LEARNING FROM DIFFERENCES BETWEEN THE FOUR COUNTRIES OF THE UNITED KINGDOM AND THE REPUBLIC OF IRELAND

The first Report of the UKPHA Devolution Special Interest Group

Summary Version

March 2006

Learning from Differences – an overview of the public health scene in the four countries of the United Kingdom and the Republic of Ireland.

Table of Contents

Foreword

Background

Commentary on the five countries

Systems in Transition

Context of public health

Mortality and morbidity

Drivers of policy and practice

Common concerns

Appendix 1 Terms of Reference of the Devolution Special Interest Group

Appendix 2 Membership of Devolution Special Interest Group

Appendix 3 Sources of Information

Foreword

This document is intended merely to give a flavour of the work of the Devolution Special Interest Group which has now been in operation for eighteen months. It aims to highlight some of the issues that were identified in the work of the Group during its first year of operation when it sought to look broadly at the health and public health systems in the five countries of the United Kingdom and the Republic of Ireland to see what similarities and differences were discernible. The resulting report, Learning from Differences between the four countries of the United Kingdom and the Republic of Ireland, and a supporting Statistical Compendium are accessible on the Devolution SIG's website at www.ukpha.org.uk
Having got an overview of the five countries, in its second year the Group has narrowed its focus to look at the different approaches being adopted in the very topical areas of food, nutrition and obesity. This work will be presented at a workshop at the UKPHA Edinburgh Public Health Forum

The stimulus for setting up the Devolution SIG was the devolution of health and public health powers from Westminster to Scotland and Wales in 1999. With the passage of time the differences in approach to common health problems in all four countries of the United Kingdom are likely to increase. The Republic of Ireland has taken its own different path since 1922. The challenge is to learn from these differences and to feed this learning into public health policy development and practice in the five countries, and possibly more widely in Europe. The Devolution SIG seeks to respond to this challenge through its own work and, hopefully, by working in collaboration with other similar groups that have been established by academic and other organisations.

February, 2007

Background

The Devolution Special Interest Group was established in 2005 following a clear indication of interest and support from UKPHA members and others at the 13th Public Health Forum in Gateshead. It comprises representatives from all four countries of the United Kingdom and the Republic of Ireland and has met six times so far. To provide a context for its main task of exploring differences in approach to common public health problems the Group's members have produced five position papers. These have been written to a more or less common format comprising an identification of key public health drivers, a description of where public health sits in the scheme of things, a section on public health quality focussing on the principal causes of death and inequalities in health, a description of the state of primary care and finally a description of the approach adopted to tackling Coronary Heart Disease as the number one cause of premature mortality in all five countries.

England has been treated, for the purpose of this exercise, as a single entity, which introduces an imbalance into any comparisons because it is almost 10 times more populous than the biggest of the other four countries. The aim is to look at England through its nine regions which are much more comparable to the other four countries in population terms. This is a task for the future. It should be noted however that a considerable amount of English regional data is included in the Compendium of Health and Wellbeing Statistics (which has also been produced by the Group) for the Four Countries of the United Kingdom and the Republic of Ireland.

The Group's Mission Statement and Aims and Objectives are detailed in APPENDIX 1.

Commentary on the five countries

In looking at the position in the five countries the Republic of Ireland is significantly different from the others in that it has defined its own separate and particular approach over the last eighty years. It is also evident however that the positions in the four home countries are different and becoming more so as the impact of devolution becomes manifest.

The main point of similarity is that the major public health challenges facing each of the countries are identical; cardiovascular disease and cancer are the main causes of premature mortality; while smoking, alcohol misuse, poor nutrition and inadequate exercise leading to obesity and overweight, drug misuse and poor sexual health, are the main lifestyle challenges. Health inequalities are substantial in all countries.
What are the key questions/issues to be pursued about public health in the five countries to highlight the differences?

Below are some such questions / issues with an appropriate summary response, based on the narrative outlined in each of the five position papers.

1. Where does public health sit in the structure of government at national and local levels? It is very centralised in Wales and less so in the other countries. It is probably least centralised in England with a significant local input at a relatively small population level.

2. How dominant are medical practitioners in the public health workforce? They are dominant to different degrees in all five countries.

3. How prominent is the role of local government in public health? While there is a growing awareness of its role in both Wales and Scotland the reform process in the Republic of Ireland has at this point reduced its degree of prominence.

4. How joined up is public health thinking and action at national and local levels? Probably most joined up at both levels in Wales because of the Health, Social Care and Wellbeing agenda and good reciprocal relationships between Local Authorities and Local Health Boards. The repositioning of the Public Health function in the new Population Health Directorate in the Republic of Ireland has enhanced its potential in this regard.

5. How important is the role of primary care in promoting the public health agenda. It is important in all countries.

6. Is there a co-ordinated coherent strategic approach to public health at central and local levels? Is there a single strategy? Yes in all countries but limited at times by a traditional perception of the scope of public health.

7. To what extent are the voluntary sector, community organisations and ordinary people engaged in the public health agenda?
There is evidence of engagement for the voluntary sector, community organisations and ordinary people in the four countries of the United Kingdom, particularly in Wales where the new Health, Social Care and Wellbeing agenda provides new opportunities. In the Republic of Ireland the consultative document entitled*: Your Views About Health* attracted over 300 organisation contributions and 1500 individual contributions.

8. How dominant is the inequality focus in the public health agenda? There is action and commitment from all countries to redressing inequalities. It is acknowledged however that the issue is a complex and difficult one to resolve.

9. To what extent has public health activity been separated into its three components – health promotion, health protection and health restoration? This process is well advanced in all five countries with the hiving off of health protection greatest in England. In Wales the separation of health promotion from health restoration is also well advanced.

10. Sentinel public health action. A complete ban on smoking in public places was implemented first in the Republic of Ireland. Other countries have developed, and are developing similar legislation.

Systems in Transition

One feature of four countries is that their public health systems are in a process of radical transition to varying degree. Wales is the exception in that it is only 3 years since it's last restructuring and that the new arrangements with Local Health Boards, Local Authorities, three regional offices as well as 14 hospital trusts are still bedding down. It will be interesting to see whether the changes in the other countries take cognisance of equivalent or previous changes in their neighbour countries.

Local Government in Northern Ireland is being restructured with a reduction in the number of authorities from 23 to 7, each having its broad public health role increased.

The restructuring in England is perhaps the most disappointing being occasioned solely by financial drivers – the search for economies of scale. The great impediment to real progress in partnership working (which is the key to rolling out the new very broad public health / health and wellbeing agenda, namely getting rid of the predominant pattern of two tiers of local government) has not been addressed and neither does it look as if it is on any short-term agenda.

An innovation that has recently been implemented in Glasgow is the employment of health visitors by the local authority. This was the traditional location for health visitors in the United Kingdom which was changed in the 1974 NHS restructuring.

An important feature in the Republic of Ireland is the focus on Primary, Community, and Continuing Care (PCCC) for the delivery of public healthcare services. The most recent White Paper in England is also following this path.

Context of public health

Each area has a coherent strategic approach to public health at central and local levels but is limited by a traditional perception of the scope of public health. There is evidence of engagement for the voluntary sector, community organisations, and individuals in each of the areas. There is action and commitment from all countries to redressing inequalities.

	Organisation/Structure	Approach/Function
England	No uniform entity in health or public health terms. Public health specialists and consultants come from a range of backgrounds.	Health protection activity has a high profile. Some joint working. NHS focus.
Republic of Ireland	The health services are currently in the process of major reform. Within this new structure a national agency HSE (Health Service Executive) is responsible for all service delivery.	First to legislate against smoking in public places (closely followed by Scotland). Focus on primary and community care for the delivery of public healthcare services.
Northern Ireland	Delivery of public health takes place at local level. Public health function sits largely within the health services structure.	Joint working between health and local authorities. Cross-cutting strategic approach to health improvement
Scotland	Health Minister focuses on NHS. Deputy CMO has a public health focus. Dominated by doctors – all consultants have a medical background.	Growing awareness of the public health functions of local authorities with increased partnerships between health and local authorise and voluntary sector at a local level.
Wales	Centralised at government level. Local authorities and health boards are co-terminus.	Growing awareness of the public health functions of local authorities with local strategic partnerships. Well-being agenda. PH legislation enacted through Westminster.

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Mortality and morbidity

Patterns of mortality and morbidity are broadly similar in the five countries with cardiovascular disease and cancer predominating in the older age groups and injuries and poisoning predominating in young adults. A detailed analysis of mortality and morbidity rates is included in the Statistical Compendium.

Drivers of policy and practice

England	Financial drivers search for economies of scale in NHS restructuring.
Republic of Ireland	Overarching strategy of: • Better Health for everyone. • Fair access. • Responsive and appropriate care delivery. • High performance.
Northern Ireland	Restructuring
Scotland	Recognition of need to develop a wider public health workforce. Community planning involves health and local authorities collaborating with voluntary and business sectors. Medical dominance.
Wales	Health Social Care and Well-being strategies

Common concerns

No explicit public health standards	The focus appears to be at specialist level although it is increasingly recognised that there is a wider public health workforce. There are a number of organisations developing sets of competencies leading to confusion.
Expectancy of collaborative working	Perceptions and practice vary. There is a need to clarify roles and responsibilities and to give time for a culture of collaboration to develop.
Terminology varies across the five countries.	Public health organisations are called by different names and the people involved in them may have a range of different (and changing) titles.
Persisting health inequalities	Despite overall health improvement, inequalities persist with demands from governing bodies for quick fixes and efficiency. The gap continues to widen in many areas.
Strategic and research capacity limitations	Expectations outstrip reality. Limited core funding for research with the main focus being on clinical research. Constant reorganisation of services affects long-term strategic development and implementation.
Limited view and fragmentation of services.	A sickness service ownership of public health results in disconnection from others who make significant contributions.

APPENDIX 1

UKPHA Devolution Special Interest Group

Mission Statement

"The Mission of the Devolution Special Interest Group is to promote the dissemination of information about developing public health policy, practice and structures in the four home countries of the United Kingdom and the Republic of Ireland with a view to determining the utility of different approaches through comparative analysis."

Aims and Objectives

The overall aim of the Devolution SIG is to provide an opportunity for UKPHA members to come together to explore the impact of devolution on public health policy, practice and structures in the four home countries of the United Kingdom and the Republic of Ireland with a view to learning lessons about what works, what doesn't work, and areas where we don't know either way, so adding to both the public health knowledge base and the public health research and development agenda. This will be done against the background of the UKPHA's three overarching policy objectives, namely:

- Combating health inequalities
- Promoting sustainable development
- Challenging anti-health forces.

More specifically, the Devolution Special Interest Group has the following objectives

1. To identify issues of common interest to members from the five countries for comparative analysis.
2. To undertake collectively or to commission as appropriate the necessary data collection, analysis and interpretation in respect of such issues to generate papers for presentation and/or publication.
3. To create awareness of the Special Interest Group's work amongst the broader UKPHA membership and among other relevant interests.
4. To network with other UKPHA members and others with similar interests from a wide variety of multidisciplinary backgrounds to promote two way information flows

Although the Devolution SIG has been established specifically to explore what might be termed in the five countries a *natural experiment* consequent upon devolution, it will also look at the growing differences in policy, practice and structures in the English regions and, where appropriate, it will make itself aware of relevant developments in Europe, focussing in particular on the EU.

APPENDIX 2

Membership of Devolution Special Interest Group (2005 – 2006)

Bill Seery: Primary Care Administration: Dublin Mid Leinster
Region: Irish Health Service Executive.

Gerry Roddy: Manager-Health Promotion Services,
HSE Dublin North East

Eddie Coyle, Consultant in Public Health, National Public Health Service for Wales

Lizi Irvine, Senior Lecturer, School of Community Health, Napier University, Edinburgh

Christopher Birt, Consultant / Senior Lecturer in Public Health, Co-Chair Heart of Mersey Trustees, NW Region (England) representative on EUKHRN

Gary McFarlane, Chief Executive, Chartered Institute for Environmental Health, Northern Ireland

Angela Mawle, Chief Executive, UKPHA

Kate Harvey, UKPHA

Paul Walker (Chair), UKPHA Trustee

Kate Fletcher, Admin Support, Welsh Council for Voluntary Action

APPENDIX 3

Sources of Information

While the main report includes many references, this appendix identifies some key web sources of information.

www.apho.org.uk

www.cmo.wales.gov.uk

www.dh.gov.uk

www.dhsspsni.gov.uk

www.dohc.ie

www.healthpromotion.ie

www.healthscotland.com

www.hpa.org.uk

www.hse.ie

www.investingforhealthni.gov.uk

www.nphs.wales.nhs.uk

www.phls.co.uk

www.publichealth.ie

www.publicheathallianceireland.org

www.show.scot.nhs.uk

www.ukpha.org.uk