Healthier Scotland

The Journal

March 2012

Socialist Health Association Scotland

SHA Scotland is a campaigning organisation which promotes health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We believe that these objectives can best be achieved through collective rather than individual action. We campaign for an integrated healthcare system which reduces inequalities in health and is accountable to the communities it serves.

SHA Scotland members meet three times a year at Glasgow City Council Chambers. The next meeting is on 10 May starting at 7pm. Membership of the Socialist Health Association costs £25 p.a. and details of how to join are on our website www.shascotland.org

Other forthcoming events:

SHA Scotland & UNISON Scotland fringe meeting at Scottish Labour conference
Friday 2 March, Queens Hotel, Dundee at 5:30pm
Speakers: Jackie Baillie MSP & Dr David Conway

Health Inequality - Mental and Physical.
Saturday 5th May 11am - 4pm at Edinburgh Quaker Meeting House, 7 Victoria Terrace, EH1 2JL.
Speakers: Dr Lynne Friedli and Dr Gerry McCartney

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Healthier Scotland – The Journal

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Welcome

to the March 2012 edition of Healthier Scotland – The Journal.

The Socialist Health Association was founded in 1930 to campaign for a National Health Service. While we took pride in celebrating the 60th anniversary of the NHS in 2008, our main focus is looking forward. We campaign for improvements in the health services and in health – but particularly in tackling inequalities in health service access and in health outcomes. We consider Health as not confined to the medical definition of absence of disease or infirmity. Health is about physical and mental health and social well-being, happiness, and about being able to live a full and fulfilling life. We believe Inequalities in Health are those differences determined by wealth, power, and prestige - or rather a lack of these.

Health inequalities are observed for just about all aspects of health. And they are most starkly demonstrated by life expectancy data. In Glasgow alone we can still see differences in life expectancy as extreme as 54 years in those from the poorest communities compared to 82 years in the richest – a near 30 year difference. Globally, rich countries average around 80 years – while the poorest countries (particularly in sub-Saharan Africa) hover between 30 and 40 years.

Healthier Scotland: the Journal is part of our attempt to take the health debate in Scotland forward. We welcome the level of political consensus in Scotland around health that means we avoid the ideological dogma that is undermining the NHS in England. However, we have huge health challenges to address and that requires new thinking on how to address them.

We have a wide range of contributions in this edition of *Healthier Scotland* that address several aspects of this debate. We are grateful to the contributors for their time and effort.

From our economic policies, to our environmental policy - we need to develop them by looking through an equality and fairness lens. Inequalities manifest themselves greatest in terms of inequalities in health and wellbeing. Not only our health policy, but all initiatives need to consider the impact of health inequalities, and focus on tackling them as a priority outcome.

Dr David Conway – Chair

Dave Watson – Secretary & Editor

The Future of Health Policy

Jackie Baillie MSP sets out a direction for future health policy.

It has almost become a cliché to say that the NHS should be a truly National Health Service rather than a National Sickness Service but the need to match rhetoric with reality is gaining more urgency with every day. The NHS is a massive success story and remains one of Labour's finest achievements, made possible through the work and dedication of thousands of its' staff. We should never shy away from saying so but neither should we cling to the view that excellent health policy is just about providing excellent treatment.

Scotland's unenviable record on public health and persistent health inequalities remain a reality and tackling this should always be a central part of Labour's health policy, as it was with our successful focus on the big three killers of cancer, heart disease and stroke by the previous Labour-led Scottish Executive. But as people are living longer, Scotland's population is getting older. We are thankful for the advances that have contributed to that trend, but it also creates a different set of challenges for us.

Nowhere is the need for change more urgent than in the field of social care. With the number of over-75s set to rise by a staggering 83 per cent within the next two decades, we desperately need to move away from sound-bites and find practical ways of addressing the dichotomy between health and social care.

This is not to say that all our older people need care. About 90 per cent of them are sustained in their own homes and communities, with very limited input from care services. We should therefore think about older people in the context not only of their care but of the contribution that they make to our communities, through their experience, time and knowledge. Many of them are the volunteers who make our communities strong, but they need to know that, should the time come when they need care, it will be there for them.

This is nothing new. Scottish Labour put in place the Joint Futures exercise more than a decade ago because we recognised that older people were falling through the gaps between health and social care. They were ending up in emergency care unnecessarily, often because of a lack of integrated care on the ground. We have seen a postcode lottery of care, costs shunted between different public organisations, differential charging and an emerging lack of fairness and equity, while the minds of the SNP Government were on other things. Once again it fell to Scottish Labour, now from opposition, to take the initiative by setting up an expert group chaired by Sir John Arbuthnott and drawing in members with expertise in health and adult social care.

Its' report called for a national framework, ending the postcode lottery of care and delivering better quality and better outcomes for older people. You might be forgiven for thinking that that is all remarkably similar to the SNP proposals, published just before Christmas, despite them rubbishing this approach during the election campaign only a few months previously. They do say that imitation is the sincerest form of flattery, but we would have gone further because our vision was for a national care service as radical as the creation of the NHS, bringing fairness and raising standards in the provision of care. The SNP have tried to square this circle by arguing we were creating another quango or bureaucratic monolith, but that deliberately misunderstands

the proposal. There would be no new body and no more civil servants; it would be about having national care standards for services that are delivered locally, which is a model that is currently used in the health service. But we did argue there needs to one budget in order to stop health and local government playing pass the parcel with people's care.

That particular debate will continue but preventing older people from requiring care in the first place is of course the real prize. Even though we know that prevention is cost effective, and that it is much better for the individual to be sustained in their own homes and community without the need for more formal care, we also know that local government is being forced to shoulder a breath-taking 89% of the SNP's budget cuts. Some community-based services that may not cost a lot of money, but have such a huge impact on the potential for long-term savings, are at risk. It is a matter of huge regret that such early intervention work and upstream activity, which is key to prevention, remains an aspiration rather than a reality. Successful health policy is dependent on high quality social care. We cannot afford to keep viewing these in isolation. Even in the frustrating position of opposition, Labour will continue to lead this debate because, quite simply, it is too important for us to fail.

Jackie Baillie MSP is the Shadow Cabinet Secretary for Health

Minimum price for alcohol?

Dave Watson looks at the Alcohol (Minimum Pricing) Bill

The Alcohol (Minimum Pricing) Bill is being considered by the Scottish Parliament's Health Committee. The Bill seeks to introduce a price at which a unit of alcohol cannot be sold below. The aim being to reduce alcohol consumption and related harms. The minimum price is not specified in the Bill, but a study undertaken for the Scottish Government indicates that 45p per unit is the likely initial figure.

The rationale behind the Bill is that price is linked to consumption, and that consumption is linked to alcohol related harms. The affordability of alcohol has increased over the years and so too have levels of alcohol consumption. Research appears to indicate that increasing the price of the cheaper brands prevents drinkers 'trading down' to maintain overall consumption levels. At 45p per unit, population consumption is projected to reduce by 4.3% with consequent beneficial effects for alcohol related harms. Recent research from Canada, where they operate a version of minimum pricing, has found that a 10% increase in minimum prices led to a 3.4% reduction in alcohol consumption.

SHA Scotland broadly supports minimum pricing. While we recognise that this measure on its own is not going to resolve the problem of alcohol misuse, some action is desperately needed.

Alcohol misuse has a significant impact on Scottish public services. There are more than 42,000 hospital discharges due to alcohol related illness and injury. Mortality as a direct result of alcohol has more than doubled since the early 1990s. Research has estimated that alcohol is a contributory factor in 1 in 20 deaths in Scotland with a quarter of male deaths and a fifth of female deaths in the 35 to 44 year old age group being alcohol attributable.

Scotland has one of the fastest growing rates of chronic liver disease and cirrhosis in the world, leading the Chief Medical Officer to add alcoholic liver disease to the list of 'big killers' alongside heart disease, stroke and cancer. 49% of Scottish prisoners (including 76% of young offenders) said they were drunk at the time of their offence and two-thirds of those accused of homicide (and whose drug status was known) were either drunk or on drink and drugs at the time of their offence.

Alcohol misuse costs Scotland an estimated £3.56bn per annum. This includes £267.8m on health costs, £727.1m on crime costs and £865.7m on lost productivity. Scottish consumption of alcohol is now 23% higher than in England.

Evidence to the Health Committee has raised a number of issues. These included:

- Unfairly penalising the majority of moderate drinkers.
- Heavy drinkers tend to be less responsive to price.
- A regressive policy as it will disproportionately affect low income groups who tend to pay less for a unit of alcohol than higher income groups.
- Some dispute the link between price and harm arguing that alcohol related harms have been decreasing at a time when consumption has remained stable.
- A detrimental impact on Scotland's alcohol industry including a 14.5% reduction in whisky exports and an increase in cross-border trade and the consumption of illicit alternatives.
- Concern that if alcohol prices increase, problem drinkers with a low income may use spending from elsewhere in their budget to maintain their consumption levels to the detriment of families.
- The compatibility of the measure with EU law has been questioned and a legal challenge seems likely. The price per unit will be important as the Government's defence will be that this is proportionate response to a public health problem.

For SHA Scotland the impact on reducing health inequalities by reducing the harm caused by alcohol is a key issue. People living in our poorer communities carry a disproportionate share of alcohol-related health and social harm. Alcohol mortality rates are six times higher in the most deprived areas.

We recognise that taxation could achieve the same benefits, with the added advantage that revenue would go to the state rather than the retailers. However, excise duty is a reserved power and there are no indications that the UK Government is prepared to act. A compensatory levy, similar to the recent 'Tesco Tax', could cover this point.

SHA Scotland believes that the primary concern should be to introduce alcohol policies which are in the public health interest and will be effective in reducing the high levels of alcohol health and social harm in Scotland. Minimum unit pricing is supported by the medical and public health community and also by the police, children's charities and a wide section of civil society. Opposition to minimum pricing comes mainly from sections (but not all) of the alcohol industry who, it could be argued, have a commercial vested interest in opposing measures which are likely to bring about a reduction in overall alcohol consumption.

We recognise that there are legitimate concerns over the effectiveness of the measure together with unintended consequences as well as doubts over its legality. Many of these could be addressed through a detailed statutory evaluation process and even a sunset clause. We would urge this approach on all MSPs.

Dave Watson is the Secretary of Socialist Health Association Scotland

Low pay is bad for your health

Eddie Follan looks at the living wage and health inequalities

It's 32 years, since the Black Report so starkly set out the gap in the life chances of men and women in Britain. The report showed that those in partly skilled or unskilled occupations were over twice as likely to die before retirement as those in professional occupations. Black was clear; poorer people die younger. Low paid work locks people into poverty and with it the increased chance of life limiting illness and decreased mortality. In effect, low pay is bad for you!

There are of course present day political, social and economic parallels with 1980's when the report was published. A government pushing through punishing welfare reforms, support for a culture of blaming and stigmatising the poor and the sick, downward pressure on wages and rising unemployment. Yes there have been changes in the labour market but this only means that there is an overreliance on service sector jobs which only serves to perpetuate high levels of low pay.

In Scotland today round 550,000 workers in Scotland are paid less than the Scottish Living Wage of £7.20. The majority of these workers are women, working in the private sector in retail and hospitality in what Black would have called partly skilled or unskilled occupations. The living wage is set at a level based on the minimum income standard (MIS). The MIS defines the minimum income need by a family or individual to ensure an acceptable standard of living.

In Scotland the Scottish Living Wage Campaign and its supporters have had partial success in persuading the Scottish Government to adopt the living wage in the public sector. As a result NHS Scotland and Scottish Government agencies pay the living wage. In addition a number of local authorities have negotiated living wage deals with trade unions. The lead taken by the public sector is important if private sector employers in Scotland are to be persuaded of the business case for the living wage.

It is this business case that demonstrates that raising the pay of those at the bottom of the pay scale can have significant benefits not only to the employer but to the individual workers themselves. Living wage employers report increased staff morale, lower staff turnover, lower sickness rates and increased productivity. These increased wages tend to be spent locally benefiting the local economy and contributing to the overall health of the local community.

It is worth noting that the living wage campaign in London grew from the concern that many families were being put under intolerable pressure as parents took on two or three jobs just to make ends meet. This often meant that children were being left on their own. It's not hard to imagine the damage to the physical and emotional health of adults and children in a situation like this.

It is for these reasons that the Scottish Living Wage Campaign believes that no worker in Scotland should be paid less than the living wage. The lessons from the past and the inequalities highlighted 32 years ago are still pertinent today. The living wage may not be a panacea for poverty but it has an enormous contribution to make to help ensure that future generations are not subject to the health inequalities that are reinforced by low pay.

Eddie Follan is co-ordinator of the Scottish Living Wage Campaign. For more information see
http://povertyalliance.org/slw-home-detail.asp?ct_id=23

The health impact of climate change

Dr David Conway looks at the long term health impacts from climate change

The potential economic and health impacts of catastrophic climate change are beginning to emerge, and are already part of the environmental agenda. However, we need to shift the debate towards how environmental change will impact on socioeconomic inequalities and in turn health inequalities. The health, social, economic, environmental effects will manifest in widening inequalities and injustice both globally and locally. Like the cuts the poorest will bear the brunt.

Let there be no doubt about the evidence on climate change. The United Nations Intergovernmental Panel on Climate Change (the IPCC) provided compelling evidence on the effect of human release of greenhouse gases from burning fossil fuels and deforestation on global climate change. Human activity is accepted to be at best a major contributory factor and at worst entirely responsible. Humans in the West are particularly responsible. The WWF report that in the UK we are living 3 planet lives – that is: the ecological footprint of the UK is 3 times the size of our country. So we would need 3 planets to sustain us if everyone on the planet lived the way we do we would need 3 planets to sustain our current way of life. This is setting us up for environmental catastrophe with a heady combination of environmental damage, climate change, population growth and ageing, out of control capitalism, competition, conflict, poverty, income inequality, weak political leadership - a potent mix and recipe for disaster.

With rising global temperatures the effects on health will be both direct including rising skin cancer, and indirect through health effects mediated by economic and social breakdown. The impacts will be on the environment, the economy, people’s and communities’ health and well-being. Let us take these in turn.

The environmental impact includes Extreme weather patterns and the melting ice-cap, increasing flood disasters recently in Pakistan and Bangladesh. Declining crop yields, particularly in Africa – but also the South Asian rice crop. The globalised world economy and food supply makes us all vulnerable. It has been estimated that a failure of the rice crop in South East Asia could effect 2 billion people. And up to 40 % of the species on earth face extinction.

The socioeconomic impact (according to the Stern report) will include the evictions of millions from their homes – 200 million people permanently displaced and massive refugee movement and crises. Leading potentially to hunger conflicts and water wars. They will include premature death from heat, cold, or climate disasters, from changes in air and water quality, and from changes and increases in infectious disease patterns and disease. The World Health Organisation’s conservative estimates are of over 150,000 and rising lives are lost annually from the effects of climate change.

The effects of temperature are already being felt. The hottest summers on record are annual occurrence. In Europe a 2 week heat wave claims up to 45,000 extra deaths. In the summer of 2010 in Moscow, 11,000 additional deaths occurred in July and August as a result of sustained 40 degree heat, drought, and smog.

Returning to our NHS. The NHS emits 18 million tonnes of carbon a year and contributes one quarter of all public sector emissions. Recycling is low, packaging is excessive, and material waste is high. Large hospital buildings are energy inefficient in terms of heating and lighting. Pharmaceuticals have a huge carbon footprint – from manufacture, packaging, and waste.
What are we going to do about all this? Three profound observations which can stimulate our action:

1) If we act like there's no tomorrow – there's likely to be no tomorrow. We need to wake up.
2) Unsustainable systems are by definition unsustainable and could collapse. We need to adopt the principle of sustainability as our economic goal.
3) Of all these inequalities presented – a central injustice is consistent. Whether it is globally – Africa, or locally – our most deprived communities, those who contribute the lowest emissions of greenhouse gases will take the biggest hit from climate change.

Unless we change by embracing the TUC Just Transition agenda. Markets are failing us on this one - we need more state action and more people action. The Marmot Report on Tackling Health Inequalities sees a need to develop common policies to reduce the scale and impact of climate change and inequalities. To create healthy and sustainable places and communities – improving social capital and reducing isolation across society. We could prioritise policies which deliver on both health inequalities and are sustainable for the environment. These include integrating planning, transport, housing, environmental and health policies and delivery organisations. Improving active travel, provide good quality spaces and physical environments. Improve access to healthy, locally produced and sustainable, affordable food and improve energy efficiency in housing.

Let me end on a positive note - well at least an optimistic one. Our environmental failure and the changes we will have to make can genuinely improve our lives. It will be very different. The world is going to be very different. Our economy and health will need to change. Let us paint the picture of how it could look.

We will be less obsessed about economic growth as the "be all and end all" central purpose.
Economic growth does not correlate with health, well-being and happiness. It has bred overconsumption of stuff we don't need: the numbers overweight or obese in the world have just overtaken the numbers malnourished. We will value our local communities more, participate more, our relationship with food will be closer from production to plate – our diet will be intrinsically healthier. We will travel less, and be more active.

Our health service will also be different. It will be more energy efficient, in fact the estate will be a net-contributor. There will be less hospitals and more primary care. Less treatment and more prevention. Expensive intensive diagnostic tests and drugs with marginal benefits will be a thing of the past. Healthcare will be rationed but continue to be based on need. Our society, behaviours, and health have the opportunity to change for the better and our economy has the opportunity to develop an alternative central purpose.

Dr David Conway is the Chair of SHA Scotland and a public health specialist

NHS Scotland at 'leading edge' of industrial relations

John Gallacher looks at partnership working in NHS Scotland

Following a 2 year study of the NHS Scotland 'partnership' system of employee relations system, Nottingham University (Nicolas Bacon & Peter Samuel, 'Partnership in NHS Scotland 1999-2011') has just published its final report . The overall conclusion is that over ten years of time, effort and commitment the Scottish Government Health Department, NHS Employers and NHS trade unions at all levels, has benefited greatly the role and reputation of trade unions in health workplaces; has advantaged workers and union members in terms of the world of work; and has improved the service delivered to the patients served by NHS Scotland.

Bacon & Samuel state: "As the longest established and most extensive set of partnership arrangements in the British public sector, NHS Scotland provides a leading edge example of the extent to which innovative industrial relations arrangements may contribute towards improving public service delivery. In our view, partnership in NHS Scotland has matured into probably the most ambitious and important contemporary innovation in British public sector industrial relations. "

The key to these longstanding arrangement are that Governments (of all parties since Devolution) support partnership in order to achieve improvements in health services. NHS Employers support partnership working as it requires staff-side representatives to cooperate with initiatives to change and improve patient services within available finances. Partnership for NHS Trade Union representatives hinges on job security and involvement in policy development.
The partnership system requires continued investment, continued strengthening, continued support against a background where joint commitment needs to be maintained to :

- Build agreement and a joint commitment to future service plans if they diverge from the post-devolution consensus in which partnership is embedded in NHS Scotland.
- Develop appropriate workforce policies to help deliver improved health services
- Handle in Scotland negotiations on pay and related matters financial pressures may require some difficult negotiations and a reduced role for the UK Staff Council and Pay Review Bodies may lead to more collective bargaining in NHS Scotland.

Partnership working does not require NHS Trade Unions to leave their independent credentials at the doorstep, or to surrender traditional industrial responses where there is failure to agree on distributive relating to pay and other terms of employment, including pensions. Recent events have shown that the partnership model can survive major dispute, and the system allows for disputes to be managed and partnership around wider workforce and service delivery issues to be preserved.

This "*most ambitious and important contemporary innovation in British public sector industrial relations*" does face challenges at local and national level . Public sector reform and future integration of health and social care will produce an interesting test in comparative industrial relations systems pertaining in NHS Scotland and Scottish Local Government. Bacon & Samuel comment here:

"Integrating health and social care in the years ahead will bring together two very different sets of industrial relations arrangements. It is probably over-optimistic to assume partnership arrangements will simply transfer from the health service into local authorities given the traditional industrial relations climate typical of local authorities. On the other hand, it is probably over-pessimistic to assume that partnership in NHS Scotland will not diffuse into the work streams that will flow from integrating services."

Procurement and outsourcing of services to Third Sector employers is also a challenging landscape for partnership employee relations. For unions like UNISON, whose spheres of influence span all these major sectors, these will be interesting times.

John Gallacher is Scottish Organiser UNISON

Housing and Health

Murdo Mathison looks at the impact of health on housing and homelessness

The impact on health of homelessness or bad housing appears so obvious that it doesn't really need statistics to back it up. Surely somewhere warm, dry and safe is the basic requirement to allow someone to be and stay healthy. Ask any health professional about the impact on the patients they see every day; or ask someone trying to bring up a child in damp or overcrowded accommodation what the effect is and you'll get as moving and eloquent a case for why we need to address Scotland's housing crisis as the best piece of academic research could ever make.

But when you do look at the numbers and where we are the facts are truly staggering. According to research published in our 2006 report 'Chance of a Lifetime' bad housing, defined in the report as homelessness, overcrowding, poor conditions or unfitness, has an utterly devastating effect on children's health and life chances.

- Children living in bad housing were up to 25 per cent at higher risk of severe ill health and disability during childhood and early adulthood.
- Increased risk of meningitis, asthma and slow growth, which is linked to coronary heart disease.
- A greater chance of suffering mental health problems and problems with behaviour.
- Lower educational attainment, and a greater likelihood of unemployment and poverty.

More recently Shelter Scotland's 2010 survey into homelessness and bad housing found that in Scotland some 155,000 children lived in homes which had problems of condensation or damp, or both, putting these children at a higher risk of asthma and other respiratory problems. Those 155,000 children equate to the entire population of a city the size of Dundee.

Shelter Scotland and other campaigning groups are sometimes accused of hyperbole and overstating our case for effect. But it's difficult not to reach the conclusion that there is a real housing crisis in Scotland when you consider those numbers. The question then is how to address this? Well, there's certainly lots happening with many innovative ideas coming from the Scottish Government on housing ranging from the welcome additional money found for the affordable housing budget to reduce the size of the sector's cut to the somewhat less welcome recent consultation seeking views on proposals to take tenants' rights away from new tenants in

the social rented sector. The truth, however, is that what politicians in Scotland should do for a start is simply implement what they've already promised and legislated to do.

The end of this year will see every unintentionally homeless person be given the right to a home – the 2012 Commitment. But what purpose is served by a right in name alone? With an acute shortage of social rented housing exemplified by the over 156,000 households sitting on local authority waiting lists the right to a home needs to be more than an unmet promise. We need to see an increase in the funding for new homes for social and affordable rent well above the levels seen under successive Scottish Governments. That means prioritising housing above other big ticket items in the capital expenditure programme to provide jobs and a new start for people on housing waiting lists. It's not all about new homes though. We should be looking to use better the homes we already have by taking every step to encourage the owners of the 25,000 properties that have been sitting empty for more than six months to get them back into use, with people living in them and rent being paid.

But I started, by saying that people's own stories made the case most emphatically. I'll finish with what Ben, then aged 8, told Shelter Scotland about his home, 'It's horrible. It's got black stuff on the walls and bathroom and when my Mum paints it, it goes all black again.'

Murdo Mathison is Campaigns & Public Affairs Manager at Shelter Scotland
For more information or to contact Shelter Scotland ***www.shelter.org.uk***

Local Healthcare Provision in Norway – An Expression of Applied Democracy

Eberhard 'Paddy' Bort looks at how Norway organises its healthcare and some possible lessons for Scotland

The Scottish Local Government elections loom, but are we, apart from the big cities, actually electing any 'local' governments? Highland council has the size of Belgium, but the population of Belfast. Distances are huge. 'Local' may actually contravene against the trade description act. And yet, we are talking about further centralisation. Why 32 councils? Would not 15 suffice? Or even fewer? All in the name of efficiency and cost-cutting.

But there are other ways to organise local democracy. We only have to look beyond our borders. Let's take Norway – roughly the same population as Scotland – but with 434 municipalities. The average Scottish council serves 162,500 people; the average Norwegian municipality has 12,500 (Riddoch, 2010). Elected for a period of four years, are the foundation of Norwegian democracy.

For decades, the devolution of central powers to local governments aimed to focus as much as possible on the municipal level. The philosophy behind this was that decentralisation is an expression of applied democracy, that it brings decision-making closer to those who are affected and promotes popular participation in local political affairs. Moreover, it was believed that delegation of authority usually leads to simplification of administrative procedures (WHO, 2000).

Take health – the Ministry of Health and Care in Oslo (the national level) has overall responsibility for the health and wellbeing of Norway's citizens. Among the reserved matters are university education and research, for health and other registries, and for institutions like the National Institute of Public Health and the National Board of Health.

The hospital reform in 2002 meant a state takeover of ownership of hospitals – formerly owned, run and financed by the regional councils, which are still responsible for specialised outpatient care, and pharmacies – and the establishment of local and regional healthcare enterprises (Hagen and Kaarbøe, 2004). The stated purpose of the reform was to transfer power to govern the daily affairs of hospitals from local politicians to local managers and professional boards, while at the same time strengthening the capacities of the central government to establish principles for hospital governance in its capacities as owner of hospitals (Byrkjeflot, 2005).

The Norwegian public health service is mainly financed through contributions to the Norwegian National Insurance Scheme (NIS), generated through taxation and supported by state grants and some user charges. The funds allocated to the 19 regions of Norway are administered by regional councils; the municipalities have the ability to raise additional funds for primary healthcare by way of local taxes. They also collect a small amount of finance by way of user charges.

Initially, counties and municipalities received earmarked block grants for each type of service. From 1986 onwards, however, under the block grant scheme, municipalities were allowed to prioritise different types of services. By giving local authorities both the autonomy to set the level of service provision and the economic means to provide the services, the aim was that this decentralised model would provide a more efficient service provision and serve local needs better than a centralised model. That is why the Norwegian law leaves a large mandate for local health care services to take part in shaping the local social structure (WHO, 2000).

The Local Authority Health Care Act defines the responsibilities of the primary health care services and patient rights. All citizens have the right to satisfactory health care, accessible in their local community. At the regional level, there are five regional health authorities, responsible for universal and equal healthcare standards as set by the Ministry, and implemented by the regional councils.

The responsibility for primary healthcare is devolved to the municipalities. These cover health promotion, primary health care, care of the elderly, care of the handicapped and mentally handicapped, kindergarten and primary school education, social work (child protection and social protection), water, local culture, local planning, and local infrastructure.

Generally speaking, each municipality has three administrative departments: for medical care; nursing and home care; and social welfare. Many of the medical services are located in health centres, often including physicians in joint practice. The welfare service responsibilities of local authorities are so huge that some scholars suggest we should use the expression 'welfare municipality' rather than 'welfare state' (Overbye et al, 2006). Local authorities account for the lion's share of public expenditure and public employment in Norway's 'local welfare state' (Rose and Stålberg, 2005). This still holds true, despite some moves in recent years away from welfare localism to direct state involvement in governance of healthcare institutions (Overbye et al, 2006).

So, let's look beyond the local elections of May 2012 and, if needs be, beyond our borders, if we're short of inspiration. Scotland's 'local' government is anything but local. Decisions are taken far away from the citizens affected by them, and democratic participation is severely limited.

In the last local elections in Norway in September 2011, 10,7812 councillors and 787 county councillors were elected – Scotland has 1241. In Norway one out of 800 citizens is an elected member of local or regional government – in Scotland the ratio is 1 : 4,000. Norwegian local councils raise 40% of their revenue, Scottish councils 20% – and they are further curtailed in their power by the ongoing council tax freeze. Turnout in Norway was 63.6% - will we get more than 30% in May?

Empowered and truly local government would mean seeing citizens not as mere customers, but as actively shaping – and sharing ownership in – their local communities and local services. Let's be guided by the late Campbell Christie's demand that "reforms must aim to empower individuals and communities receiving public services by involving them in the design and delivery of the services they use."

Eberhard 'Paddy' Bort is the Academic Coordinator of the Institute of Governance and a Lecturer in Politics at the University of Edinburgh.

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Scotland in the midst of an obesity epidemic

Richard Simpson MSP looks at obesity in Scotland

There are three major public health issues facing us in Scotland today. Tobacco remains the most serious contributor to premature death. It is associated with one in four deaths. Moreover the skew in deaths to the less well-off reflects the differential in smoking levels from ten per cent in the highest socioeconomic group to forty three per cent in the lowest. The second problem is with alcohol. Though the reasons are complex, for the third time in the last two centuries we face a significant increase in consumption with the associated disruption to society as well as deaths from cirrhosis.

But it is the third epidemic which perhaps least understood is obesity.

With tobacco the cultural battle is being won, though there remains the continued need for vigilance, effective control and particularly the tackling of health inequalities. With alcohol, the 2005 Licensing Act appears to have arrested the upward trend in consumption which hopefully the more recent 2010 Alcohol Act will complement as long as a longer term strategy to address alcohol culture is carried through.

But the obesity epidemic threatens to reverse many of the health gains of the past forty years across much of the developed world. Obesity is the product of poor or even over nutrition in the maid coupled with inadequate physical activity. It used to be indicative of wealth but now it is more associated with poverty.

In Scotland over one in four adults are now obese and one in three is overweight, whereas in 1980, only one in 14 adults were obese. For children the patterns of weight gain over time are similar. Like tobacco, the problems of poor nutrition and lack of physical activity are part of our health inequalities. As with alcohol the first challenge is in getting everyone to recognise that there is a problem. Scotland not only consumes twenty three per cent more alcohol than England but a similar excess of sugary drinks.

Comprehending Body Mass Index (BMI) calculation is even less accessible than units of alcohol. Also like alcohol the labelling systems are either the unhelpful GDAs or the simplistic red amber green traffic light system. So how can we all begin to make rational decisions? The levels of misinformation and spin in advertising is grotesque: 'reduced fat', 'less than 3% fat', 'new improved' or even 'healthier'. Yet the public attitude is reflected in the culture of slim or even close to anorexic role models. It is reflected in the size of the diet products market.

The food industry has responded positively to pressure by removing industrial transfats from 80% of food. Some supermarkets make a virtue of declaring the absence of such transfats in their products. But too many fast foods still contain this most damaging form of saturated fat and are rich in salt and often also sweetened to enhance taste

Other countries have started to introduce controls. Voluntary self-control is also showing results in reduction in salt content, though we have still a long way to go. It is saturated fat and energy concentration that are the twin problems that need to be tackled. Some countries have tired of waiting for action from industry and are now taxing saturated fats and sugary drinks. Whilst the effect of these taxes is still playing out, there are some measures that should be adopted now - firstly a ban on industrial transfats, secondly all prepared foods, restaurants and fast food outlets should be encouraged to display both the calorie values and the fat content on menus. If this does not succeed legislation could be considered. Thirdly in schools, nutrition should be a compulsory part of the curriculum and the drive to improve school meals at all stages should be refreshed.

The free fruit and vegetables programme should be extended to encourage the next generation to develop a taste for healthier snack and in so doing narrow the gap with England in their consumption. The low levels of physical activity in and beyond schools must be addressed as a priority while advertising reaching children should be further restricted. Public sector institutions and work places should also be mandated to demonstrate best practice in both food and drink provision and encouraging physical activity. The burgeoning food cooperative self-help movement should be supported. Finally, evidenced based approaches to tackling obesity in children must be core funded and mainstreamed.

For tobacco it took over twenty years from Richard Doll's first research evidencing a link with cancer for the public attitude to change. The debate on our current wave of alcohol problems began around 2000 and may be changing attitudes. We must now tackle obesity, nutrition and physical activity if we are to make any headway in tackling health inequalities.

Dr Richard Simpson is Scottish Labour’s Public Health spokesman but writes here in a personal capacity.

The English Health Reforms: Prevention is better than Cure

Stephen Adshead tells us why we should be grateful for devolution.

Those of us who can still remember the last Conservative government will remember GP fundholder's, NHS quangos, inner city riots, the Falklands war, and the Queen's jubilee. Well the news down South is that even though the Falklands war, inner city riots and the Queen's jubilee are back on the cards, GP fundholding and NHS quangos are definitely not! Yes, were breaking new ground and introducing GP Commissioning Consortia and Health and Wellbeing Boards instead. Now I know what you're thinking, so I shall try and explain.

We knew before the election in May 2010 that the NHS was going to have to save £20 billion pounds from somewhere. The Labour plan was to do this through providing better services for less money. This sounds completely bizarre but in reality it means that by spending more on public health to prevent people from becoming unwell in the first place you end up having to spend less on expensive hospitals and treatments in the end. With this sort of strategy however much you spend on the NHS you should end up with a net gain for the taxpayer.

Now since the war there has been an unwritten alliance between the NHS and pharmaceutical suppliers whereby more and more expensive medication, is purchased for longer and longer term conditions, for older and older people. Via this mechanism the UK taxpayer has seen the NHS grow to the size of the Chinese red army, UK pharmaceuticals top the FTSE 100, UK universities build world leading animal laboratories and the UK public become fatter, lazier and more senile. Thus, the medical establishment did not like Labour's plan for preventative medicine but it absolutely detests Cameron's plan to stop the taxpayer funding their cabal.

When the Conservatives came to power they noted that Labour had put in place a regulatory mechanism that made an internal market and public health reform possible. The next move seemed simple. They agreed to devolve public health spending to local GPs, in order to satisfy the ambitions of their coalition partners, and privatise the internal market. In doing so they would stimulate the recovery, reduce the tax burden and come away with a healthy profit as fundholders. Surprisingly this has alienated every other private company in the UK. They just want their workforce to stay healthier for longer, thus yielding a greater return on their national insurance contributions; take away the national insurance and you take away the public incentive for prevention rather than cure.

Thus, through his continued support for privatisation Cameron has alienated his main supporters and united his foes against him. If the Bill fails, a vote of confidence will follow, if not this year then next, when Lansley is safely out of the picture. So it seems ironic now to look back to the 90's, to the tyranny of Thatcher, and remember that at least when she sold off our national industries we got the occasional boom out of them; all that we seem to get with Cameron is sicker and more and more bust!

Stephen Adshead is a mental health nurse and lecturer at University of Essex

NHS Scotland – the real challenges

Matt McLaughlin takes a look at NHS Scotland from the sharp end

There is no doubt, that on the face of it at least, NHS services across Scotland have benefited from significant capital and revenue investment since devolution.

New acute hospitals, the creation of centres of excellence and the multi million pound refurbishment of many hospitals has certainly given credibility to the political rhetoric that NHS spending is being protected. Add in the cost of GP contracts; consultant contracts and new pay systems for all other directly employed NHS staff and the top line figure is in fact quite impressive.

However the reality is something else. Yes, the new buildings exist and they are being fully utilised, but in doing so many 'local' hospitals have lost services (or are quietly losing services) as Health Boards try to get the balance right between fit for purpose buildings, transferring hard cash from the acute to primary care setting and meet the ongoing financial pressure of never having enough money to pay for the services you actually deliver at any point in time.

Of course the political answer (apart from the spin) has been to impose tougher targets around delivery of services, talk about the presumption being against closures and demand cash releasing efficiency savings, which are toped up here and there with specific money for specific projects which it is hoped will drive change. NHS Scotland remains mired at the same crossroads it has been stuck at for more than a decade.

It accepts (and indeed champions) the view that by investing heavily in communities we can prevent many of the diseases that blight our communities and cost the service significant sums of money. It accepts fully that institutional care for the elderly or people with disabilities is a thing of the past. However it acknowledges, in private at least, that it is concerned that despite raiding budgets, centralising services and reducing beds across the Acute sector to release money, which can be invested in communities that there seems to be little tangible progress in some areas and that the service now teeters on the brink of being able to do neither.

Whether it be Joint Futures , a new statutory agency (as proposed by Labour in 2011) or Health and Social Care Partnerships, politicians seem determined to get the rhetoric right without having to deal with the detail or the real time problems with this idea. Ask anyone on a street corner if it's a good idea for our NHS and Social Work professionals to be better connected and they will say yes. Ask them if they would be happy to see their local care of the elderly hospital closed to pay for 'better' community services and the answer is likely to be much less positive.

The reason for this is simple and goes back to the time when Scotland was 'mis-sold' care in the community. I say mis-sold, because the fundamental investment that was needed at that time was quite simply not made, with councils and others racing to the bottom of the cost ladder when they were commissioning services.

The much heralded paper on integration from the SNP Government fails to tackle the big issues and is at real risk of being yet another political fudge because it fails to deal with the institutional and professional tensions which have always poisoned the waters of this debate.

Looking forward Scotland NHS needs a fresh start based on honesty (with itself and with the public). It needs to be allowed to draw breath and consider the challenges as we move ahead. Utilities, medicine and even wages (all be it that they are frozen again this year) have a significant inflationary affect on the NHS. Whilst the service should not be allowed to opt out of the need for financial vigour, we do need to start making tough decisions if we are to continue to demand North European Health Care and North American taxation. On that basis the service needs a genuine stand still budget for one year to allow it the time to review progress and prepare for further (arguably more dramatic) change.

Centralisation has identified that our public services do not do joined up thinking, pulling more and more staff onto fewer and fewer 'mega sites' might help the pay bill, but it does nothing positive for worklife balance, carbon footprint or the communities who adjoin NHS sites and feel blighted by irresponsible parking.

If tackling inequality is key to our future good health, the NHS in Scotland needs to go beyond its current commitments and ensure that services provided either directly or with commissioning partners are provided under the auspices of a living wage. As the focus and energy moves even more towards care in the community we need to establish a sensible way to measure services and we need urgently to get past cheapest is a best attitude.

We should develop a greater understanding around unplanned admission and re admission rates. Are some communities admitted more readily to hospital? Does a quick readmission suggest that patients were released too quickly or inappropriately?

Of all of our great institutions our NHS is the only one which is truly ours. It is time that we as a society started to shape and define the service we want for the future.

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Coronary Heart disease

Janet McKay argues for disease prevention and targeted intervention to tackle heart disease

Coronary Heart Disease (CHD) is a leading cause of death across the world, with Scottish CHD mortality amongst the highest in Western Europe[i].This preventable disease killed over 8,000 people in Scotland in 2010[ii]. Significant attention has been paid over recent decades to reducing mortality and morbidity from CHD and this has led to a reduction in deaths of around 40 per cent over the last ten years[iii]

A number of factors increase the risk of heart disease, including smoking, family history of heart disease, diabetes, ethnic background, high blood pressure, high cholesterol, age, physical inactivity and being overweight. However increasingly, the focus has shifted to include deprivation as a significant risk factor for CHD. Recent data suggests that there is a strong positive relationship between deprivation and CHD mortality rates. Individuals, under 65 years of age, who live in the most deprived areas are 4.5 times more likely to die of CHD compared to those who live in the least deprived areas[iv]. In addition, the evidence suggests that there is an inequity of access to, uptake of, or supply of interventions to more deprived populations[v]

The notion that disease determinants are in part environmental was emphasised by Durkheim when he stated that a population is more than only the sum of all individuals[vi] This notion was developed in Rose's idea of the importance of distinguishing between the causes of individual cases of disease within a population, and the causes of differences in the rates of disease across populations[vii]. For example, if people within the same community share the same socioeconomic environment, access to healthcare resources, norms settings and lifestyles, they may shape a common level of cardiovascular health beyond individual characteristics. This concept is one that underpins some of the recent work looking at community versus individual risk.

Risk Assessment for CHD has traditionally been based on the Framingham Heart study in America [viii] with a range of risk prediction algorithms for various cardio-vascular diseases. In Scotland much cardiovascular disease is associated with social deprivation. However these algorithms do not include deprivation in their calculations. So the Framingham score does not target the socially deprived for treatment as much as they deserve compared with other social groups. The ASSIGN score, developed as part of SIGN Guideline 97 [ix] is the first to include social deprivation as part of the scoring.

However, being able to identify those at risk, is only one aspect of the challenge that faces the health community. We must also target resources at those communities most at risk. This is the ethos that underpins the Keep Well programme across Scotland, which aims to reduce risk in individuals in the most deprived areas. It focuses its efforts on the under 65's and is a cornerstone of the plans to tackle health inequalities in Scotland. However disease prevention is only one element of care and this approach of targeted intervention needs to be replicated in other areas of health care provision such as diagnosis, intervention, and treatments such as cardiac rehabilitation, if we are to have the widespread impact that is required to significantly alter the health experience of our most deprived communities.

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[i] Audit Scotland report on Cardiology 2012

[ii] *Registration data*, National Records of Scotland, 2011

[iii] Audit Scotland report on Cardiology 2012

[iv] ISD Nov 2011

[v] ISD Feb 2011

[vi] *Durkheim E. The rules of sociological method [Originally published in 1895]. [Luke S, ed] New York: Free Press, 1982.*

[vii] *Rose GA. Individuals and populations. The strategy of preventive medicine. Oxford: Oxford University Press, 1992.*

[viii] http://www.framinghamheartstudy.org/risk/index.html

[ix] SIGN 2007

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