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3

Health and social care systems

Anna Coleman, Jolanta Shields and Tim Gilling

Introduction

The National Health Service (NHS) has a key role in improving population health in Britain. Yet despite progress, health inequalities persist (PHE, 2018a), as noted in Chapters 1 and 2. Life expectancy has increased for some groups, including those living with complex, multiple and chronic conditions, but others have experienced a widening of the inequality gap (Raleigh, 2018); see Chapters 1 and 2 for a social determinants perspective on health inequalities. The demographic shift towards an ageing and growing population places new demands on the health care system, raising questions about its long-term sustainability (Guzman-Castillo et al, 2017). Successive governments have pursued centralisation, delegation, devolution and privatisation as means of addressing growing demands across the health and social care system (Peckham et al, 2005). Recently, in England, a clear consensus has emerged to embed (public) health in all policies (HiAP), taking into account wider determinants of health and including prevention (LGA, 2016).[1] Local Authorities (LAs) are seen to be uniquely positioned to facilitate this transformation, being close to local communities with an understanding and responsibility for issues such as environment, employment, housing and education. These socio-economic factors are seen to significantly impact on people's health and wellbeing in a way that the NHS cannot address alone. The NHS Long Term Plan (NHSE, 2019) and the earlier 'Prevention is Better than Cure' document (DHSC, 2018) set out the government's ambition to reshape the existing health care model by strengthening public health and prioritising primary medical and community health services. Central to this are Integrated Care Systems (ICSs), planned to be in place across the whole of England by April 2021, which provide a stronger basis from which the NHS, LAs and other organisations can work together on prevention, wellbeing and health. However, on average, local government spending on services has fallen by 21 per

cent in real terms since 2009–10 and these cuts have not been equally distributed across the country, being greater in more deprived areas (Amin-Smith and Phillips, 2019, p 2).

Against this backdrop, this chapter offers a critical analysis of the role of LAs in relation to promoting health and wellbeing for local communities. Taking Dahlgren and Whitehead's 'rainbow model' (1991) as a starting point (see Preface to this volume), the chapter traces recent policy initiatives and illustrates the complexity involved in tackling inequalities in the newly emerging health care systems. The chapter begins by briefly outlining the relevant policy and legislative context to better understand the role of LAs in advancing the public health agenda. It then draws on the example of health and social care devolution in Greater Manchester (GM) to illustrate both the opportunities and challenges faced by local organisations in operationalising and implementing national policy in the context of austerity.

The wider policy context

The role of local government in public health functions, as detailed in Part III of this volume, can be traced to the social and economic developments in the 19th century that resulted in rapid urbanisation with poor housing and workplace provision (Gorsky et al, 2014). Since then, public health duties have expanded, conferring more responsibility for population health on local government. However, public health functions were incorporated within the NHS in 1974 and did not return until 2013 (see Chapter 16). The White Paper *Healthy Lives, Healthy People* (Department of Health, 2010), informed by the findings from the Marmot Review (Marmot et al, 2010), proposed a new approach to public health whereby 'local government and local communities […] [would be] at the heart of improving health and wellbeing for their populations' (Department of Health, 2010, p 4). This was a significant shift from prioritising clinical treatment to prevention of illness with a focus on interventions to address the wider determinants of health (identified by Dahlgren and Whitehead, 1991) seen to be closely aligned with the functions of LAs, examples of these being housing, leisure, transport and planning. The Health and Social Care Act (HSCA12, ref 195(1)) transferred responsibility for health improvement (as part of public health responsibilities) to LAs and obliged them to establish Health and Wellbeing Boards (HWBs) in their local area to work closely with Clinical Commissioning Groups (CCGs), NHS England and local communities through local

Healthwatch (the independent advocates for people who use health and social care services).

The HSCA12 also created Public Health England (PHE), an executive agency of the Department of Health and Social Care, as well as the other bodies detailed in Table 3.1. These changes echoed the wider commitment of the Coalition government, articulated under the Localism Act (2011), aimed at devolving decision-making powers from national government to the local level. The landscape is complex as, for example, responsibilities for improving the health of local populations, including a reduction in health inequalities, sit with upper tier and unitary local authorities (those with social services responsibilities), while the delivery of some public health functions, including protection and promotion of health (for example, immunisation and screening services), rests with the NHS.

The previous 20 years had seen numerous calls for health and care services and other services impacting on the wider determinants of health to become more integrated. However, in England there has long been a fundamental tension as NHS services are free at the point of use and means-tested social care is provided by local government. Policy initiatives in England have included the 2006 NHS Act Section 75 flexibilities, HWBs, the Better Care fund (from 2013) and

Table 3.1: Selected healthcare and associated organisations introduced under HSCA12

Organisation	Description
Clinical Commissioning Groups (CCGs)	Health commissioning organisations replacing Primary Care Trusts (PCTs) in April 2013. Responsible for planning and buying of NHS healthcare. CCGs are membership organisations led by family doctors (GPs) to gain a clinical voice.
NHS England (NHSE)	Arm's-length executive body with delegated (via annual mandate) responsibility to deliver health services. It sets the priorities and direction of the NHS and encourages the national debate to improve health and care.
Public Health England (PHE)	An executive agency, sponsored by the Department of Health and Social Care, which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It advises government and supports action by local government, the NHS and the public, and health protection.
Health and Wellbeing Boards (HWBs)	Hosted by upper-tier local authorities, bringing together the NHS, public health, adult social care and children's services, including elected representatives and others, to plan how best to meet the needs of their local population and tackle local inequalities in health. Set local strategic direction.

Integrated Care pilots (from 2013). There were also some wider public sector initiatives (including elements of health, local authorities and national government) introduced to promote place-based approaches to funding and service configuration, including Total Place Pilots in 2009, Whole Place community budgets in 2011, the 2013 troubled families initiative and latterly English devolution deals (Miller and Glasby, 2016).

The Five Year Forward View (NHSE, 2014) called for a 'radical upgrade in prevention and public health' with 'stronger public-health related powers for local government and elected mayors' giving shared responsibility for health and social care of local population (NHSE, 2014, para 4). The document consolidated earlier efforts for joint working and local health leaders were asked to come together in 44 geographically defined 'footprints' across England, to produce Sustainability and Transformation Plans (STPs) (later known as Partnerships) for transforming services using an allocated funding envelope (NHSE, 2014). It also introduced New Care Models, with 50 'Vanguards' selected to trial the development of new ways of integrated working (Checkland et al, 2019). At the same time, many initiatives focused on integrated person-centred care involving both the NHS and LAs (see Table 3.2).

The NHS Long Term Plan (NHSE, 2019) sets out the ambition for joined-up care that reduces dependency on emergency care and supports local approaches to blend health and social care budgets,

Table 3.2: Initiatives introduced to focus on integrated person-centred care

Initiative	Description
Better Care Fund	2015–16 £3.8 billion of pooled funding into a single budget for health and social care services (2015–16) to work closely together to protect adult social services while reducing demand for acute beds. Provided a context where the NHS and local authorities work together, as equal partners, with shared objectives. Plans are developed in a local area by the relevant CCG(s) and owned by the relevant HWB.
Personal Health Budgets	Part of the NHS's comprehensive model of personalised care to support healthcare and wellbeing of individuals. Planned and agreed between an individual and the CCG.
Troubled Families Programme	Administered by the Department for Communities and Local Government and funded by central government, it involves LAs identifying and working with 'troubled families' via dedicated workers, and only receiving payment on the successful completion of the case; for instance, moving a family into permanent employment.

among other initiatives (NHSE, 2019, p 4). Under ICSs, NHS organisations, in partnership with LAs and others, will take collective responsibility for managing resources and improving the health of the population they serve. The long-awaited Adult Social Care Green Paper is also expected to strengthen the approach, prioritising person-centred integrated care. Local government has a vital role to play in delivering this agenda through its public health and social care functions. Local communities are integral to the health care system and play an important part at population and individual level (often asset-based), with individuals taking greater responsibility for their health and wellbeing. However, budget pressures in adult social care present challenges across many areas.

Place based planning and integrated care systems

The strength of place-based initiatives in England is that they focus on the impact of the wider determinants of health, not just ill-health. In turn, this draws attention to the key functions of LAs, which were described by Lyons (2007, p 51) as 'place-shaping' – 'the creative use of powers and influence to promote the general well-being of a community and its citizens'. The legitimacy of LAs as 'democratically accountable stewards' is central to this approach, allowing LAs to respond and shape services in the way that these are responsive to local needs (Department of Health, 2011, p 1). As planning authorities, LAs, for instance, have an opportunity to influence the built environment so that it supports adopting healthy lifestyles (leisure, transport, housing, and so on). For example, a refreshed memorandum of understanding (PHE, 2018b) was signed by over 25 stakeholders in 2018, emphasising the importance of housing in supporting health and setting out a shared commitment to joint action across government, health, social care and housing sectors in England. Likewise, the licensing powers of LAs allow them to consider the wider impact of fast food and gambling outlets, particularly if these are to be established close to schools. For example, in Sheffield, the council adopted an innovative approach by framing tobacco and obesity as commercial determinants rather than lifestyle choices, shifting investment directly towards control and enforcement as well as interventions that sought to change public attitudes (LGA, 2019a). In 2013, Coventry City Council became a 'Marmot City', an initiative spanning seven LAs working with public and voluntary sector organisations on innovative projects that aimed to reduce inequalities by embedding six policy objectives of the Marmot Review (2010).[2] Since adopting the status, Coventry has reported

a narrowing of the life expectancy gap between the most affluent and most deprived and improvements in educational, employment and health outcomes (Faherty and Gaulton, 2017). Attention has additionally been drawn to the fact that LAs are major employers as well as 'anchor intuitions' closely connected to the wellbeing of the populations they serve (LGA, 2018a). The Department for Communities and Local Government (DCLG, 2017) estimated in 2017 that the total procurement expenditure of LAs stood at over £60 billion, meaning these organisations also have the potential to indirectly impact on the lives and 'the conditions of many more workers that they do not employ' (LGA, 2018a, p 27).

The focus on 'place' as a source of problems as well as solutions is not new, and has been widely used in regeneration studies (Lawless et al, 2010). In particular, New Labour's Neighbourhood Renewal (SEU, 2001) set out to tackle inequality and social exclusion by empowering local communities and strengthening the role of LAs through Local Strategic Partnerships. These were not dissimilar to what STPs/ICSs are trying to achieve, although the emphasis is now strongly on integration between health and social care.

For LAs, 'place' matters, although the term takes different meanings and purposes. Increasingly, though, LAs are using place-based initiatives to address complex health inequalities. Since the passing of the Social Value Act (2012) and HSCA 2012, public bodies have had to consider the wider social, environmental and health implications of their commissioning decisions, with LAs required to improve health outcomes and reduce health inequalities. HiAP, mentioned earlier, provides an important collaborative framework to achieve this 'by incorporating health considerations into decision making across sectors, policy and service areas, and addressing wider determinants of health' (PHE, 2016, p 4). In Liverpool, the council extended the approach to include Health in all Policies and Places, emphasising the role of LAs in driving this agenda forward (LGA, 2019a, p 8).

Dorling (2010), however, argues that defining inequalities in terms of LAs' boundaries is not necessarily helpful as LAs engage at different levels, including regional, national and recently system level. He also suggests that focusing on single measures such as income or population size is likely to miss important cleavages, an example being the extreme variations between areas and neighbourhoods. Purdam (2017) makes this point compellingly by using the Metrolink map in GM to illustrate, for instance, how male life expectancy at birth in Rochdale is nine years shorter than in Milnrow, areas only three tram stops apart. In this sense, the concept of place is far more nuanced and contested

especially in the context of STPs/ICSs (predicted to cover populations between 1 and 3 million) with their emphasis on collaboration as a panacea for deeply entrenched structural problems. Hammond and colleagues (2017, p 225) argue that 'turning down the noise on political contestation through evoking notions of local consensus' risks obscuring the reality of austerity policies and their impact on LAs that are delivering health and social care to the local population.

According to the National Audit Office (NAO, 2018), LAs have been facing significant challenges since 2010–11 as funding has been reduced despite growing demand, particularly for social care. The fiscal stress under which LAs operate means that balancing statutory provision requirement with financial survival is likely to affect the quality of public health interventions. The NAO offers some optimism, citing cases where LAs were able to make progress by successfully commissioning for quality and best value (NAO, 2018). The Local Government Association (LGA) also reported a largely positive impact of relocating public health to LAs in England, claiming these were able to deliver 'better outcomes [in a number of areas] at less cost than the NHS did when they controlled public health' (LGA, 2019b, p 3). However, a note of caution is sounded in relation to the proper funding for LAs' public health and meaningful engagement with councils to make further progress around prevention and avoid a postcode lottery. This is particularly pertinent in the light of the recent analysis by the BBC based on the resilience index prepared by the Chartered Institute of Public Finance and Accountancy (CIPFA), which found that 11 LAs were close to fully exhausting their reserves within four years' time if no action was taken (CIPFA, 2018; BBC, 2019).

The organisational landscape around which public health functions operate is increasingly complex and changing. Commissioning in complexity is discussed in Chapter 13. The earlier development of some STPs lacked public visibility and left a legacy that has been difficult to overcome (Coleman, 2016). The absence of wider engagement of all parties (LAs, the public) in early development resulted in local priorities having to be retrofitted into the plans. Recently, Corcoran (2019) identified 11 separate governance and accountability challenges that NHS and LAs may face when seeking to work more collaboratively. For instance, the report drew attention to how LAs talk about places and residents whereas the NHS tends to talk about premises and patients. It also highlights different funding regimes, planning cycles and geographies that can be problematic for decentralisation and local integration, alongside the enduring issues of historically embedded siloed thinking and organisational focus and oversight. The NHS

Long Term Plan (NHSE, 2019), while intended to take a system-wide view, appears to be 'written by the NHS for the NHS, not for the whole health and care system, since the funding settlement excludes public health, social care, education and training' (Humphries, 2019). This resonates with the report by the Health and Social Care Select Committee, 'First 1000 days of life' (DHSC, 2019), which noted the structural problems with government financing that hinder early local interventions. Although the government claims it encourages departments 'to work across traditional boundaries to deliver improved public services', the reality can be far more complex in practice. The Centre for Public Scrutiny (CfPS), suggest that this may be because political and organisational cultures have not yet had time to adapt. Central to the process of transformation is 'good governance [...] from which councils can build and sustain the changes and respond to local needs' (CfPS, 2019, p 5). According to the CfPS, the traditional aspects of governance find themselves increasingly at odds with the emerging models, prompting calls for new forms of decision-making. This may involve, for instance, creating a 'constitution for the place' (see the Wigan and Preston model, Chapter 8) or, as the CfPS calls it, 'the community constitution', which emphasises collaboration based on transparent lines of accountability, responsibility and ownership for the agreed outcomes (CfPS, 2019).

This approach is particularly pertinent in the context of the reforms introduced by HSCA12, which resulted in territorial boundaries that do not necessarily align with developing STPs/ICSs and can cut across LAs and HWBs. The ICSs, for instance, are intended to operate at three levels simultaneously: system (working together to set priorities, plan and agree the overall level of integration, 1–3 million population), place (within the system and focused on planning localised services alongside the delivery of secondary and community care, 250,000–500,000 population) and neighbourhoods (centred around primary care networks with general practitioner (GP) networks covering populations of 30,000–50,000 and with multidisciplinary teams working together to provide primary and community care). This raises questions about levels of accountability and rights of patients, residents and communities to health and social care services. This matters if HWBs are to produce joint strategic needs assessments that look at the current and future health and care needs for their local area, allowing to better plan and commission health, wellbeing and social care services within the LA.

While the argument for developing ICSs is compelling, and Corcoran (2019) provides a series of potential enablers (e.g. joint appointments

and shared objectives) that have already been used to drive the progress, this should not preclude the case for careful examination of proposals. In this context, LAs have a number of important roles through their decision-making and scrutiny arrangements. LAs with social care responsibilities have powers to review issues relating to planning and delivery of health services and in certain circumstances can refer proposals for major changes to health services to the Secretary of State (CfPS, 2017). As well as powers relating to NHS bodies, there is a key role for scrutiny committees to review the actions that LAs are taking to improve public health (Ferry and Murphy, 2018). Overview and scrutiny and other forms of local assurance have a vital role to play, providing democratic and other links between national policymakers, commissioners, providers and the communities they serve. As champions of local needs, elected representatives and others with an assurance role help to safeguard the quality and safety of health and social care as well as promoting actions on the wider determinants of health. The current challenge is for the NHS and LA scrutiny to develop agreed ways of working to facilitate effective timely scrutiny of strategic issues, outcomes expected from ICSs and people's experiences of local services.

Deloitte's (2019) report suggests nine success criteria against which to measure a more joined-up, population-oriented approach to health and care that STPs/ICSs could utilise. These include developing a common language to enable better data sharing; provision of funding, infrastructure and leadership support; agreeing appropriate performance measures (KPIs) across systems; establishing wider public engagement in prevention; and promoting patient activation and empowerment. The development of integrated ways of working is presently dependent on establishing successful local alliances rather than changes to primary legislation, meaning progress is varied and can be delayed by unresolved problems related to, for example, VAT liabilities, KPIs and exemptions that are different for NHS trusts and private providers.

The dominance of central institutional policy and regulatory frameworks plays an important role in affecting the development of STPs/ICSs. Earlier reforms introduced by the HSCA12 weakened regional structures, questioning the resilience of the health and social care system to deliver government policy (Exworthy et al, 2017).

The devolution and decentralisation agenda are problematic when LAs have no control over national funding streams, albeit increased autonomy over spending. According to the LGA (2018b), funding for adult social care faces a gap of by £3.5 billion by 2025. This is

significant since much of the NHS Long Term Plan (NHSE, 2019) is centred on initiatives that aim to tackle wider determinants of health with an expectation that LAs would be able to help close the inequality gap. The increasing deficits in the acute (NHS) sector also mean that planning around long-term goals in health and social care is difficult. There is still an uncertainty about the vision for social care, and until the Green Paper is published the issue of prevention is open to debate.

Learning: health and social care devolution in Greater Manchester

An insight into devolved metropolitan authorities is presented in Chapter 5. The devolution of health and social care in GM illustrates some of the issues of establishing place-based healthcare initiatives that require the involvement of local government by referencing health and social care devolution in GM. Since 2015, local partners have taken 'devolved control' of the region's health and social care budgets (£6 billion per annum for the 2.8 million population). GM prioritised the creation of an integrated system, with distinctive local provision, and increased scope for joint commissioning, the pooling of public resources, the creation of provider alliances and promotion of new ways of working (Walshe et al, 2018).

In February 2015, plans to devolve decisions over health and social care spending in GM to a newly established strategic partnership board (GMHCP) (AGMA, 2015) were announced. This initial deal was negotiated quickly by key leaders (including the LA) across GM following wider devolution powers being granted to GM in November 2014. The new GMHCP Board brought together 10 LAs, 12 (latterly 10 owing to a merger) CCGs, 15 NHS trusts and foundation trusts, and NHS England, which set out an ambitious strategy – 'Taking Charge' (GMCA, 2015) – including reforms, governance arrangements and targets. Four high-level reform themes were proposed: upgraded population health prevention, transformed community-based care and support, standardised acute and specialist care, and standardised clinical support and back office services. Developments were facilitated by stable GM leadership and close political cooperation of the 10 LAs over 20 years, and more recently joint working by the 10 CCGs across the GM footprint.

Since the 2015 devolution agreement, much effort has gone into enhancing relationships, setting up governance arrangements and agreeing strategies and plans. The GM Partnership has embraced complexity and started tackling reconfiguration across the whole

system. Walshe et al (2018) describe a 'soft' devolution due to a lack of statutory authority and formal levers for use over NHS organisations and fewer over LAs. The associated Transformation Fund (extra funding to facilitate change) has been used imaginatively to encourage change, but this is non-recurrent funding and the system still needs to operate effectively and meet national targets against which individual organisations are still measured.

The inclusion of LAs and other relevant organisations, as well as health, has encouraged change across the system. This has included delivery of integrated care via ten single commissioning functions based on the local authority footprints that work across health and social care; local single hospital services bringing together providers of hospital-based services; and a series of local care organisations to facilitate the joined up working of community health services, social care, GP services, mental health services, voluntary services and private sector providers (Walshe et al, 2018).

At the time of writing, health and social care devolution in GM remains in transition and it is too early to gauge its success (Walshe et al, 2018). In April 2019 (three years after the GMHCP went live) two interrelated initiatives have come together: the GM Model of Public Services announced in December 2018 (following on from the GM Strategy 'Our People, Our Place', GMCA, 2017), proposed that every area of public service should have health benefits as an objective: housing, education, work, digital and transport connections, environment and so on. It suggests that the complex challenge of improving the population's health is now being locally addressed in ways that national government could not accomplish. In parallel, the five-year Prospectus released by the GMHCP in April 2019 (GMHCP, 2019) sets out ambitions for a population health system, where inclusive economic growth is a main theory that focuses on upstream prevention rather than cure. Linkages to the forthcoming GM industrial strategy and Northern Powerhouse initiatives will also be of great interest.

Despite progress, some historic challenges endure. The gap in health inequalities with the rest of England remains in many areas, while the health economy is struggling to meet increasing demand for services and to reach some of the national target measures, such as Accident and Emergency discharge times (Dunhill, 2019a). Recent national policy changes, integrating NHS England, NHS Improvement and PHE responsibilities, have resulted in a new regional level director for the North West being appointed, to whom the leader of GM's health and social care devolution programme will now report rather

than directly to NHS England's Chief Finance Officer. While GM suggest this is no more than creating a clearer single line of reporting to facilitate ongoing change and improvement locally, others suggest a dilution of local autonomy (Dunhill, 2019b).

Discussion and conclusion

The wider determinants of population health conceptualised by Dahlgren and Whitehead (1991) as rainbow-like layers of influence illustrate the interdependence of multiple factors on the health and wellbeing of the population; see Chapter 2, Figure 2.1. The model is useful for identifying policy responses that are holistic and therefore extend beyond the narrow medical model of illness. The NHS can no longer be exclusively to treat the sick but a service that works in partnerships to address the wider determinants of health, many of which (transport, housing, worklessness, for example) are heavily influenced by LAs. In this chapter, the authors have illustrated how in the last decade the policy has shifted towards integration, where a variety of organisations are now responsible for setting strategic direction, service provision and encouraging asset-based working to reduce social inequalities together. Policymakers are looking for smarter ways of working, which focus on upstream prevention and general wellbeing as well as treating ill health, shifting the mindset from reactive to proactive developments. These initiatives bring attention to the third layer of the rainbow model, with, for example, social and community networks in association with LAs playing a greater role in facilitating conditions to ensure people stay healthy and independent for as long as possible. At the same time, to solve enduring 'wicked issues' (Rittel and Webber, 1973), organisations across all sectors (health, local government, voluntary, etc) are having to find ways of effectively working together to meet local demands within constrained budgets.

As the chapter has demonstrated, this is challenging in a system that is constantly evolving and in which organisations have unique institutional logics, governance, accountability, funding, budgets and decision-making cycles that do not align easily. Even with political will, the progress is dependent on reconciling difficult issues to do with regulation that cut across organisations and sectors and varying levels of responsibility for particular aspects of health and wellbeing. The layering of new initiatives upon old ones has also created challenges, with some programmes effectively operating in direct conflict, an example of this being integrated working and increased competition.

Changes to legislation may be required to overcome these obstacles (for example, moving funding away from being activity-based to population-based) and it had been hoped the NHS Long Term Plan (NHSE, 2019) and the long-anticipated adult social care Green Paper (still awaited at the time of writing, May 2020) would help to clarify this. The policy responses, however, need to be formulated and implemented through the meaningful engagement and intersectoral partnerships rather than driven by crisis in the acute sector. Different sectors need to be recognised as having more expertise in certain areas and, despite the cultural challenges, be included in all developments that look to integrated ways for working. Recognising where power is located in the local system and who is driving change will help to increase accountability but also inject the necessary pragmatism to ensure realistic expectations. This is important if community and social networks, in which LAs are integral, are to be fully engaged in tackling the causes of complex health inequalities.

This will be even more pertinent in the post COVID-19 pandemic landscape, with potentially different and more complex needs emerging as a result. There is already evidence that links the disease to inequality (Ahmed et al, 2020) with figures from the Office for National Statistics (Barr, 2020) suggesting that residents in areas of deprivation have experienced double the death rates of those in affluent areas. What is apparent is that the risks from COVID-19 are further exacerbated by social and economic inequalities, and issues linked to ethnicity, gender, age and underlying health conditions (Begum et al, 2020). Significantly, though, the current pandemic exposes the fragilities of the health, social care and public health systems in England that will need to be addressed to adequately respond to enduring inequalities in UK society and the increasingly global nature of health challenges.

Notes

[1] In the UK, the devolved administrations of England, Scotland, Wales and Northern Ireland have adopted different approaches to health and social care. In this chapter the authors focus on the English situation. For further information, see Part II of this book.

[2] 1) giving every child the best start in life; 2) enabling all children, young people and adults to maximize their capabilities and have control over their lives; 3) creating fair employment and good work for all; 4) ensuring a healthy standard of living for all; 5) creating and developing sustainable places and communities; 6) strengthening the role and impact of ill-health prevention.

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