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PUBLIC HEALTH IN SCOTLAND

This SPICe briefing provides an overview of the subject of Public Health and aims to provide an introduction to some of the issues present in Scotland. It is divided into two parts. The first examines the health of the people of Scotland through an analysis of epidemiology. The second relates to the public health function and infrastructure.

WHAT IS PUBLIC HEALTH?

Public Health has been defined as:

“The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.”¹

This definition demonstrates that Public Health goes beyond the efforts of medical practitioners and health services. If Public Health is considered as “the control of factors harmful to health”² the term can encompass just about any social reforms or initiatives which would facilitate that aim.

¹ The Acheson Committee Report (1988) *Public Health in England: the Report of the Committee Inquiry into the Future Development of the Public Health Function* (CM 289) London, HMSO

² Warren MD (2000) *A Chronology of State Medicine, Public Health, Welfare and Related Services in Britain 1066-1999* London, Faculty of Public Health Medicine

THE ORIGINS OF PUBLIC HEALTH

Public Health means different things to different people and many still associate it with its early origins in communicable disease prevention, for example, the control of cholera in London in the 1840's through the regulation of the water supply. For many years, this characterised Public Health as it struggled to combat the major infectious diseases such as small pox, TB, scarlet fever and measles. However, over the last century, many of the major diseases have been eradicated and controlled, predominantly through vaccination programmes and improvements in hygiene and living conditions. As a result, the focus of Public Health has shifted to tackling the chronic lifestyle-associated conditions common to today's populations.

THE HEALTH OF SCOTTISH PEOPLE

Scotland has one of the poorest health records in Europe and has often been called 'the sick man of Europe'. This section will outline the main indicators of Scotland's health.

SCOTLAND'S HEALTH BY INTERNATIONAL COMPARISON

Figures 1 & 2 show the life expectancy of Scots in comparison to the rest of Europe. Scotland falls behind most of Western Europe, and Scottish people generally live 1 or 2 years less than their UK neighbours.

Figure 1: Male Life Expectancy at Birth (Years) by Selected Countries; 1996 (Source: WHO)

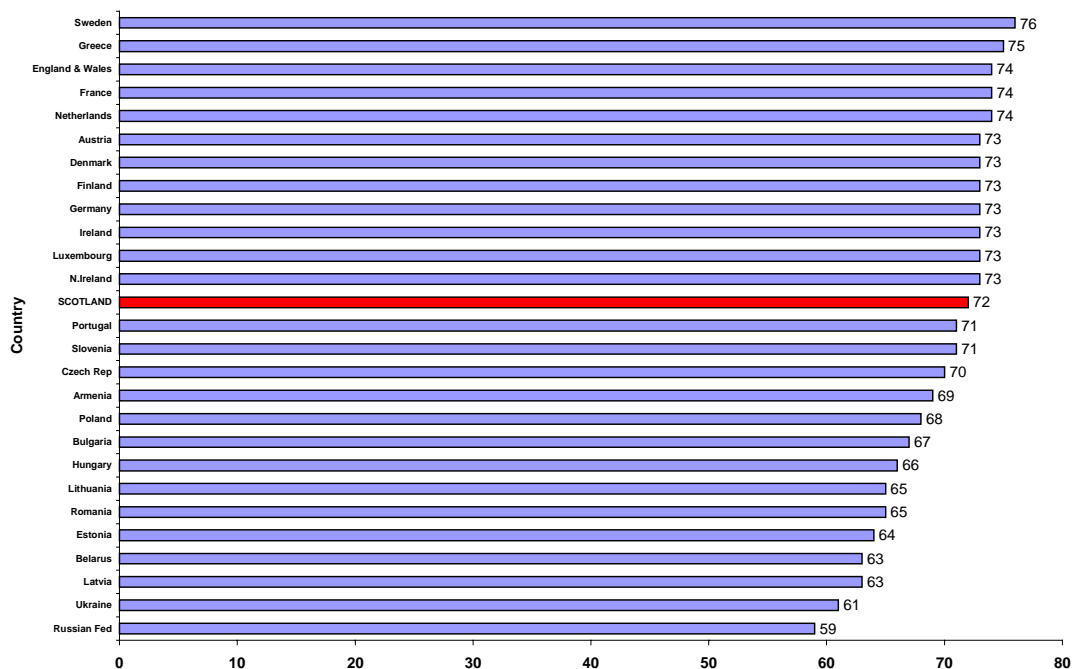
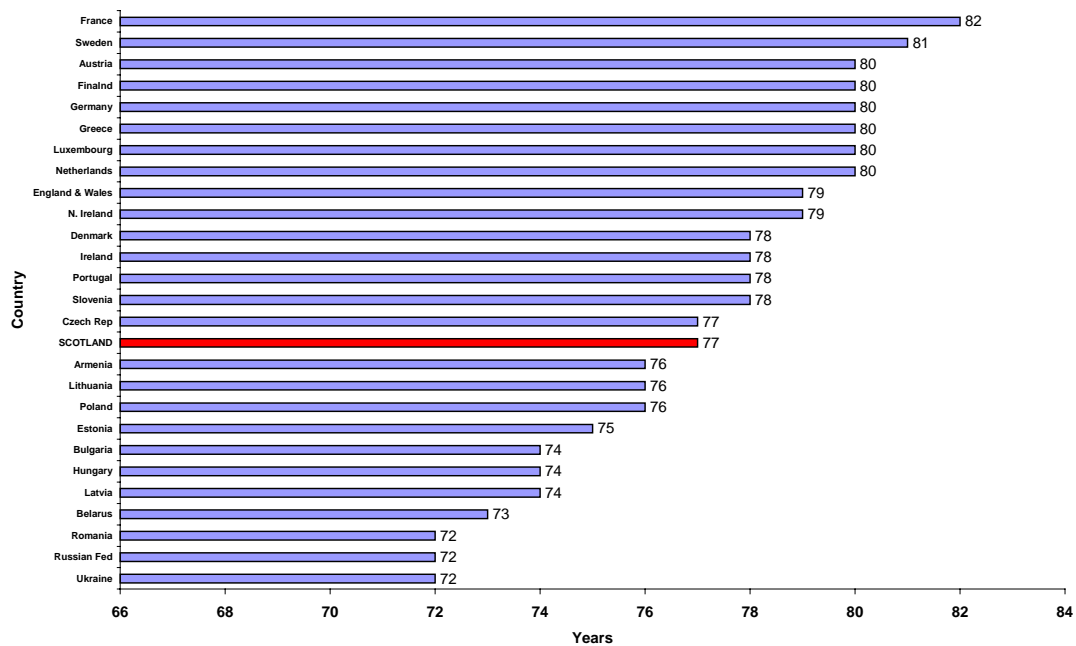
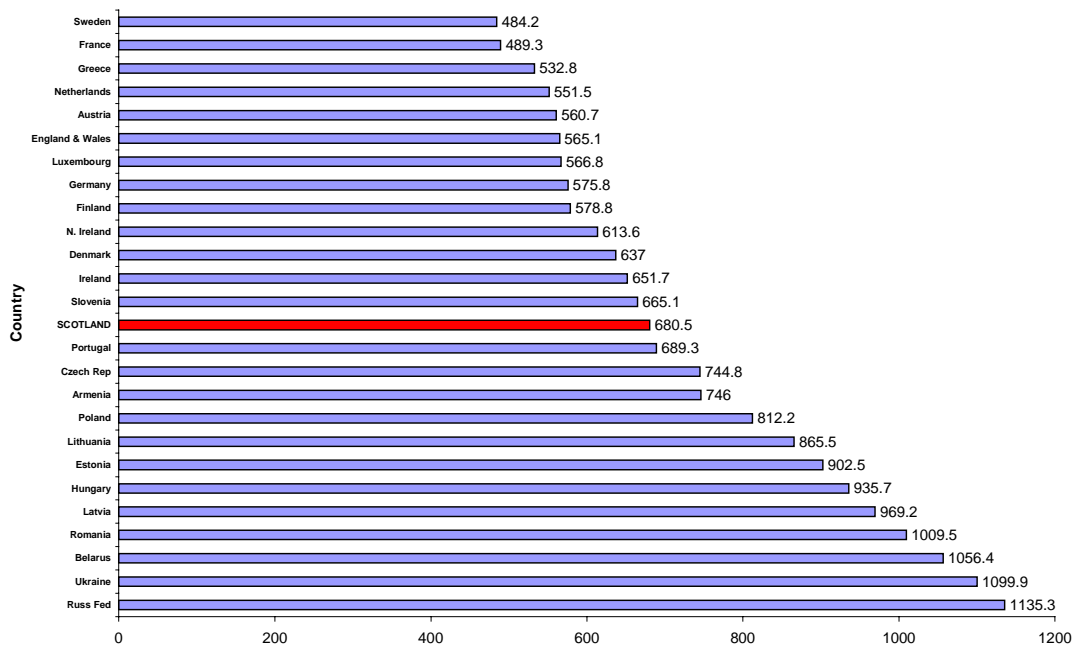


Figure 2: Female Life Expectancy (Years) at Birth by Selected Countries; 1996 (Source: WHO)



Analysis of the data shows that Scotland has higher mortality rates than the rest of the UK, including every region in England³. Figure 3 compares Scottish mortality rates with the rest of Europe.

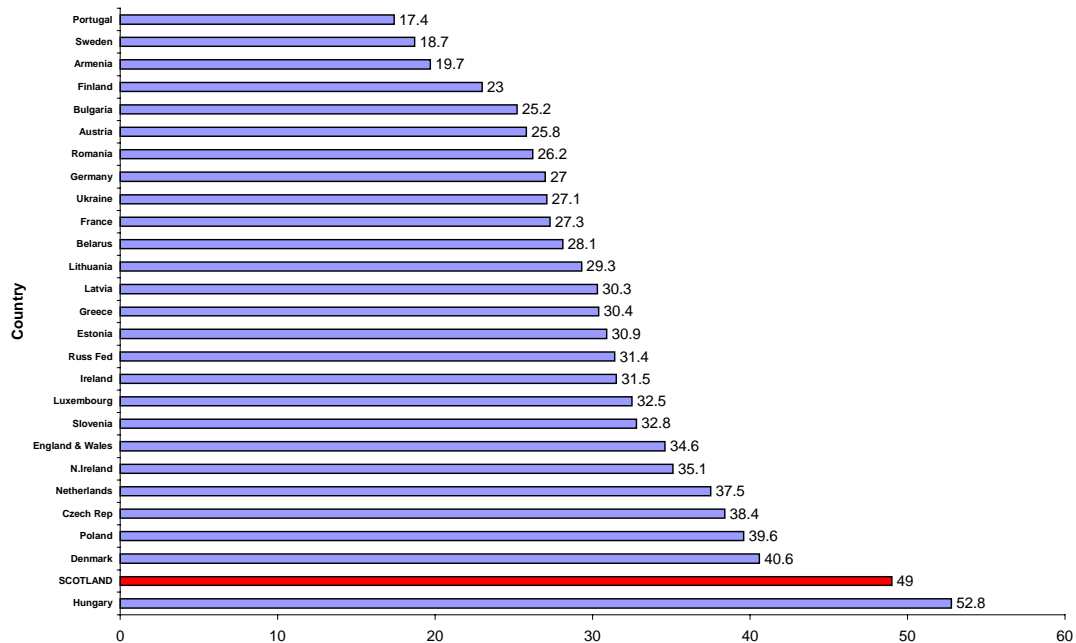
Figure 3: Age Standardised Death Rates (per 100,000 population) by Selected Countries: All Causes – 1996 (Source: WHO)



³ [Fitzpatrick J., Griffiths C., Kelleher M.\(2000\) "Geographic Inequalities in Mortality in the United Kingdom during the 1990s". ONS Health Statistics Quarterly 07, Autumn: pp 18-31.](#)

The major killers in Scotland are Cancer, Coronary Heart Disease (CHD) and Stroke. In relation to CHD and stroke, Scotland is positioned in the middle of the European league tables. However, when looking at comparisons for cancer and more specifically, lung cancer, Scotland drops almost to the bottom of the table.

Figure 4: Age-standardised Mortality Rates (per 100,000 population) by Selected Countries for Malignant Neoplasm of the Trachea, Bronchus & Lung



In 1999, 14,789 people in Scotland died from cancer, 16,505 people died from CHD and 6,785 people died after suffering a stroke. Other major causes of death in Scotland are respiratory disease, accidents and suicide ⁴.

INEQUALITIES IN HEALTH

One major theme frequently cited in relation to the health of the Scottish population, is the correlation between health and socio-economic status.

In 1980 a working group on inequalities in health set up by the UK Department of Health and Social Security published its report ⁵. This report, known as 'The Black Report' after the chairman of the group Sir Douglas Black, provided a detailed analysis of the relationship between mortality and morbidity, and social class. The main findings of the report were that:

- At every stage of life death rates are higher among people in lower socio-economic groups
- Children born in lower social groups had lower birth weights and a shorter stature
- Those in social groups 4 & 5 suffer disproportionately from all major diseases

⁴ [ISD Scotland \(2000\) Scottish Health Statistics 2000 Common Services Agency](#)

⁵ Townsend, P & Davidson N (1982) *Inequalities in Health: the Black Report* London, Penguin
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Almost 20 years after the labour government had appointed Douglas Black to chair the working group, the UK Department of Health appointed Sir Donald Acheson to lead an independent inquiry into health inequalities. The [Acheson Report](#) was published in 1998 and contained 39 wide ranging recommendations which emphasised the importance of socio-economic factors in determining inequalities in health.

The unequal distribution of morbidity and mortality in more deprived groups has also been evidenced in Scotland. In the 1980s, research found that the higher rates of mortality in Scotland compared to the rest of the UK could be attributed to Scotland's higher levels of deprivation⁶. A more recent analysis of data from the 1990s has shown that even when levels of deprivation are taken into account, every region of Scotland, bar Grampian, has higher levels of mortality than England & Wales⁷. This excess mortality which cannot be accounted for by deprivation alone has been termed 'the Scottish Effect'. Currently there is no definitive explanation to account for the 'Scottish Effect'.

MENTAL HEALTH

The World Health Organisation define health as

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

Taking into account this definition, Public Health should not just aim to improve the physical well-being of the population, but should also try to promote and protect the mental and social well-being of individuals.

Mental ill-health is a common cause of morbidity and mortality in Scotland. Suicide is one of the main causes of premature death, and has increased steadily in young men since the 1970s. Similarly, deliberate self-harm is one of the most common reasons for admission to hospital⁸.

Depression also has a high prevalence in Scotland and now accounts for a large proportion of GP consultations. Every year there are 300 mental health consultations for every 1000 patients on a GP's list⁹.

CHILDREN & YOUNG PEOPLE

Infant mortality in Scotland has dropped from around 1 in 10 at the beginning of the 20th century, to roughly 1 in every 200 births at present¹⁰.

⁶ Carstairs V & Morris, R. (1989) "Deprivation: explaining differences in mortality between Scotland and England & Wales" *British Medical Journal*, 299: 886-889

⁷ [Public Health Institute for Scotland \(2001\) 'Chasing the Scottish Effect'](#)

⁸ Scottish Executive Health Department (2001) National Framework for the Prevention of Suicide and Deliberate Self-Harm in Scotland: A Consultation Document

⁹ [Chief Medical Officer \(2001\) 'Health in Scotland 2000' The Stationery Office, Edinburgh](#)

¹⁰ [ISD Scotland \(2001\) Scottish Health Statistics 2000 Common Services Agency](#)

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Despite the decline in infant deaths, child health has become a focus of Scottish Executive policy as it is considered to be a major influence in determining a person's health in adulthood. This includes the pre-conception and ante-natal health of the mother, as well as immediate post-natal care.

Statistics show that 27% of women in Scotland were smokers at the start of their pregnancy, and just 35% of mothers were found to be breastfeeding their babies when they are 6 weeks old. This is the second lowest rate in Europe and both of these behaviours are strongly associated with deprivation¹¹.

The health of Scottish children is also characterised by a poor diet and lack of exercise. 8% of boys and 7% of girls are now classed as obese and levels of physical activity are low, particularly among young girls. There is also a tendency for activity levels to decline as children get older¹².

High levels of smoking, drinking and drug use have been recorded among older children in Scotland. A survey of nearly 5,000 Scottish 12-15yr olds found that 12% of this age group smoked (this figure rose to 19% among 15yr olds). Despite a decrease in prevalence among young boys, smoking levels in young girls has remained consistently around 13-14% over the last 4 years¹³.

The same survey also found that 21% of 12-15yr olds had had an alcoholic drink in the previous week. This also differed according to age, with 6% of 12yr olds drinking in the previous week, compared to 39% of 15yr olds. The survey showed that the proportion of drinkers in this age-group consuming spirits had increased from 46% in 1990 to 69% in 2000. There had also been an overall increase in the past 10 years in the amount of units consumed by this age group.

Similarly, 17% of the sample reported ever having used illegal drugs. Among 15 year olds, one third reported having used drugs at some point, with 22% having done so in the last month. Cannabis was the most commonly used drug.

Rates of teenage pregnancy in Scotland are among the highest in Europe. The current rate is around 9 per 1,000 girls, with higher rates evident in excluded communities. Similarly, levels of sexually transmitted infections among young people have been increasing in recent years. Since 1997/98, the number of 15-19yr olds attending Genito-Urinary Medicine (GUM) Units has increased by 9.9% for males and 9.1% for females¹⁴.

¹¹ [Chief Medical Officer \(2001\) *Health in Scotland 2000* The Stationery Office, Edinburgh](#)

¹² [Chief Medical Officer \(2001\) *Health in Scotland 2000* The Stationery Office, Edinburgh](#)

¹³ [The Scottish Executive \(2001\) *Smoking, Drinking & Drug Use Among Young People in Scotland in 2000* The Stationery Office](#)

¹⁴ [Information & Statistics Division \(2000\) 'Genitourinary Medicine Statistics Scotland: Year Ending 31st March 1999' Common Services Agency](#)

COMMUNICABLE DISEASES & ENVIRONMENTAL HEALTH

Immunisations and improvements in hygiene and living conditions have contributed to improved control of infectious diseases. Some diseases have been eradicated altogether (e.g. smallpox) but many still require high levels of vaccination and vigilance to assist continued control.

Childhood Infectious Diseases & Immunisations

Scotland has higher uptake rates of vaccinations against childhood illnesses than the rest of the UK¹⁵. A recent issue that has gained much media attention is the alleged link between the Measles, Mumps and Rubella vaccine (MMR) and the incidence of autism and bowel disease in children. More detailed information on this topic is contained in [SPICe Research Note 00-74](#)

A decrease in uptake of the vaccine may result in a rise in the incidence of measles, mumps and rubella. So far, there has been no reported increase in any of the diseases in question but the most recent data suggests a slight decrease in uptake of the vaccine¹⁶.

Tuberculosis (TB)

Despite reported increases of TB in parts of the UK, there has been no recorded increase of cases in Scotland. However, 400-500 cases occur every year, a small number of which are multi-drug resistant¹⁷.

Food-borne Illness

Gastro-intestinal disease from food-borne organisms is a significant cause of morbidity in Scotland. Scotland still has many more cases of E Coli 0157 than in England & Wales and, as figure 5 shows, the number of notifications of food poisoning have remained consistently high over the last 10 years.

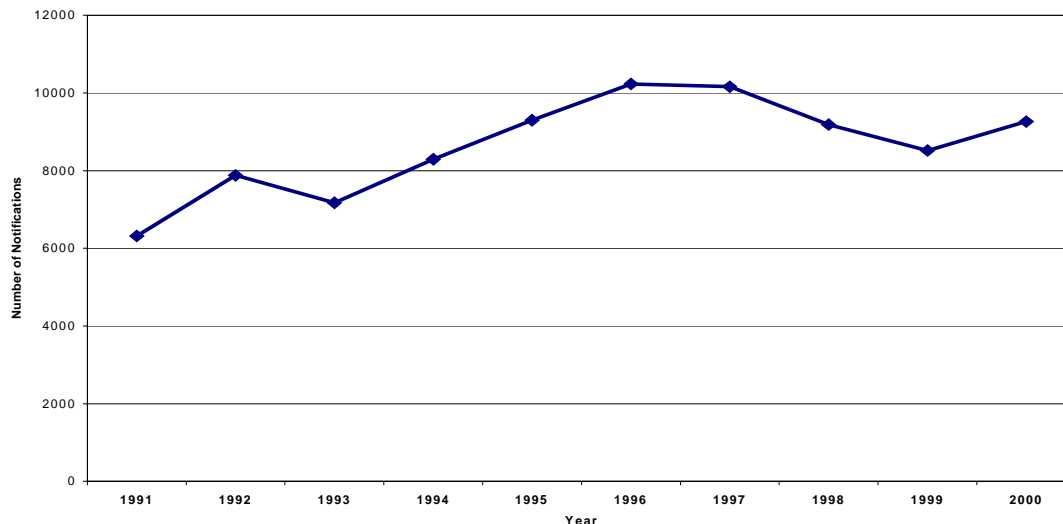
¹⁵ [Scottish Centre for Infection and Environmental Health](#)

¹⁶ [Scottish Centre for Infection and Environmental Health](#)

¹⁷ [Scottish Centre for Infection and Environmental Health](#)

Figure 5: Notifications of Food Poisoning in Scotland; 1991-2000¹⁸

Blood Borne Viruses



The term ‘blood borne virus’ is generally used to refer to the Human Immunodeficiency Virus (HIV), Hepatitis B & Hepatitis C.

In Scotland, HIV has historically been associated with injecting drug use, but recent epidemiology has shown that sexual intercourse has become the dominant mode of transmission. As of 31st September 2001, there were 3,312 diagnosed cases of HIV and 1,083 AIDS cases recorded in Scotland⁷.

The total number of people in Scotland known to have Hepatitis C is 10,929 (as of June 30th 2000) although the total prevalence is thought to be around 35,000¹⁹. In 1999, 386 cases of Hepatitis B were diagnosed. Most Hepatitis B & C infections are thought to have been acquired through unsafe injecting practices²⁰.

Sexually Transmitted Infections

One of the main issues of concern in Genitourinary Medicine is the number of people becoming infected with Chlamydia. Chlamydia is a bacterial infection easily treated with antibiotics, but it is usually symptomless. In Women, chronic infection may cause pelvic inflammatory disease and fertility problems. The majority of these infections occur in 15-24yr olds²¹.

Environmental Health

Environmental health is the branch of Public Health that protects against the effects of environmental hazards that may adversely affect human health. It is an area governed by much legislation, and therefore a lot of the work of environmental health professionals is concerned with monitoring potential hazards

¹⁸ [Scottish Centre for Infection and Environmental Health](#)

¹⁹ [Scottish Needs Assessment Programme \(2000\) Hepatitis C Office for Public Health in Scotland Glasgow](#)

²⁰ [Scottish Centre for Infection and Environmental Health](#)

²¹ [Information & Statistics Division \(2000\) ‘Genitourinary Medicine Statistics Scotland: Year Ending 31st March 1999’ Common Services Agency](#)

in order to ensure they fall within stated regulations (e.g. lead levels in water, air pollution).

Another aspect of environmental health is reacting to potential new hazards and their possible effect on human health. A recent example of this would be the controversy over the health effects of mobile phones and transmitters.

DENTAL HEALTH

Surveys have shown that the dental health of Scottish people is comparatively poor, although improvements have been made in recent years. In one survey ²² 55% of five year olds were shown to have experience of dental decay, with higher levels evident among social groups 4 & 5. Statistics also show that, dental health and frequency of check-ups, tends to decline with age²³.

A more recent survey²⁴ found that 18% of Scottish adults are missing all of their natural teeth. Despite this being the lowest level in the last 25 years, Scotland still falls behind the rest of the UK. Table 1 shows a more detailed analysis of trends in dental health since 1972.

Table 1. Adults in Scotland with no natural teeth by age group, gender and social class 1972-98²⁵

	1972 n=2717	1978 n=1420	1988 n=1542	1998 n=1204
Age Group	% of group			
16-24	2	2	1	1
25-34	13	10	2	0
35-44	35	27	7	4
45-54	54	54	33	13
55-64	78	64	48	33
65+	87	85	72	56
Gender				
Women	48	42	31	21
Men	39	35	22	14
Social class (head of household)				
I, II, III, IV, V	33	32	18	12
III, IV, V	41	38	29	20
IV, V	53	45	38	28
All	44	39	26	18

²² [Pitts NB, Nugent ZJ & Smith PA \(2001\) "Report of the 1999/2000 Survey of 5 Year Old Children" Scottish Health Board's Dental Epidemiological Programme](#)

²³ [Health Education Board for Scotland \(1997\) Health Education Population Survey](#)

²⁴ [Nuttall, N.M. \(2001\) 'Oral Health in Scotland: 1972-1998' Health Bulletin 59\(5\) September](#)

²⁵ [Nuttall, N.M. \(2001\) 'Oral Health in Scotland: 1972-1998' Health Bulletin 59\(5\) September](#)

THE DEVELOPMENT OF PUBLIC HEALTH IN SCOTLAND

Public Health became a medical speciality in 1871 when the General Medical Council introduced the first specialist diplomas in this area. Since then it has been closely associated with the medical profession.

In 1892, the Burgh Police (Scotland) Act required commissioners of Burghs to appoint a medical officer who should be a medical practitioner and holder of a specialist diploma in 'sanitary science, Public Health or state medicine', thus creating the first Medical Officer of Health (MOH) posts. The lead for Public Health was placed with local authorities and this remained the case for most of the 20th century.

When the NHS was formed in 1948, the first divisions began to emerge. Some of the responsibilities of Public Health went to the hospital boards (communicable disease control, immunisation) while others remained within the local authorities (provision of community and Public Health services).

Following the NHS (Scotland) Act 1972 and the Local Government (Scotland) Act 1973, many of those involved in Public Health were amalgamated into 'community medicine' within local authorities. At the same time, the 1972 Act appointed Designated Medical Officers to health boards and assigned them functions they would exercise on behalf of the local authorities.

From 1974 onwards, community medicine dwindled and in 1988 the Acheson Committee Inquiry²⁶ was launched to investigate the loss of skilled labour from community medicine. The inquiry was responsible for redefining Public Health and gave a focus to the wider determinants of health.

In 1988 a NHS circular asked each health board to establish a department of community medicine and designate a Chief Area Medical Officer (CAMO). Together with the CAMO, community medicine specialists were employed to provide medical advice on Public Health matters to local authorities.

As community medicine developed and became recognised as a medical speciality, CAMOs were afforded the additional title of Directors of Public Health, and the associated specialists became Consultants in Public Health Medicine. This is the structure that exists today²⁷.

PUBLIC HEALTH LEGISLATION

There is no overarching Public Health legislation, due to the all-encompassing nature of Public Health. The basic statute remains the Public Health (Scotland)

²⁶ The Acheson Committee Report (1988) *Public Health in England: The Report of the Committee Inquiry into the Future Development of the Public Health Function* (CM 289) London, HMSO

²⁷ [Scottish Executive Health Department \(1999\) *Review of the Public Health Function in Scotland*](#)
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Act 1897, which placed the lead for Public Health with local authorities and was based on the principle of 'protection from nuisances'.

Some parts of the 1897 act (which have not been superseded by subsequent legislation) remain unchanged. The following table outlines broad areas of Public Health functions, together with some examples of associated legislation.

Table 2: Areas of Public Health and Examples of Related Legislation²⁸

Area of Public Health	Associated Legislation
Control of the General Environment	<ul style="list-style-type: none"> • Air Quality Standards Regulations 1889 • Rivers (Prevention of Pollution) (Scotland) Act 1951 • Clean Air Act 1956 • Water (Scotland) Act 1980 • Litter Act 1983
Prevention & Mitigation of Disease	<ul style="list-style-type: none"> • Cleansing of Persons Act 1897 • Food & Drugs (Scotland) Act 1956 • National Health Service (Scotland) Act 1972 & 1978 • Health Services and Public Health (Scotland) Act 1968 • Animal Health Act 1981 • Food Standards Act 1999
Control of Infectious and Contagious Diseases	<ul style="list-style-type: none"> • Infectious Disease (Notification) Act 1889 • Public Health (Scotland) Act 1945 • Food & Drugs (Scotland) Act 1956 • Immigration Act 1971 • AIDS (Control) Act 1987
The Creation of Sanitary Conditions	<ul style="list-style-type: none"> • Sewerage (Scotland) Act 1968 • Health & Safety at Work etc Act 1974 • Civic Government (Scotland) Act 1982 • Local Government and Planning (Scotland) Act 1982 • Roads (Scotland) Act 1982
Regulation of Offensive & Dangerous Trades	<ul style="list-style-type: none"> • Slaughter of Animals (Scotland) Act 1980 • Petroleum (Consolidation) Act 1928 & 1936 • Health & Safety at Work etc Act 1974

²⁸ Law Society of Scotland (1988) *The Laws of Scotland - Stair Memorial Encyclopaedia* Edinburgh, Butterworths Vol 19

THEORY OF PUBLIC HEALTH

Public health is not merely about the prevention and control of diseases or NHS management. The determinants of health are complex and varied but may be divided into the following ²⁹:

Fixed – Genetic Disorders, Gender and Ageing

Social & Economic – Poverty, employment, education

Environmental – Air Quality, housing, water quality

Lifestyle – Diet, exercise, smoking

Access to Services – NHS, Social Services, Transport

The prevention of ill health also works on different levels:

- *Primary Prevention* - the prevention of a disease before it occurs;
- *Secondary Prevention* - the prevention of recurrences or exacerbation of a disease that already has been diagnosed; and
- *Tertiary Prevention* - the reduction in the amount of disability caused by a disease to achieve the highest level of function.

Secondary and tertiary prevention relate mainly to the provision of health care services, and although they are the areas which use up most of the health service resources, the policy focus in recent times has shifted towards primary prevention.

One model proposes that the promotion of Public Health can be achieved through 3 inter-related areas³⁰. These are:

1. Health Protection - deals with regulations and policies such as the implementation of a workplace smoking policy or the banning of tobacco advertising
2. Health Education - influencing behaviour on positive health grounds and seeks to help individuals, groups, or whole communities to develop positive health attributes
3. Prevention - focuses on services such as immunisations, cervical screenings and the use of nicotine-containing chewing gum to aid smoking cessation

The above areas overlap, but all are concerned with the prevention of ill health at the 3 different levels mentioned above.

THE PUBLIC HEALTH INFRASTRUCTURE IN SCOTLAND

The mechanisms of Public Health take place within a wide range of organisations, however the main bodies and people operating with an overarching Public Health remit are as follows:

²⁹ 'Our Healthier Nation: A Contract for Health' (1998) London, Stationery Office

³⁰ Downie, RS, Fyffe C & Tannahill A (1990) Health Promotion: Models and Values Oxford University Press
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Scottish Executive Health Department & the Chief Medical Officer

The Chief Medical Officer acts as the principal medical adviser to the Scottish Executive and is directly involved in the development of health policy in Scotland.

Public Health Institute for Scotland (PHIS)

[PHIS](#) was created in July 2000 in response to the Scottish Executive's '[Review of the Public Health Function](#)' and was tasked with providing leadership in Public Health in Scotland. The institute is a division of the Common Services Agency and its aims are:

- To protect and improve the health of the people of Scotland by working with the relevant agencies and organisations to increase our understanding of the determinates of health and ill health
- To help formulate Public Health policy
- To increase the effectiveness of the Public Health endeavour

The Health Education Board for Scotland (HEBS)

[HEBS](#) is a special Health Board within the NHS in Scotland and is the leading national body for health education.

NHS Boards & Public Health Departments

Since the publication of [Towards a Healthier Scotland](#), NHS Boards have been considered to be 'Public Health organisations', and as such are meant to provide the drive and impetus for improving the health of their local populations. [Our National Health: A Plan for Action, A Plan for Change](#) outlined that this should be achieved through the development of Local Health Plans.

Public Health departments usually comprise the Director of Public Health (also Chief Administrative Medical Officer), beneath whom there are Consultants in Public Health Medicine, Public Health Specialists and Consultants and Nurses in Communicable Disease Control and Environmental Health. The Director of Public Health, in his dual role as Chief Administrative Medical Officer is expected to produce an annual report outlining what he/she sees as the health needs of their local population. This report is meant to be independent of the NHS Board.

Public Health departments have many statutory functions and duties (e.g. communicable disease control). However, their main aims are to prevent disease and promote health by:

1. Giving independent medical and epidemiological advice to Health Boards
2. Working in partnership with key agencies.

1. Independent Medical and Epidemiological Advice

The role of the Public Health specialist can be likened to that of a general practitioner. For the Public Health specialist, their patient is the local population. They use epidemiology³¹ to assess local health needs in much the same way a GP would use signs and symptoms to reach a diagnosis. Similarly, they must recommend a 'treatment'. In Public Health, the treatment can take many forms, for example, screening programmes, breakfast clubs for schoolchildren or education programmes. Regardless of what the problem is, the 'treatment' should be based on the best available evidence of what has already been shown to be effective.

2. Working in Partnership with Key Agencies

The main idea of partnership working is to feed into the formation of policy and legislation with a view to getting the relevant people to consider the impact on the health of the population. This has become an increasing focus in recent years and has led to the development of what is called 'Health Impact Assessments'.

Health Impact Assessment

A Health Impact Assessment can be defined as:

“a combination of procedures or methods by which a proposed policy, program or project may be judged as to its potential effects on the health of a population and the distribution of those effects within a population.”³²

Health impact assessment is increasingly being recognised as an important Public Health tool. It recognises that almost every piece of social policy will have an impact on the health of a population, and aims to assess key policies in order to judge the potential health impact. In Scotland it has been used in areas such as the development of a local transport strategy³³.

Health Improvement Plans & Local Health Plans

Health Improvement Programmes previously represented the main vehicle for planning Public Health at a local level. In May 2001, the Scottish Executive issued guidance to NHS Chairs & Chief Executives on how to implement [Our National Health: A Plan for Action, A Plan for Change](#). One of the commitments set out in the document was that:

³¹ The study of the distribution and determinants of health related states and events in populations and the control of health problems – [Online Medical Dictionary](#)

³² World Health Organisation (1999) *Gothenburg Consensus Paper*

³³ Scottish Needs Assessment Programme (2000). *Health impact assessment of the City of Edinburgh council's urban transport strategy*. Glasgow: SNAP,.

“in each NHS Board area, the existing separate Health Improvement Programmes and NHS Trust Implementation Plans should be replaced by a single comprehensive document – a Local Health Plan.”

The Executive’s [Rebuilding Our National Health Service](#) outlined the new planning arrangements for health improvement. NHS Boards are now expected to work with local authorities and community planning partners to develop health improvement plans for each local authority area. These plans will also form a chapter in community plans.

Similarly, the NHS Board will be required to draw up a single local health plan which will include NHS action points taken from the health improvement plans, together with a joint version of what was formerly the health improvement programme and the trust implementation plan.

Health Promotion Departments

Health Promotion Departments are located within NHS Boards. There is a lot of overlap between the work of the Public Health departments and health promotion departments. Health Promotion Specialists hail from a variety of disciplines and much of their work is community based and carried out in partnership with key agencies.

Local Health Care Co-operatives & Public Health Practitioners

Local Health Care Co-operatives (LHCCs) came into being on April 1 1999. They consist of groups of GP practices and primary care professionals who are meant to work together to improve the provision of services and care for their local populations.

The Public Health Practitioner posts have been newly created as a result of the recommendations set out in the review of nurses’ contribution to the Public Health function in Scotland.³⁴ They are primarily responsible for taking a lead and co-ordinating Public Health issues within the LHCCs.

Public Health Intelligence

Epidemiology

The main bodies responsible for the collation of epidemiological information in Scotland are the [Scottish Centre for Infection and Environmental Health](#) (SCIEH) and the [Information and Statistics Division](#) (ISD). Both organisations are divisions of the Common Services Agency. SCIEH is responsible for the national surveillance of communicable diseases and environmental health hazards, while ISD collects data on health service activity, staffing and finance.

³⁴ [Scottish Executive Health Department \(2001\) *Nursing for Health: A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public’s Health in Scotland*, Edinburgh](#)
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Research Evidence Base

There are many national and international bodies who contribute to the research evidence base used in Public Health. One of the main functions of the recently developed [Public Health Institute for Scotland](#) is to consolidate and make available the evidence base of effective interventions and programmes for use in Public Health. The [Health Education Board for Scotland](#) also performs a role in expanding the evidence base.

THE POLICY CONTEXT IN SCOTLAND

Towards a Healthier Scotland

The 1999 white paper³⁵ set out the focus for improving Scotland's health across 3 areas:

- Life Circumstances (e.g. Employment, Housing and Education)
- Lifestyles (e.g. Smoking, Diet and Physical Activity)
- Health Topics (e.g. Cancer, Coronary Heart Disease and Mental Health)

An overarching aim across these areas was tackling inequalities. The priority areas of health identified in the paper were as follows:

- Child health
- Dental and oral health
- Sexual health including teenage pregnancies and sexually transmitted diseases
- Coronary heart disease and stroke
- Cancer
- Mental health
- Accidents and safety

The paper also announced the development of the 4 national demonstration projects; 'Starting Well', 'Healthy Respect', 'Heart of Scotland' & 'Cancer Challenge' and stressed the importance of joint working with local authorities. It also recommended that the Chief Medical Officer should undertake a review of the Public Health function in Scotland and that the Chief Nursing Officer should undertake a review of the contribution of nurses to Public Health in Scotland.

National Demonstration Projects

Following the commitment set out in [Towards a Healthier Scotland](#), the Scottish Executive pledged £15 million to support the establishment of these 4 [demonstration projects](#) over 3 years. The idea of the demonstration projects is to carry out innovative health promotion work in each of the identified areas. Each project will be independently evaluated and successful programmes will be extended to the rest of Scotland.

³⁵ [The Scottish Office \(1999\) Towards a Healthier Scotland](#) Edinburgh, The Stationery Office
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Heart of Scotland

This £6 million project is also known as 'Have a Heart Paisley' and is a community based project overseen by a multi-agency steering group. The aims of the project are:

- To change the lives and perceptions of every citizen of Paisley by impacting on life circumstances, lifestyle and specific cardiovascular issues
- To prevent heart disease from developing
- To delay the progression of existing heart disease
- To ensure access to appropriate care once symptoms of heart disease are present and to prevent them from getting worse

Healthy Respect

Healthy Respect was given £3 million and commenced in April 2001. The Lothian NHS Board oversees the organisation of the project and its main aim is:

- To promote positive sexual health and relationships, to reduce the level of teenage pregnancies and to prevent the spread of Sexually Transmitted Infections among young people in Lothian.

Starting Well

The Starting Well Project is based in Glasgow and was given £3 million to improve child health. The project is co-ordinated by the Glasgow Healthy City Partnership and has set up a variety of programmes aimed at supporting parents and families in two disadvantaged areas of Glasgow. The project was officially launched in November 2000.

Cancer Challenge

Cancer Challenge is a 2 year, £2.5 million initiative piloting a screening programme in the North East of Scotland for the detection of colorectal cancer (one of the most common causes of cancer deaths). It aims to study the public's willingness to become involved in screening and to determine how best to screen the general population. If successful, it will be developed into a national screening programme.

Review of the Public Health Function in Scotland

This remit of this review³⁶ conducted by the Chief Medical Officer was:

“to re-assess the role, relationships and locus of Public Health medicine and Public Health dentistry to ensure the optimal use of all available resources in the drive to safeguard and improve Scotland's health.”

³⁶ [Scottish Executive Health Department \(1999\) Review of the Public Health Function in Scotland](#)
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The review recommended that the locus of Public Health should remain within Health Boards, but that national leadership should be driven by the Public Health Institute for Scotland. It also outlined the potential for enhancing the role played by other professions allied to Public Health medicine and suggested enhancing the role of the designated medical officers within the local authorities.

Nursing for Health – A Review of the Contribution of Nurses, Midwives

This review³⁷ by the Chief Nursing Officer recognised the influential role nurses can, and do, play in Public Health. It also set out numerous recommendations to develop and enhance this role within the Public Health function. One of the main recommendations to emerge was the development of the new Public Health Practitioner Posts to co-ordinate and lead the Public Health agenda within Local Health Care Co-operatives.

ISSUES IN PUBLIC HEALTH TO CONSIDER

IS THERE A NEED FOR A NEW PUBLIC HEALTH ACT?

There have been no major pieces of new Public Health legislation since the Public Health (Scotland) Act 1897. The question of new legislation has been raised in England³⁸ whose main Public Health statute is almost 50 years older than Scotland's. In England there was suggestion that certain areas, such as communicable disease control and environmental health, may need some legal amendment³⁹.

SHOULD THE LOCUS OF PUBLIC HEALTH BE SHIFTED FROM THE NHS AND THE MEDICAL MODEL OF HEALTH?

One criticism of the Public Health function is that it is too closely related to NHS management and that issues such as the cost effectiveness of clinical services are prioritised over Public Health, due to these being the areas that NHS Boards and ministers will be judged on⁴⁰. Suggestions such as removing the Public Health function from the NHS and linking it to structures such as local government formed much of the focus of the inquiry into Public Health by the House of Common's Health Committee⁴¹ and the review of the Public Health function in Scotland.⁴² It was also suggested as a way of linking it more closely to the organisations that have an influence over the wider determinants of health.

³⁷ [Scottish Executive Health Department \(2001\) *Nursing for Health: A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health* NHS Scotland](#)

³⁸ [Calman K \(1998\) "The 1848 Public Health Act and its relevance to improving public health in England now" *British Medical Journal* 317: 596-598](#)

³⁹ [Aldersdale R \(1998\) "The Public Health Act 1848" *British Medical Journal* 317: 549-550](#)

⁴⁰ [Butler P "Public Health: the issue explained" *The Guardian* November 6 2001](#)

⁴¹ House of Common's Health Committee (2001) *Public Health: Second Report* London, The Stationery Office

⁴² [Scottish Executive Health Department \(1999\) *Review of the Public Health Function in Scotland* providing research and information services to the Scottish Parliament](#)

Similarly, the Public Health function has been criticised for being dominated by the medical profession to the exclusion of other relevant disciplines. Some say that the lack of career structure for non-medical staff deprives Public Health of much needed skills (e.g. Statisticians, Health Economists) and that the continued dominance by medics supports the prioritisation of NHS services over primary prevention⁴³.

SHOULD THERE BE A PUBLIC HEALTH MINISTER?

In 1999 Towards a Healthier Scotland identified all of the then six Scottish Office ministers as co-sponsors of the white paper. However, there has been criticism that commitment to health improvement varies across the Scottish Executive departments⁴⁴. A report by the Scottish Council Foundation in 1998⁴⁵, made a call for “not just better health policy but for ‘healthy public policy’ across the board”. After an audit of the Scottish Executive’s policies⁴⁶, they suggested that this could be achieved by the appointment of a Minister for Public Health who would work across all of the departments. The UK Department of Health created the post of Minister for Public Health in 1997.

Research Notes are compiled for the benefit of Members of Parliament and their personal staff. Authors are available to discuss the contents of these papers with Members and their staff but cannot advise members of the general public.

⁴³ McPherson K, Taylor S & Coyle E (2001) “For and Against: Public Health does not need to be led by doctors” *British Medical Journal* 322: 1593-1596

⁴⁴ Cook A (Ed) (2000) *Promise and Practice: Will Government Policy Improve Our Lives?* Scottish Council Foundation

⁴⁵ [Stewart S \(Ed\) \(1998\) *The Possible Scot: making healthy public policy* The Scottish Council Foundation](#)

⁴⁶ Cook A (Ed) (2000) *Promise and Practice: Will Government Policy Improve Our Lives?* Scottish Council Foundation