Lessons for health strategies in Europe

The evaluation of a national health strategy in England

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Objectives: To determine the impact of the national health strategy for England, 'Health of the Nation' (HOTN) at the local level; the mechanisms by which this was achieved; and to provide lessons for the new strategy, 'Saving lives: our healthier nation'. Design: Case studies. Semi-structured interviews with key actors across a range of organisations (n=133), analysis of documents (n=189), and analysis of expenditure for the period 1991/1992 - 1996/1997. Setting: Eight randomly selected English health authorities. Main outcome measures: Perceptions and documentary evidence of the impact of HOTN on local policy and changes in expenditure. Results: Three models of implementation were identified: strategies based directly on HOTN; HOTN plus additional elements ('HOTN plus'); and strategies under another label such as healthy cities or urban regeneration. There was clear commitment to intersectoral work and some support for joint appointments of directors of public health by health and local authorities. HOTN was seen as failing to address underlying determinants of health, reducing credibility with key partners. Views were divided on whether to adopt a population- or disease-based model. Consistency in central government policies and communication of the strategy were criticised. HOTN was universally perceived as increasing health promotion activities, particularly in the key areas. HOTN received few mentions in corporate contracts and general practice reports. Expenditure on health promotion activities increased slightly then declined, and HOTN appears to have had only limited influence on resource allocation. Conclusions: Central government, in England, should enable rather than prescribe strategy implementation. It should ensure appropriate structures are in place and that national polices are consistent with the strategy. There is a debate about where the responsibility for health strategy should lie, whether with the NHS or local authorities. The new strategy should address different audiences: local government; the NHS; the voluntary sector; the private sector; and the public. One model is the matrix approach of the European Commission health promotion programme. HOTN failed to engage three groups: the public, primary care, and the private sector. This study has important implications for the monitoring of the new strategy. It needs to be firmly embedded in the work of those who must implement it. It should be incorporated into the NHS performance management framework. The current financial reporting mechanisms preclude monitoring expenditure on a health strategy. Ring-fencing some resources for the new strategy should be considered, if only to give it the high priority it requires. This study, both in terms of the methods used to evaluate the strategy and the lessons learned, could be used by other European countries developing and evaluating their own health strategies.

Keywords: health strategies, evaluation, health targets

The *Health of the Nation*[1] (HOTN) strategy for England was launched in 1992. It built on the World Health Organisation's 'Health for All Strategy',[2] focusing on five key areas and with 27 individual targets. Although the English Department of Health's Central Health Monitoring Unit has undertaken detailed monitoring of the extent to which these targets have been achieved,[3–6] the way the strategy was used by central government as a means of influencing national and local health policy has not been evaluated.

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The HOTN strategy sought to widen the responsibility for health, an emphasis reflected in the establishment of a Ministerial Committee to oversee its development, implementation and monitoring. At local level, health authorities were given responsibility for co-ordinating implementation through alliances with other organisations such as local authorities, voluntary organisations, and the private sector.

Following the election of a Labour government in May 1997 and the appointment of the first Minister for Public Health, the government announced its intention to launch a new health strategy[7] that will address important underlying causes of mortality and morbidity. A Green Paper[8] was published in February 1998 as part of a major consultation process. The white paper *Saving lives: our healthier nation* was published in July 1999.[9] Other important policy developments which intersect with the

public health strategy are the proposals set out in *The new NHS* White Paper;[10] the consultation paper on assessing performance in the NHS;[11] the emerging findings from the Chief Medical Officer's report on the public health function;[12] the Acheson inquiry on health inequalities;[13] and the government's response.[14]

Lessons from the implementation of HOTN are likely to be of relevance to those implementing national health strategies elsewhere and noted in countries such as Italy, Luxembourg[15] and Portugal[16] where strategies similar to HOTN have been adopted. This paper reports the results of an evaluation of HOTN, assessing how it has worked at local level and identifying these lessons. This paper is a summary of a much more detailed report that has been published by the English Department of Health.[17]

METHODS

Given the problems of evaluating such a strategy in terms of the many confounding factors and the difficulty of ascribing causality, the evaluation adopted a 'contextual' approach, defined as the analysis of organisational change in terms of the context and process, as well as its content. Data collection was designed to identify patterns in the process of change and the 'how' and 'why' as well as the 'what' of policy changes[18] – an approach which has been applied to the study of health care organisations.[19] The focus of the evaluation is on the *perceptions* of key actors at the local level on the impact of the HOTN and *documentary evidence* of such impacts, including evidence of policies and activities and, where possible, data on expenditure.

The evaluation sought to address a series of questions. What changes did the strategy give rise to locally, within and outside the NHS? What mechanisms were effective and are they sustainable? How useful are the key components of the strategy, such as key areas, target setting, and healthy alliances? Which factors facilitated or obstructed change? How did the strategy relate to other initiatives such as the general practice contract and what impact did it have on conditions outside the key areas?

The research was undertaken in eight districts (districts typically have a population of between 0.5 and 1 million and are the basic geographical unit within the NHS), with one selected at random from each of the English NHS regions. Interviews were conducted with key actors in each district drawn from the following organisations: health authorities, local government authorities, provider trusts (hospitals and community service providers), general practitioners, community health councils (the bodies established to represent the views of the public to the NHS), relevant voluntary organisations, police and the private sector. Semi-structured interview schedules were developed for each type of organisation, with a set of core questions which were addressed to all respondents.

Interviewees were identified through 'snowball sampling'[20] in which initial respondents were asked to identify key informants within the health authority and in other organisations. Where contacts in a particular category were not identified by initial interviewees they were located by other means, to avoid selection bias that could have arisen if those with greater involvement with or knowledge of HOTN were preferentially included. Interviews were supplemented by examination of official documents and analysis of financial data. For the expenditure analysis, health promotion activities were defined as 'narrow' (designated health promotion activities by trusts, health authorities, and in general medical service budgets) or 'broad' (narrow plus family planning and cancer screening services). To examine any impact on other areas, three areas outside the key areas (asthma, diabetes, and childhood immunisation) were studied.

RESULTS

The districts selected were distributed evenly in terms of structural and demographic characteristics including the OPCS Area Classification and Jarman scores (both commonly used measures of deprivation in the UK) and standardised mortality ratios (SMRs) *(table 1)*. Real *per capita* expenditure increased in all districts except one over the study period (1991–1997), with an average real increase of 1.94% per year (Hospital and Community Health Services Pay and Price Index).

133 semi-structured interviews were conducted in the eight districts covering all sectors. 189 documents were collected. A comprehensive data-set from health authority, former Family Health Services Authority (bodies responsible for primary care that merged with health authorities in the early 1990s) and Trust accounts, AIDS Control Act Reports (statutory reports on expenditure on HIV/AIDS) and resident population estimates were obtained for each district. Local expenditure data were

Table 1 The demographic characteristics of health authority districts studied[a]

District	Local Government	OPCS Area Classification[b]	Population (1000s)	UPA score (Decile)[c]	SMRs[β] (Quintile)
A	Unitary	Most prosperous	250–300	1	1
B	Unitary	Services & Education	450–500	9	2
C	Unitary	Mixed economies	700–750	8	3
D	Two-tier	Resort & Retirement	550–600	6	2
E	Two-tier	Mixed Urban & Rural	550–600	5	3
F	Two-tier	Mixed Urban & Rural	650–700	5	1
G	Unitary	Manufacturing	250–300	6	5
H	Unitary	Resort & Retirement	300–350	7	4

a: All data taken from the Public Health Common Data Set Indicators (1996).
b: This is a cluster analysis of a range of socio-economic and demographic variables to group health authorities into similar area types.[28]
c: Under-privileged area (Jarman) score is a measure of deprivation. The score is the weighted total of eight census variables.[29]

obtained from all health authorities to varying degrees of completeness.

HOTN was implemented by health authorities through a variety of management structures. Only one operated a designated budget covering all HOTN development activities. Four others had allocated partial (non-staff) budgets for development in certain key areas.

The models of implementation also varied, with some districts developing strategies based directly on HOTN; some using HOTN but developing it further, for example, by adding key areas ('HOTN plus'), and some developing strategies under another label, such as healthy cities or urban regeneration.

Those interviewed were clearly committed to intersectoral work for health improvement and those with a positive experience of partnership for other purposes, such as drugs action or economic regeneration, were especially favourable towards partnership for health improvement.

There was some support for the proposal that directors of public health be appointed jointly by local authorities and health authorities, as an enabling structure for the new strategy *(table 2)*.

There was widespread criticism that HOTN did not address the underlying determinants of health and, especially, inequalities. This acted as a barrier to local implementation because the strategy had less credibility, particularly with local authority and voluntary sector partners. Despite this, many districts included these issues in their local health strategies. Interviewees strongly supported inclusion of the determinants of health and inequalities in the new national strategy.

There was less consensus about another aspect of the underlying philosophy of the strategy, with some favouring a population-based and others a disease-based model *(table 3)*. This division did not directly mirror organisational loyalties, with calls for a population-based model coming from the NHS, local authorities and the voluntary sector.

Central government was seen as having an important role, both positively, where an enabling but hands on approach was called for at local level, and negatively, as with conflicts between policies of different government departments, with several interviewees mentioning the episode when the Labour government opposed a ban on Formula One tobacco sponsorship shortly after having received a £1 million donation from a leading businessman involved in motor racing.

Central government also had a key role in communicating the strategy to all involved, but this was considered to have been poorly executed. Some important groups, such as environmental health officers, reported not receiving key documents. The language and concepts in much of the material produced, while resonant with those in public health or health promotion, failed to engage some groups, reflecting the differences in attitudes to the underlying philosophy, as noted above.

The tools used to support the strategy received mixed views. 90% believed the key areas addressed important

Table 2 Should directors of public health be joint appointments between health authorities and local authorities?

	DPH	HA Chief Exec	HA HOTN Lead	HP Manager	HA other	LA HOTN Lead	CHC	Total
Yes	3	0	2	1	6	0	5	17
Unsure	0	0	0	0	0	2	0	2
No	1	0	1	0	1	0	3	6
Missing	4	8	7	3	3	1	0	26
Total	8	8	10	4	10	3	8	51

DPH: Director of public health; HA: Health authority; HOTN: Health of the Nation; HP: Health promotion; LA: Local authority; CHC: Community health council

Table 3 Could the key areas have been based around population groups, or something else, rather than around diseases? (all interviews)

	All		Public health/ Health promotion		Local authority/ Voluntary sector	
	Number	%	Number	%	Number	%
Yes, population groups	34	26	5	23	14	30
Yes, something else	13	10	3	14	6	13
Arguments on both sides/can't decide	20	15	5	23	8	17
Matrix/Must use many approaches	9	7	2	9	2	4
Doesn't matter where you start	9	7	3	14	0	0
Yes possibly	5	4	0	0	3	7
No, disease-based areas are right	31	23	3	14	10	22
Don't know	4	3	0	0	1	2
Missing	8	6	1	5	2	4
Total	133	100	22	100	46	100

problems but only 47% thought that they should all be retained in a new strategy. 73% thought that new areas should be introduced.

The existing national targets had little credibility (*table 4*) and 59% of those interviewed would like to see them changed. The concept of targets was, however, welcome, although 69% thought they should be developed locally. A particular concern was the emphasis on outcome targets, which in some cases were seen as rather less appropriate than process targets, such as the development of alliances. There was concern that lessons from the use of targets in other sectors should be learned.

The Department of Health has created a Performance Management Framework, designed to enable ministers to hold the NHS accountable for policy implementation. A frequent criticism was the failure to incorporate within the performance management framework a review of progress towards the targets in, which was interpreted as evidence of a lack of top-level commitment. Instead, the framework tended to focus on matters such as waiting lists and financial performance.

The majority of respondents found targets helpful as a way to prioritise and focus efforts, but they suggested that national targets must be credible, based on sound and convincing evidence, and that local targets can be useful. There were mixed views about the need for additional resources for a national health strategy (*table 5*), with nearly half qualifying their replies to specify the importance of carefully targeted spending to support structured action for health improvement at the local level. There was, however, support for a stronger evidence base.

Turning to the local impact of HOTN, it was perceived as having increased prevention activity overall, particularly in relation to the key areas and alliance work. In particular, it was perceived as improving co-ordination and enabling health promotion efforts to be prioritised. There is some evidence for ownership of HOTN outside Health Authority departments of Public Health, particularly through purchasing plans and contracts with providers (*table 6*), but there are also areas where ownership appears weaker, such as a lack of reference to it in corporate contracts and general practice reports. The impact of HOTN on key policy documents did, however, increase over the study period, to a peak in 1993, tailing off slightly thereafter (*table 7*).

HOTN appears to have stimulated and focused multisectoral health strategies in some districts, while others have been able to develop strategies without using it. Health authorities have found particular difficulties in involving the police and private sector. These groups are willing to engage in partnership, but prefer working on specific measures rather than in less well-defined 'strategic' partnerships. Five out of eight health authorities had explicitly earmarked funds for alliances; amounts varied 100-fold, from from £2,000 to £200,000 suggesting very different approaches.

The impact of HOTN was also examined in terms of any effect on health promotion expenditure as a proportion of total NHS. For both 'narrow' and 'broad' measures of health promotion there were slight increases over the study period to a peak in 1994/1995 with a gradual tailing off, so there is little evidence to suggest that HOTN had anything other than a limited influence on resource allocation at local level (*table 8*). Analysis of individual

Table 4 Are the targets credible? (all interviews)

	Number	%
Yes, all	15	11
Yes, most/some	37	28
No	48	36
No, but they are important pointers	12	9
Don't know	15	11
Missing	6	5
Total	133	100

Table 5 Should the government provide additional resources? (all interviews)

	Number	%
Yes, unqualified	63	47
Yes, qualified, or No	56	42
Don't know	3	2
Missing	11	8
Total	133	100

Table 6 Inclusion of HOTN in contracts

Health authority	Number of contracts supplied	Include HOTN in quality standards	Include HOTN in info. requirements
A	0	n/a	n/a
B	2	y	y
C	0	n/a	n/a
D	1	n	y
E	5	y	y
F	1	y	n
G	2	n	n
H	1	n	n
Total	12		

y: yes; n: no; n/a: not applicable

Table 7 Mention of HOTN in key documents by year

Year		Mention HOTN Number	%
1992	n=12	7	58
1993	n=19	15	79
1994	n=26	20	77
1995	n=27	20	74
1996	n=38	28	74
Total	N=122	90	74

health authorities suggests that population-based health promotion may be a 'soft target' and may be reduced to achieve savings. Expenditure on HIV/AIDS prevention activities increased as a share of total population-based health promotion funding, suggesting that some authorities are using this ring-fenced budget to cross-subsidise other health promotion activities, and also raising the question of using ring-fenced resources to implement the new health strategy.

There had been concern that the focus on a few key areas would adversely affect other areas. Compared to the level and type of activity in the HOTN key areas, strategic activity and activity involving alliances and targets, or based in innovative settings was low in the non-key areas studied, with only a slight increase in 'HOTN-type' activity where these themes were designated as local key areas. Work in asthma, diabetes and childhood immunisation is based largely on well established mechanisms in primary care.

DISCUSSION

The results of this evaluation have considerable implications for the British government's new health strategy. Much work was undertaken within the framework of the former strategy in all eight districts, but this involved a range of models and approaches. It seems important that a national approach should not be overly prescriptive, allowing sufficient flexibility to adapt to local circumstances, including the use of other labels, such as healthy cities, where appropriate locally.

Those interviewed did, however, see an important role for central government. This encompassed a range of tasks, from ensuring that the appropriate structures were in place and that national policies were consistent with the strategy to developing appropriate support tools and ensuring that the strategy was effectively disseminated.

In terms of structures, there is still uncertainty about where responsibility for health strategies should lie, with some questioning why responsibility should necessarily rest with the NHS given that most of the determinants of health are outside its control. In the absence of a resolution of this issue that will satisfy everyone, it is important that the government clearly defines the respective roles of the NHS and local authorities. Some interviewees called for a statutory framework, which clearly relates to the proposal in the Green Paper[8] for a 'duty of partnership', but this concept needs to be developed further.

A related question is where the public health function should sit, particularly in the context of *The new NHS* and the development of Primary Care Groups (PCGs), in which consortia of general practitioners will assume many of the existing responsibilities of health authorities. There was some support for the proposal that directors of public health be appointed jointly to local government and health authorities. The report of emerging findings of the Chief Medical Officer's project to strengthen the public health function in England rejects the need for organisational and structural change at this time.[11] However, given the huge changes that may take place in the organisation of the NHS over the next 10 years, it will be important to keep this under review. *The new NHS* White Paper also proposes fewer and larger health authorities, which creates challenges as interviewees stressed the importance of co-terminosity and not having to relate to a large number of local authorities.

In the same context, it is clearly a challenge to sustain momentum of a strategy that has to continue to produce results for 10–20 years in the 'short-termist' climate which besets the NHS.[21] The NHS has been subject to large-scale organisational changes in the past 10 years and will continue to experience such changes in the coming years, as will other agencies vital to the strategy's implementation. In this context, a new strategy must be flexible enough to adapt to these changes and to regularly renew itself to maintain its relevance.

A second area where central government should be involved is the development of resources to support the strategy. There are clear economies of scale if many of these are developed nationally and again, the evaluation has some lessons for the future. The most important is the need to address different audiences who often use different languages: the NHS; local government; the voluntary sector; the public; and the private sector. One possible solution is to base the strategy on a matrix that makes explicit the inter-relationships between issues, settings, and population groups, an example being that used by the European Union health promotion programme.[22] In addition, the strategy must be marketed in ways that allow different audiences to relate to it, with documents appropriate to each audience.

Once developed, a key issue for a new strategy is communication. Too often ownership of HOTN was limited to public health departments within health authorities. Given the intersectoral philosophy underlying HOTN, it was noteworthy that there was little involvement of the public at either national or local levels. A new strategy should be communicated to the public in an exciting and imaginative way.

Health authorities found it particularly difficult to involve the private sector in partnerships. Some businesses are willing to become involved but they want to know what specific actions that they can take and what the benefits might be for their own work. Effective commun-

Table 8 Expenditure on health promotion and prevention: Mean real spend *per capita* (£)

Year	Narrow	Individual	Broad
1991/92	3.06	4.46	7.51
1992/93	3.14	4.41	7.57
1993/94	2.87	4.66	7.67
1994/95	3.36	4.80	8.28
1995/96	3.14	4.70	7.90
1996/97	3.12	4.30	7.48

Constant 1991/1992 prices (HCHS Pay & Prices Index).
Narrow: expenditure by trusts, HAs, and in GMS budgets designated as health promotion;
individual: expenditure on family planning and cancer screening;
broad: narrow plus individual.

ication is important, with relevant material that shows awareness of what partners' core business is.

Another group that must be better involved is general practitioners, especially in view of their increasing commissioning role in, for example, PCGs. It is likely that this will be problematic because of the time that will be required, but there is a case for the creation of PCGs being conditional on their ownership and involvement in local health strategies (via the newly created Health Improvement Programmes in which Health Authorities develop local intersectoral strategies).

The evaluation had several important implications for the monitoring of a new strategy. The new strategy should be embedded firmly in the work of government departments and local agencies which must implement it. As a minimum, it needs to be seen to be high on the agenda of the Department of Health and the NHS through incorporation in the performance management framework, with health authority chief executives and other senior managers being judged on their performance in implementing Saving lives, as well as on their ability to manage waiting lists. Unfortunately, the consultation document on a national framework for assessing performance[11] only includes the monitoring of health improvement as assessed by standardised mortality ratios, although the Green Paper on public health[8] makes reference to the monitoring of 'local processes' (p. 83). A barrier to effective monitoring of the new strategy is the weakness in current financial reporting mechanisms. The absence of any requirement to monitor spending on HOTN development made it impossible compare the resources invested in the implementation of the strategy.

A key lesson from HOTN is that, if implementation of the new strategy is to remain a priority, the resources connected with it must be identified, isolated and monitored (regardless of their source) *from the outset*. This may not necessarily require a general programme budgeting framework to be developed for the whole NHS but it does require a local, comprehensive budget to be established for Saving lives, incorporating all the resources (especially human) closely involved in strategy implementation and delivery. The importance of intersectoral working across multiple settings also raises the question of whether such a new programme budgeting system should be developed for the NHS alone, or whether a form of 'matrix' programme budgeting, cutting across agencies, functions and settings is required.

A related issue is that of ring-fenced funding. Its absence from HOTN seems to have sent an implicit message about the priority attached to the strategy, and the absence of active monitoring of local expenditure on implementation lowered its priority in the eyes of local NHS decision-makers.

There are several key questions for the new strategy. Will there be new funds from central government? If so, are they to be ring-fenced? Ring-fencing tends not to be popular at local level, and does not sit comfortably with locally-led decision-making, but it does appear to have ensured the survival of some population-based health promotion activity in health authorities who had greatly reduced local funding for these activities. Are these funds for strategy implementation or for 'service delivery'? Successful strategy implementation may well require greater funds for essentially 'managerial' activities. Does the strategy seek to increase activity and funds for 'health promotion' activities by shifting local resources, or is the current balance of resources acceptable? HOTN did not explicitly seek to alter the 'preventive'/'curative' balance in the NHS and – not surprisingly – it does not seem to have had any such long-term effect.

Some of these lessons have been incorporated into the new strategy.[23] For example, proposals to strengthen research and development in public health via a new Health Development Agency, which will replace the existing Health Education Authority, addresses the need to provide an evidence base for the new strategy by producing guidelines for health programmes and evaluating and disseminating research on public health. However, the priority areas (coronary heart disease and stroke; cancer; mental health; and accidents) and the targets remain primarily disease-based; and the lead role for implementing the strategy remains with the NHS. The strategy will be monitored through separate performance assessments for the NHS and local government but leaves open the question of how joint monitoring is to be undertaken.

Clearly, the specific findings of this study relate to England (Scotland, Wales and Northern Ireland have their own strategies) but we believe that the methods used, involving a combination of qualitative and quantitative methods and the use of process measures such as trends in expenditure, in the absence of changes in health outcomes that could reliably be attributed to the strategy, offer a model that can be used elsewhere. Furthermore, the issues raised, such as communication of the strategy, scope for monitoring activity, the role of ring fenced funding, and the use of a model that incorporates different approaches to prevention provide the basis of a checklist that could be used elsewhere.

The development of strategies for health and setting targets is increasing in Europe.[24] England, with Finland,[25] is a pioneer in Europe in developing health strategy. Many country's followed England's example of a mainly disease and risk factor-based strategy, although more recent strategies have also included population groups such as the disadvantaged (Italy[26]), school children (Luxembourg[14]) and older people (Portugal[15]). Ireland[27] has a matrix strategy structured around population groups, lifestyles and diseases. In general, though, a disease-based strongly led from the Health Ministry dominates.

The lessons learnt from the evaluation of HOTN, both as a means of evaluation and from the findings, will be applicable beyond England.

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