectional and LRO are participating.
- Ethnic Health - all the Regional partners to the London Health Strategy have significant work programmes and networks in place to improve services for and engage black and minority ethnic groups across London. The ALG is currently undertaking a commission on Health and Race The LRO have an ethnic health network which is now in its second year, with a membership of over 200 people. The Steering Group has agreed a work programme for this year and is looking to extend the network beyond the health sector. The network seeks to share information, good practice and learning and developing work in new areas; for example the last workshop addressed how black and minority ethnic needs could effectively be addressed in Health Improvement Programmes.
- Housing - the LRO are working closely with GOL not only on SRB and New Deal for Communities, but also on the Housing Improvement Programmes. LRO and the Housing Corporation (London) also have been pursuing a programme of joint work over the last 18 months which has developed our understanding of how health and housing interface and resulted in ongoing partnership projects and joint learning.

10. What is Trying to be Achieved and How will Success be Measured.

The overall objective of a health strategy for London is to improve the health and quality of life of the population of London. This is a long term objective and even on a long term basis there are poor overall measures of health and generally reliance is placed on measures of mortality and ill-health.

As part of the strategic framework, indices, which can be used to measure success, will need to be developed. These will need to include short, medium and long term measures. The measures will also need to be applicable to more than one sector, and not only applicable for example to either the health service or to social benefit or to housing. They will be the sort of measures that quantify that progress is being made in a partnership way.

Some of the early, shorter term measures may be 'process' orientated but the clear aim is to have 'outcome' measures, in order that the real differences in people's health and wellbeing in response to action can be seen.

Early work on the parts of London where there are multiple action zones may form the basis of this work.

11. Methodologies to Underpin the Health Strategy

The Health Strategy for London will need to be in line with the national strategy, Our Healthier Nation.

The research and evidence base on which a strategy is to be formed has already been outlined. A summary of the social determinants of health and the evidence linking them to health has already been published by WHO in the report "The Solid Facts"²⁸.

It has already been emphasised that partnership working, at a variety of 'levels' and across levels will be crucial for the success of a health strategy for London. Considerable work is already underway in partnership and there has been work to underpin and support the development of partnership working within London. The LRO, with Regional and local partners, have and continue to provide support and advice to health and local authority partnerships across London. Resources, development, shared learning and facilitation are part of this, including the publication of the partnership resource tool "Unlocking the Potential, effective partnerships for improving health"²⁹. This provides a practical and flexible support tool for those developing and trying to sustain effective partnerships. This resource builds on a lot of the partnership work that exists in local authorities. The challenges of establishing effective partnerships are just as real at a London-wide level as they are locally and work is ongoing to "practice what we preach"! This conference is an example of our partnerships.

Health Impact Assessment and Health Inequalities Impact Assessment are increasingly being recognised as key methodologies. There is both a science and an art to these methods. Work is underway to develop both comprehensive research approaches but also to develop methodologies that can be applied in a more 'quick and dirty' way³⁰. A new public health network is being set up for London. The first meeting of this will be on Health Impact Assessment and Health Inequality Impact Assessment in June 1999. A practical example in London is a health impact proforma developed by the LRO to assess 54 Single Regeneration Round 5 Bids that were received by GOL.

The key determinants of health emphasise the need for the process of improving health to be 'bottom up'. Approaches will involve community development and the enhancement of social equity and democratic inclusion. Many local authorities are already undertaking substantial work in this area. Learning from other sectors and particularly the voluntary sector will be crucial to the success of the health strategy.

Similarly a Health Strategy for London, without involving Londoners themselves, would be inappropriate. How to engage with over 7 million people in London is a challenge. Initial work will build on what has already been undertaken at a local level by a variety of sectors and agencies. This may include local citizen's juries, focus groups etc but will not undermine nor replicate the local work. Some further work on the values and social ethics, which will underpin the strategy, is being commissioned.

12. Who Needs to be Involved in Developing a Health Strategy for London.

It can be seen that the answer to this is 'everyone', but is this realistic?

Emphasis has already been placed on the need to build on what already exists and for the health strategy to add value, building on the 'bottom up' and not being 'top down'. The engagement of key stakeholders, including Londoners themselves, and the process of development of the strategy will influence its success. Leadership and champions will be crucial if the health strategy is to be effective. Some multisectoral health leadership programmes such as "Leading for Health" are already running.

The existing public health function across London is key. Those working in public health departments within Health Authorities are already undertaking much of the work locally to improve health, both

within the NHS and with their partners. Similarly those in health promotion departments both within health and local authorities are working in this field.

The capacity and capability of the public health function has been addressed nationally by the CMO's project. Several major groups can be identified as contributing to the public health agenda:

- Public health and health promotion practitioners, both medical and non-medical.
- Professionals with a population focus, including health visitors and environmental health officers, etc.
- Others within the NHS and local authorities and other organisations who may focus more on individual patients or clients, but who need to address broader health issues. This includes many in PCGs (Primary Care Groups) whose functions include improving the health of their communities, and those within mainstream health and other services where a focus on improving health may be appropriate.
- Many in health and other sectors are already practising public health or 'health improvement', for example through addressing poverty and homelessness.

The educational and training needs of all these groups and to develop new practitioners in the field needs to be addressed.

At the present time with the renewed emphasis on improving health and wellbeing and on partnership working, the agenda for public health practitioners has grown. There are expectations of input from public health practitioners on many areas within the New NHS. These include for example the wider health determinants and partnership initiatives such as Sure Start, SRBs, Drug Action Teams, Crime and Disorder, addressing inequalities, development of Primary Care Groups (and PC Trusts), clinical quality in terms of National Service Frameworks, Clinical Governance, and specialist commissioning, as well as many initiatives in other sectors which require a public health input. These pressures require quantification and appropriate public health workforce planning for the future. An initial study in the former South Thames Region has been undertaken to identify the issues.

13. How the Health Strategy Relates to Health Service Strategies

The health strategy is focusing mainly on improving health in its widest context. The aims can only be achieved by multisectoral working. Preventing ill health is part of the work.

The spectrum of interventions includes :-

- Health promotion/prevention/health improvement
- Treatment
- Rehabilitation
- Care

The main focus of the health strategy will be on the first of these. Health service strategies tend to focus on the others, possibly with partners such as social services in relation to the latter.

The example of cardiovascular disease can be taken, as it will shortly be the subject of a National Service Framework (NSF). Working through the spectrum, much of the improving health/health promotions/prevention action require interventions that address smoking/diet/exercise/obesity/poverty/stress/employment. These are multisectoral actions to address the root cause of diseases.

For treatment through to care, the focus is more on primary, secondary and tertiary health services. Getting the health service delivery right will be what affects the outcomes, once "ill health" has occurred. The separation of wider health (determinants) from health services cannot, however, be absolute. Secondary preventative programmes once someone has had a heart attack also involve smoking cessation, exercise, diet, etc and these will be dependent to a degree on social and economic circumstances.

| | | |
|-------------------------------|---|--------------------------------|
| Health improvement/prevention | } | mainly Health Strategy |
| Treatment | } | |
| Rehabilitations | } | mainly Health Service Strategy |
| Care | } | |

14. A Possible Framework for the Health Strategy

The complexity of public health issues in London is such that within the overall framework there will be a series of topic based strategies. These will need to be grouped. Possible groupings are:

1. Values and social ethics – to underpin the framework
2. Health Improvement
 - a) disease specific (eg CHD/cancer/mental health/accidents)
 - b) population groups (eg children/refugees/elderly/young people)
3. Health Protection
 - a) pollution and environment
 - b) infectious diseases (eg TB/AIDS)
 - c) smoking and tobacco
 - d) substance misuse
4. Wider Health Issues
 - a) housing
 - b) transport
 - c) regeneration and employment
5. Addressing Inequalities
 - a) in health needs (eg ethnicity)
 - b) in access
 - c) social exclusion (eg homeless)
6. Development of Methodologies
 - a) health impact assessment
 - b) community development
 - c) EU comparisons
 - d) WHO healthy cities
7. Information
 - a) health information
 - b) indices/measures of progress
8. Research and Development – including evidence base
9. Workforce and Education and Training – public health capacity/capability

15. Priorities

This paper outlines the range and complexity of a Health Strategy for London. It can be seen that all aspects cannot be tackled immediately. Part of the process of development of the strategy will be to identify what might be the priorities. The process of priority setting itself is a complex area. Criteria may need to be identified to inform the priority setting process. These might include such aspects as where maximum effect may be achieved, or more pragmatically what might be early 'wins'.

Part of the essence of a health strategy for London is to focus effort in order to achieve demonstrable change. The intention would be to identify what may need to be tackled first within an overall framework of a health strategy. The opportunity exists at the conference 'Towards a Health Strategy for London' to identify the way forward both for particular priorities and for the overall framework.

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May 1999

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TABLE 1

KEY HEALTH ISSUES IN LONDON :

Deprivation, social exclusion, homelessness:

- 40 % of the population of London live in wards that are amongst the most deprived in the country.
- Nearly 40 % of the unemployed in 1997 had been unemployed for more than a year.
- Unemployment among people from black and minority ethnic groups is significantly higher than the twice as high as national averages
- One in five residents are from black and minority ethnic groups, which represents nearly a half of the black and minority ethnic communities of Great Britain.

Coronary heart disease and cancer

- Coronary heart disease and stroke are a major cause of early death, a third of all deaths in men and a fifth in women under 65. The reduction in mortality rates is slower in London than that seen nationally.
- One in four Londoners will develop some form of cancer before the age of 75. For most cases the London's death rate from cancer are lower than the average. The exception is lung cancer in women.
- The chances of dying before the age of 65 are almost twice as high in the most deprived areas of London as in the least deprived. This variation is also seen in other health indicators such as infant mortality, teenage pregnancies etc. There is evidence that the health divide is widening both in London and the UK, and trends in London's mortality rate, although falling, are not falling as fast as national averages.

Child health

- Infant mortality rates in parts of Inner London are three times those of Outer London. The rate for mothers born in the New Commonwealth is 50% higher than those born in the UK.
- Some of the highest rates of teenage pregnancy in the country are found in parts of Inner London, which is linked to deprivation and social class.

Communicable disease:

- Inner London is the national focus for the HIV epidemic. It is estimated that at the end of 1996, of all adults with HIV in England & Wales 42% lived in Inner London. Notifications of other sexually transmitted diseases also tend to be high in London.
- Tuberculosis is a major and growing concern in London. Notifications for TB are concentrated in areas of high deprivation, in the black and minority ethnic communities and in the homeless. Immunisation and vaccination programmes remain one of the most effective tools in the prevention of infectious disease in childhood. Parts of Inner London have a low uptake of immunisations.

Mental Health

- London has higher levels of serious mental illness than any other city in the UK, and demand for services is rising. Almost twice as many patients in London are detained under the Mental Health Act than elsewhere. Drug misuse is a major problem for Inner London, for examples about a fifth of notifications to the home office were from London, and London has the highest prevalence of injecting drug use amongst men.