Memo

To: Health Select Committee
From: The Bow Group Health & Education Policy Committee
Date: June 2011
Re: Public Health Inquiry

Executive Summary of Submission

1. The Bow Group supports the motives and rationale behind the creation of Public Health England, which if properly implemented will help support people in maintaining and improving their health, mainly at a community level through local councils, whilst keeping a firm national grip on public health issues such as flu pandemics at a national level.

2. However, we would particularly like to bring to the Committee's attention our view that it would be the wrong decision to abolish the Health Protection Agency, and we call for the Government to think again and reverse this policy.

3. The Government's plan to give Local Authorities more power and responsibility for their population's health can be seen as a positive step and consistent with the wider vision to devolve healthcare decision-making to the local level. However, more detail is needed to explain how these plans will be implemented and how responsibilities will be allocated. At this point, the Government has only postulated a broad framework for implementation and important detail is missing.

4. We support the proposed framework of Health and Wellbeing Boards and hope they will go some way to bring together those local bodies responsible for the improvement of local population health.

5. The Bow Group welcomes the rationale behind the Public Health Outcomes Framework and would urge the Government to build on this by developing a national standard for public health interventions.

6. We would like to see a greater focus from the Government so that all healthcare professionals, from the student to the consultant, from the nurse to the dietician, are trained, skilled and motivated to practice preventative medicine.

Introduction

7. The Bow Group exists to develop policy, publish research and stimulate debate within the Conservative Party. It has no corporate view, but represents all strands of Conservative opinion.

8. The Bow Group are delighted that the Health Committee has chosen to undertake an inquiry into public health. In recent years, the Bow Group has taken a great interest in developments around public health and we have previously published a considered response to the Government's White Paper on public health, 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' which can be downloaded by accessing the following link: http://www.bowgroup.org/files/bowgroup/Bow_Group_Public_Health_White_Paper_Response_FINAL%2029%2003%2011.pdf

9. We are grateful for the opportunity to provide this response to a number of the Committee's questions.

Creation of Public Health England

10. A central part of the White Paper concerns the creation of a new public health service called Public Health England. Operating within the Department of Health (DH), Public Health England will oversee national public health programmes in areas such as vaccination, screening, health visitors and family nurses.

11. The Bow Group supports the motives and rationale behind the creation of Public Health England, which if properly implemented will help support people in maintaining their health, mainly at a community level through local councils, whilst keeping a firm grip on national public health issues such as flu pandemics at a national level. In principle, it should help to provide a focal point for prioritising an overall improvement in public health. Public Health England should also provide an excellent opportunity to coordinate health, social and other services, which currently often work in isolation. The critical challenge will be implementation and explaining to people within the NHS and outside how exactly this new part of the healthcare system will function and operate; a significant challenge the Government is already confronting with its wider NHS reform programme.

12. The White Paper confirms that a ring-fenced funding pot of at least £4 billion will be provided for tackling public health issues. Part of this money will be spent by local councils and the rest by Public Health England. The Bow Group is pleased with this development and believes this will go some way to ensure that public health budget will no longer be "raided" by the NHS to cover deficits. However, in future it will be essential that Public Health England is funded adequately to undertake its important role. This cannot be a one-shot measure or an easy target for spending cuts when the going gets tough. The White Paper is less convincing and reassuring in this regard.

13. It is also concerning that there is increasing evidence already that the £4 billion expected to be allocated to Public Health England might lead to an underfunded system in the future. For example, Health England data from 2009 showed a £3.7 billion spend on public health and health improvement in 2006-07, increasing to £5 billion if some categories of medication were included. The same report identified a further £1.3 billon when environmental health services, food safety measures and health visiting services were factored in[i]. A new public health service will only work with proper funding, and there is an immediate worry that the finances have not been fully thought through.

14. There is a real need to challenge conventional thinking in this regard. Otherwise, there is a real danger that the important work of Public Health England could be undermined from the start due to a lack of financial backing and sustainable funding. We urge the Government to set out at the earliest opportunity how the funding structure for public health will precisely work and how this will be sustained over time.

Abolition of the Health Protection Agency (HPA)

15. In addition, we have some concerns about reports that the two QUANGOs being pulled into Public Health England, the National Treatment Agency and the HPA, risk losing around 15-20% funding over the next year adding more pressure to the proposed budget[ii]. In the case of the HPA, a breakdown of its accounts shows the agency to be largely self-sufficient in many areas of its *modus operandi* due to international research grants and other external funding – something that does not cost the beleaguered taxpayer a single penny. This is primarily due to the HPA's strong international reputation – arguably an "asset" rather than a "liability" in financial terms.

16. With this in mind and given the Government's rationale for cutting the size of the QUANGO state, i.e. to reduce costs and deliver economic efficiencies, the abolition of the HPA and its integration into a new Public Health Service would seem odd and counter-intuitive. We feel it is the wrong decision to get rid of the HPA, and we call for the Government to think again. One other viable option is to make the HPA an "executive agency", which would be politically acceptable but ensure critical functions are not jettisoned or messily merged into the DH itself.

Structure of Public Health England

17. There is also a clear need for more detail on how exactly Public Health England will be configured, organised and structured. This is particularly important given that the new Public Health Service will be assuming critical roles and responsibilities.

18. As discussed above, one such example is health protection where the functions of the soon to be abolished HPA will soon be transferred to Public Health England. The HPA's current responsibilities are by no means trivial, covering highly skilled and intricate areas such as preparedness and protection against

health hazards, infectious disease, and hazardous chemical, poisons and radiation. In the extreme sense, the HPA has responsibility for advising the Ministry of Defence (MoD) on issues to do with chemical and biological warfare. How will Public Health England subsume such critical, and in extreme cases "life and death", responsibilities without undermining current arrangements and ongoing research work?

19. With all such functions, there is a big question mark as to how these responsibilities will be effectively transferred ensuring that independence in assessment is retained (per the original "arms length body" rationale) – something seminal to the credibility of health protection both domestically and internationally – without undue political interference and/or Whitehall obstruction. The Government needs to urgently provide clarity on the practical details of its proposed new structure, not least given that these reforms are all directly tied up with the larger reorganisation of the NHS.

Local Government

20. A critical part of the White Paper concerns the involvement of local government and ringfenced budgets to advance the Government's key policy proposals. The desire to devolve responsibility for public health to local government is a positive step and consistent with the wider vision to devolve healthcare decision-making to the local level. However, more detail is needed to explain how the plans will be implemented and how responsibilities will be allocated. At this point, the Government has only postulated a broad framework for implementation, which in isolation is not really sufficient.

21. The White Paper sets out the framework for how the new Public Health service will operate through Public Health England in the DH down to GP consortia and Directors of Public Health (DPH) at the local level. It is the implementation of this framework that will decide whether this is a radical success or a demonstration in good intentions not translating into practice.

22. Importantly, this new framework will be locally driven and therefore has a greater potential to be in line with local needs. Arguably the most controversial aspect of this new policy approach concerns the amount of power being handed to local authorities (LAs). It is stated very clearly that the Government intends to "keep to a minimum the constraints" on how LAs will fulfil the public health role and spend budgets.

Directors of Public Health (DPH)

23. The White Paper outlines an increased role for DPH. This can be considered a sound decision that should help to ensure that there is a visible figure directly responsible for the improvement of local public health. Furthermore, since DPH are accountable to the Chief Medical Officer (CMO) and will be jointly appointed by the LAs and Public Health England the issue of accountability should not be a problem as some have precipitously suggested. This should foster a certain level

of ‘quality-control’ between different areas, and avoid too much potential for DPH to go too far in one direction without proper checks and balances as to whether this aligns with national imperatives.

Health and Wellbeing Boards (HWBs)

24. The creation of HWBs is a philosophical shift that bravely challenges the previous ethos of centralisation. This is true even when considering the minutiae of policy implementation. It allows those in local government to demonstrate their talents and makes decisions in accordance with local needs. Although we are supportive of more local and therefore responsive decision-making, any such philosophical shift does confer potential problems. There is no guarantee that each LA will be capable of taking on and successfully carrying out the vast range of responsibilities. It is therefore imperative the DH is not an idle spectator on the touchlines, but rather a leader and promoter of good practice where needed.

25. The Government’s proposed framework of HWBs should help to bring together those local bodies responsible for the improvement of local population health. The weaving together of these different bodies into a statutory body ought to result in effective joint working. These boards will bring together GP consortia, DPH, Social Care, Children Services, and make them all accountable for the public health needs of the local population. These boards will, like DPH, provide a visible body to ensure accountability. We strongly advise that local HealthWatch, as part of minimum membership requirements, guarantee the involvement of local charity and patient groups in HWBs. This would help to ensure that local people who are not directly involved in public health have an opportunity to be represented and engaged in the process from the outset.

26. In line with the more general theme of “centralisation doesn’t work”, this proposed structure puts responsibility for success squarely in the hands of local bodies. This is what has been called for by local health representatives for many years if not decades. It remains to be seen whether those at a local level with the responsibility to promote public health will be as able and as willing as historical rhetoric implies. Again, this is an area the DH must keep a close eye on as the reforms progress and early performance indicators come through.

Public Health Budgets

27. Ring-fenced budgets are low-hanging fruit in the world of quick political wins; translating the policy into a funding reality is much harder. At a time when LAs are facing cuts to their budgets across the board, a ring-fenced budget for public health is good and should be supported. It should mean the public’s health is not secondary to other financial pressures, and keeping the public healthy is of course a long-term financial saving.

28. It is short-term pressures that will make this ring-fenced pledge something of a financial challenge. Just as important, what is the mechanism to stop any attempt by a LA to use the budget for something other than public health using loose justification via the classic "wider determinants of health" argument? Moreover, at a time when local facilities are being cut and reduced how easy will it be to justify keeping this budget ring-fenced? Given that public health is about many different local services working together (including social services and mental health services), what can be done to ensure the funds are used to support all these public health services and are not siphoned into politically advantageous schemes for individual authorities? The Government needs to answer these important questions as part of its consultation.

29. The White Paper describes the health premium as policy to improve the health of the poorest, fastest. Through a simple formula, LAs will be rewarded for improvements to the local populations' health based on the public health outcomes framework. Those areas with the worst health outcomes will receive an "incentive" payment. It is not clear whether those Las deemed to have good public health when measured against the public health outcomes framework will receive any incentive to make additional improvements.

30. It is difficult to argue with the principle of improving the health of the poorest with priority, but the devil is in the detail. This could potentially leave the Government open to accusations that LAs who already have a good level of local public health or do not make any progress in improving their public health will face cuts. The latter is actually recognised in the White Paper, "Potentially an area that makes no progress might receive no growth in funding for these services." The key to this are the words "potentially" and "might". This formula is being developed with unidentified "key partners" and so we do not yet know how this premium will function in practice.

31. There is no timescale for when the detailed model will be available as it is clearly stated "we will only set out a detailed model when we have established the baseline and potential scale of the premium clearly, and have agreement about the outcomes we will use." This is somewhat frustrating given it was first raised in *Equity and Excellence* in July 2010. If the health premium is successfully delivered, it will be a truly progressive reform. It will ensure that those areas facing the greatest challenges achieving real outcomes in improving health (rather than hitting targets) will be rewarded. Until we can assess how this premium will be formulated, it is only possible at this stage to speculate on its potential rather than comment on detail on its likely success.

Public Health Workforce

32. In the White Paper, the Government rightly acknowledges the importance of maintaining a well-trained and highly motivated public health workforce that utilises an evidence-based approach to clinical practice. Importantly, it is

recognised that clinicians and other professionals have an essential role to play in improving and protecting population health.

33. This is undoubtedly an area that has been undervalued by previous Governments of all persuasions, but nonetheless constitutes a critical piece of the public health jigsaw. If the Government's ambitious public health reforms are to have a chance of success, it is essential that all healthcare professionals, from the student to the consultant, from the nurse to the dietician, are trained, skilled and motivated to practice preventative medicine. There is a long way to go.

34. Unfortunately, the White Paper makes no mention of undergraduate medical and dental education, and similarly undergraduate health education. At present, medical training and education around public health and the management of conditions like obesity, drug and alcohol addiction receives little if, in some cases, any attention at all. This has to change and change quickly – a massive piece of the jigsaw missing from the public health White Paper.

35. It is from this perspective that the Bow Group calls on the Government to overhaul public health education across the healthcare sector particularly at the undergraduate level.

36. Innovative, engaging teaching styles are needed to educate our future healthcare professionals in a vitally important area of medicine. This is one of the key determinants in securing the future health of our nation. After all, if our healthcare professionals are not properly skilled and equipped to tackle head on the public health challenges of today and tomorrow, what chance have the rest of us got?

Health Inequalities

37. The White Paper set out plans for Public Health England to work with the NICE and the DH to set indicators for the Quality and Outcomes Framework (QOF). Public Health England and the new NHS commissioning board will also be charged with working collaboratively to ensure GP consortia "maximise their impact on improving population health and reducing health inequalities".

38. The Bow Group sees this as a positive step and will aid developments towards a QOF which will do more to encourage GPs to help patients to achieve key public health targets, such as weight loss, smoking cessation and reduced alcohol consumption.

39. Alongside this development, the Bow Group is pleased that the White Paper confirmed plans for at least 15% of all QOF funding will be assigned to public health and primary prevention indicators from 2013. This idea was originally mooted by the DH after the Lord Darzi Review. As a report published by the Bow Group in 2010 proposed, a greater proportion of the framework dedicated to public health "would help to potentially shape a culture that is more consciously

focused on prevention rather than the traditional and prevailing model of reactive/curative healthcare"[iii].

40. Following on the seminal work of the Marmot Review, it is promising that the Coalition Government are committed to reducing health inequalities, noting that these have got worse over recent years. The White Paper rightly identifies that health inequalities are determined by a plethora of factors, ranging from early years care to social policies. In order for the proposals to reduce health inequalities to work, it will require departments across government to implement effective social policies which foster a focus on equity right from the outset. Despite the fiscal constraints and the reality of Government departments facing significant cuts, it will be crucial that the Government invest in making this a reality.

41. The role of GPs in tackling health inequalities should not be underestimated. GPs are normally the first point of medical contact within the NHS and they play a vital role in preventive care, which typically involves diagnostic screening and providing advice on how to lead a healthy lifestyle. The Bow Group has previously argued that in its current form the QOF has not been designed effectively enough to address health inequalities. The Coalition Government should urgently look into the possibility of introducing new incentives for GPs in deprived areas with a view to improving services for patients in those areas.

Public Health Outcomes Framework

42. The Bow Group welcomes the rationale behind the Public Health Outcomes Framework. This should help provide clarity and focus on the key issues of importance in public health for those involved in the provision and commissioning of public health interventions. GPs can play a vital role in achieving good outcomes against all of the proposed domains within the Public Health Outcomes Framework, and therefore the amended QOF should be indexed to the Public Health Outcomes Framework to ensure coherence.

43. The Bow Group welcomes the Government's aim to promote confluence where possible between the NHS Outcomes Framework and the Public Health Outcomes Framework. This will promote a more joined up approach to commissioning, and will likely lead to a situation where public health is seen as a top priority by local GP commissioning consortia.

44. Finally, we call for enforcement of a national standard for public health interventions. Whilst NICE guidelines are extremely useful, they are exactly that – only guidelines and, regardless of the reality, most providers tend to claim they are compliant. By linking a national standard for public health services providers with the NHS Outcomes Framework and the Public Health Outcomes Framework, greater scrutiny on intervention quality would be possible and in turn lead to better outcomes and value for money. This is a current area of weakness

in the White Paper and something the Government should think about further as part of its consultation.

References

[i] Health England, Health England Report No. 4: Public Health and Prevention Expenditure in England, Health England, 2009.
[ii] Graham Burgess, Local Government Chronicle 9th December 2010, Accessed 22nd January 2011.
[iii] Page 14, The Quality and Outcomes Framework – What Type of Quality and Which Outcomes? Gary Jones, Stuart Carroll & Jennifer White (BG Health Committee) February 2010.

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