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Thinking about...Public Health

The Government's plans for improving England's health are radical. Much of the comment on these plans has focused on the proposed changes to the commissioning and delivery of healthcare. This is probably right given the scale of resources involved. Yet the proposed reforms to the public health system are no less radical, and have attracted far less attention. Impacts here could also be far-reaching and profound – especially given the proportion of ill health determined by lifestyle choices and the broader environment within which these choices are made. In this paper, Fraser Battye, a Principal at GHK Consulting, examines the proposed reforms to the public health system.

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The agenda set out in the White Paper is, in many respects, a positive break with the past. Local government is well placed to deliver

If Sir Douglas Black were alive today, he would have just witnessed a further vindication of his 1980 'Black Report.' That report was – in the current parlance – buried because it contended that health inequalities are the outcome of broader economic and social inequalities, rather than individual lifestyle choices. It is therefore instructive to reflect that Black's analysis is now the received wisdom. That it should form the starting point for the agenda set out in the 2010 Public Health White Paper 'Healthy lives, healthy people' was by no means a given.

The White Paper proposes a series of reforms that aim to 'improve the health of the poorest, fastest'. It is framed in part as the Government's response to last year's Marmot Review - something that would have been beyond Douglas Black's most optimistic dreams. It takes a social determinants and life-course based approach - as advocated by Black, Acheson, Marmot, Wilkinson & Pickett, NICE, the World Health Organisation, and others. It also builds upon the work of the previous administration.

Healthy lives, healthy people sets out where action is best taken at national level (through the forthcoming agency, Public Health England) and where delivery is best led locally. Given the philosophy behind its approach, giving local government (back) responsibility for local public health is sensible. The question at local level then becomes one of managing the transition such that existing skills, knowledge and experience is not lost.

The devil is in the practicalities & detail of implementation

While there is much to like about the direction and content of the White Paper, it has injected further uncertainty into the health service. The most substantive questions over these reforms are in the detail of implementation. The accompanying structural changes will almost certainly lead to a loss of productivity as the new arrangements take time to bed down; new risks will also arise.

The role of the Director of Public Health is vital

In his 2006 book 'Evidence-Based Policy', Ray Pawson suggested that evidence was, "the six-stone weakling of the policy world". He then pitted that weakling against, "the four-hundred pound brute called politics". The evidence vs. politics battle will remain a one-sided affair,

but those of us with a commitment to evidence must give it all the support we can muster – especially since moving responsibility for public health to local government will increase the scope for politics and unsubstantiated theories to exert an influence.

This is part of the reason why the role of Director of Public Health is so vital. The Director will be responsible for promoting public health within the local authority, 'making the case' across a range of directorates and policy areas (e.g. planning, transport, early years), producing an annual report, and reporting to Public Health England.

The Director's remit suggests a direct report to the Chief Executive. Yet, currently, this is left to local areas to decide. This raises the prospect that public health could be siloed - partly defeating the arguments about addressing a broader range of the social determinants of health.

There is a risk of losing talent in the transition. How far will local authorities invest in public health staff currently in Primary Care Trusts?

The proposed transfer of responsibility comes at a time of dramatic cuts in local authority budgets and services. This increases the chance that public health skills will be lost. It will also lead to a very porous 'ring-fence' around the local public health budget.

Primary Care Trusts' (PCTs) public health staff are understandably concerned for their own futures. They are currently affected by the need to make savings in the NHS; the promise of a move to their local authority will not provide enough comfort for some. These uncertainties will lead to the loss of skilled staff.

More specifically, there is uncertainty as to whether local authorities will invest in acquring the kind of analytical capacity to the extent that PCTs' public health departments have. Very few local authorities currently make the level of investment required to employ registered Consultants in Public Health, for example. Yet their skills will be needed. High quality analysis will be central to supporting GP consortia in understanding population health, producing Joint Strategic Needs Assessments and local strategies, and providing inputs to the Health and Wellbeing Boards. Working out a means of retaining local analytical capability is therefore an important part of the transition.

There is an immediate job to be done in clarifying the different remits and investments of the NHS (GPs) and public health. Health and Wellbeing Boards have an important role

Prior to these reforms, PCTs' investments in health improvement services led to benefits that accrued (not always, but in large part) to PCTs themselves. Investment in smoking cessation services, for example, might then lead to reduced tariff payments for related 'down the line' use of secondary care.

The proposed reforms change the incentive structures in the system. The NHS (represented by GP consortia) and the public health service (local government) will be addressing a similar health improvement agenda, but from different ends of a continuum. The NHS will be responsible for treatment; public health for prevention. Where the two meet – weight management or smoking cessation services for example – there is a need for local clarity on the respective organisations' investments. Relationships between NHS and social care investments also remain critical.

The proposed Health and Wellbeing Boards provide a forum for these discussions. Again, much depends upon the ability of local organisations to establish effective arrangements

for roles, remits and responsibilities – and to start doing so quickly. One key risk here is the creation of the sort of talking shop seen in the early days of Local Strategic Partnerships. This risk is enhanced by the significant challenges GP consortia face in coming to terms with their new role as NHS commissioners (they will be busy with other things) and in the likely lack of common geographical boundaries.

Nanny has done more for public health than 'Nudge' ever will

The leaflet accompanying the White Paper states that "Local communities working together, and with a good understanding of human behaviour, will achieve more than extra laws and lectures from the government." This is a difficult case to sustain. The hope of the White Paper is that approaches set out in Thaler and Sunstein's book 'Nudge' can be employed in the field of public health. This is partly a means of sidestepping the common charge of 'nannying' adults.

Yet Nudge is pretty thin gruel for the public health practitioner, who has long recognised the foibles and flaws in human decision making. Instead, policy makers at all levels should acknowledge the trade-offs between improving health and other 'goods' – notably in this case an individual's liberty to act in a way that harms their health. Health gains brought about by the workplace smoking ban are a good example here; the debate was full and acknowledged these problems. From this perspective, nudging looks like a sideshow.

All the 'usual' challenges remain

Finally, amongst all of this change, it is easy to forget (and many will) the scale and complexity of the day job. Healthy lives, healthy people notes progress and problems in relation to the 'usual' public health concerns – such as smoking, sexual health, obesity and emergency planning – and adds a stronger focus on public mental health and (the new kid on the policy block) wellbeing. There is also the perennial challenge of making sure that services are as cost-effective as possible, and of gathering and using evidence to inform decisions.

Not one of the challenges described here is insurmountable. But each needs to be managed in a skilful, informed and sensitive manner. It is a cliché of policy analysis, but the reforms described here genuinely do present opportunities and threats. In the main, the opportunities lie in the agenda and the threats in the practicalities of implementation. The ability of local managers to work through the reforms – while not forgetting the day job - is the critical factor in reaping potential benefits.

GHK has undertaken a range of assignments in public health; our services can support a successful local transition

GHK is an employee-owned, multi-disciplinary research and consulting organisation. We have undertaken assignments relating to public health for NICE, Age UK, PCTs, Strategic Health Authorities, Skills for Health, Local Authorities, the Office of Fair Trading, regeneration programmes, Big Lottery, the European Commission, the Child Poverty Unit, and individual social enterprises and voluntary organisations. These assignments have covered topics such as obesity, smoking, sexual health, infant mortality, diet, exercise, domestic violence and mental health.

Our services include needs assessments, service design, training in evaluation and economic analysis, community and stakeholder consultation, facilitation and partnership reviews. We have a particular specialism in evaluation.

If you want to discuss any of the issues raised here, or would like to commission GHK for a specific assignment, please contact Fraser Battye on 0121 2338900 or fraser.battye@ghkint.com. More details of GHK and our services are available online at www.ghkint.com.