Public Health White Paper: Healthy Lives, Healthy People

Overview

Healthy Lives, Healthy People: Our strategy for public health (Public Health White Paper), was published on 30 November. It sets out in more detail the proposed reform of public health in England that was announced in the health white paper Equity and Excellence: Liberating the NHS.

The reforms will have significant implications for local government and they present major opportunities, as well as some risks. They are taking place at the same time as unprecedented spending pressures on local authorities and as part of huge structural change in the NHS.

The white paper does clarify some issues from the health white paper, but there are still several critical areas that are not yet clear – mainly because there are further consultation documents due to be published, particularly those on the outcomes framework and on funding and commissioning. These will be important documents and councils should respond to them, as well as to the white paper itself.

This briefing summarises the key points for local government in the white paper and sets out our initial thoughts on it.

Briefing in full

This white paper has been keenly anticipated by local government – following the publication of *Equity and Excellence: Liberating the NHS*, the health white paper. The Public Health White Paper provides more details on some of the key proposals that will fundamentally affect local government, particularly the transfer of public health responsibilities to local authorities. There are several important consultations outstanding, such as on funding and commissioning of public health and on the outcomes framework, so this white paper leaves some major issues unresolved at this stage.

The Secretary of State's foreword to the paper stresses the government's localist vision:

"*We need a new approach that empowers individuals to make healthy choices and gives communities the tools to address their own, particular needs. The plans set out in this White Paper put local communities at the heart of public health. We will end central control and give local government the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area. There will be real financial incentives to reward their progress on improving health and reducing health inequalities, and greater transparency so people can see the results they achieve".*

The white paper logically follows from the government's wider policy direction. Instead of 'top down' targets, there will be a national outcomes framework, setting out the broad public health and health inequalities outcomes. The approach to improving health encompasses concepts around choice and individual responsibility: *"all capable adults are responsible for these very personal choices (over lifestyles")*, but it also recognises that "*at the same time, we do not have total control over our lives or the circumstances in which we live. A wide range of factors constrain and influence what we do, both positively and negatively*". There are shared responsibilities for health and wellbeing between the individual, communities, the state, and the private and voluntary sectors.

The paper succinctly states the government's approach to improving health and wellbeing – "relevant to both national and potential local actions" – based on the following, strengthening self-esteem, confidence and personal responsibility; positively promoting 'healthier' behaviours and lifestyles; and adapting the environment to make healthy choices easier.

Health and wellbeing today

Healthy Lives: Healthy People recognises the critical importance of public health – *"most of the major advances in life expectancy over the last two centuries came from public health rather than healthcare".*

Preventing poor health is a major theme of the paper:

"*We know that a wide range of factors affect people's health throughout their life and drive inequalities such as early years care, housing and social isolation. Despite this, our health efforts focus much more on treatment than on the causes of poor health. The contrast between what we know about the causes of premature death and illness in our society and the domination of our attention and spending on secondary care represents a profound challenge to our policy and our society as a whole. At a population level, it is not better treatment, but prevention – both primary and secondary, including tackling the wider social factors that influence health – which is likely to deliver greater overall increases in healthy life expectancy".*

The paper sets out the challenges the country face in improving health and wellbeing, particularly in bridging the health inequality gap. There still are major public health challenges; rates of tuberculosis and sexually transmitted infections are rising; pandemic flu is still a threat; rising levels of obesity; the high levels of illicit drug use; regular heavy drinking by a minority of people.

The health inequality facts are well rehearsed: people in England are healthier and living longer than ever before, but people living in the poorest areas will, on average, die seven years earlier than people living in richer areas and spend up to 17 more years living with poor health.

The paper refers extensively to the 2010 independent review of health inequalities in England by Professor Sir Michael Marmot '*Fair Society: Healthy Lives'*. It follows the Marmot review approach in considering the 'life course' and in the emphasis on early years and young people:

"Starting well, through early intervention and prevention, is a key priority for the government, developing strong universal public health and early education with an increased focus on disadvantaged families. This approach, proportionate universalism, was advocated in the Marmot Review into health inequalities".

The new public health system

With the abolition of primary care trusts (PCTs) and Strategic Health Authorities (SHAs), the government is to create a new public health system in England. The new system is made up of two elements: the creation of Public Health England and of local government taking on new responsibilities for improving people's health and tackling health inequalities at the local level.

The paper highlights that the NHS will continue to have a crucial role in public health:

"Preventing ill health, screening for disease, supporting people with long-term conditions, improving access to care for the whole population and tackling health emergencies are all key functions that the NHS provides. GPs, community nurses, allied health professionals, dentists and pharmacists in the community, and hospital-based consultants and nurses all play a vital part".

Public Health England

Public Health England (PHE) will be created within the Department of Health, accountable to the Secretary of State for Health. PHE will hold a ring-fenced public health budget which is estimated to be around £4 billion. PHE will bring together public health functions that are

carried out in different parts of the system currently. It will incorporate the functions of the Health Protection Agency, the National Treatment Agency, the regional directors of public health and the Public Health Observatories. It will work with local government, the NHS, other government agencies and other partners in preparing for and responding to emergency threats and in building partnerships for health.

Public Health England's role will include:

- providing public health advice, evidence and expertise to the Secretary of State and the wider system, including working with partners to gather and disseminate examples of what works
- delivering effective health protection services
- commissioning or providing national-level health improvement services, including appropriate information and behaviour change campaigns
- jointly appointing Directors of Public Health (DsPH) and supporting them through professional accountability arrangements
- allocating ring-fenced funding to local government and rewarding them for progress made against elements of the proposed public health outcomes framework.

The new role of local government

"For the first time in a generation, local government will be given the responsibility, backed by ring-fenced budgets and new freedoms, to make a major impact on improving people's health and tackling health inequalities in every community".

The Health and Social Care Bill will provide that upper-tier and unitary local authorities will have a duty to take steps to improve the health of their population.

The key elements of the new system are:

Joint appointments of Directors of Public Health (DsPH)

DsPH will be employed by local government in upper tier and unitary authorities and jointly appointed by the relevant local authority and PHE. DsPH will lead local public health efforts: this role can be shared with other councils if agreed locally. They will be professionally accountable to the Chief Medical Officer (CMO) and part of the Public Health England professional network.

DsPH tasks will include:

- promoting health and wellbeing within local government
- providing and using evidence relating to health and wellbeing
- advising and supporting GP consortia on the population aspects of NHS services
- developing an approach to improving health and wellbeing locally, including promoting equality and tackling health inequalities
- collaborating with local partners on improving health and wellbeing, including GP consortia, other local DsPH, local businesses and others.

Local public health grant and the health premium

PHE will allocate a ring-fenced grant, weighted for inequalities, to upper tier and unitary local authorities, The budget will fund improving population health and wellbeing and some statutory services such as immunisations. There will be scope, as now, to pool budgets locally in order to support public health work.

The public health grant will be made under section 31 of the Local Government Act 2003. As a ring-fenced grant, it will carry some conditions about how the budget is to be used. The

paper says that the government will *"seek to enable flexibility for local areas to determine how best they can use this funding to improve the health and wellbeing of their community*".

There will be 'shadow' allocations to local authorities for each local area for this budget in 2012-13, providing an opportunity for planning before allocations are introduced in 2013-14.

There will be a health premium for health improvement, applied as part of the overall public health budget. PHE will award the premium to local authorities. Building on a baseline allocation that is weighted towards areas with the worst health outcomes and most need, local authorities will receive an incentive payment, or premium, for these services that depends on the progress made in improving the health of the local population, based on elements of the proposed outcomes framework.

The paper says that the *"premium will be simple and driven by a formula developed with key partners. Disadvantaged areas will see a greater premium if they make progress, recognising that they face the greatest challenges"* However, an area that makes no progress might receive no growth in funding for these services.

The consultation on funding and commissioning of public health will discuss issues around the health premium. The paper stresses that the government will only set out a detailed model when they have established the baseline and potential scale of the premium clearly, and have agreement about the outcomes to be used.

Health and Wellbeing Boards

How health and well beings boards will function is subject to the current consultation on them – the government will shortly publish their response to the consultation. The boards will bring together the key NHS, public health and social care leaders in each local authority area to work in partnership.

The public health white paper does give, however, a somewhat clearer picture of how the government envisage the boards working than was in the health white paper.

The paper confirms that the DH will put forward detailed proposals for the establishment of health and wellbeing boards in every upper-tier local authority.

"They will have the flexibility to bring in the local expertise of district councils. There will be a proposed minimum membership of elected representatives, GP consortia, DsPH, Directors of Adult Social Services, Directors of Children's Services, local HealthWatch and, where appropriate, the participation of the NHSCB. Subject to legislation, these members will be required to be part of the board, and local areas will be able to expand membership to include local voluntary groups, clinicians and providers, where appropriate".

GP consortia and local authorities, including DsPH, will each have an equal and explicit obligation to prepare the Joint Strategic Needs Assessment (JSNA), and to do so through the arrangements made by the health and wellbeing board.

The outcomes framework

The public health outcomes framework "will sit alongside" the proposed NHS outcomes framework and social care outcomes framework.

The proposed framework is likely to cover five broad 'domains' of public health:

Domain 1 – Health protection and resilience: protecting people from major health emergencies and serious harm to health;

Domain 2 – Tackling the wider determinants of ill health: addressing factors that affect health and wellbeing;

Domain 3 – Health improvement: positively promoting the adoption of 'healthy' lifestyles;

Domain 4 – Prevention of ill health: reducing the number of people living with preventable ill health; and

Domain 5 – Healthy life expectancy and preventable mortality: preventing people from dying prematurely.

Legislation

The Health and Social Care Bill will give upper tier and unitary councils a duty to lead public health efforts in their area and enact proposals in the WP. The bill will now not be published until after Christmas, but the DH says that they will publish its response to the Health White Paper 'Equity and Excellence' consultations in December.

Timetable – subject to parliamentary approval of legislation	**Date**
Consultation on:	
• specific questions set out in the white paper • the public health outcomes framework • the funding and commissioning of public health	Dec 2010 – March 2011
Set up shadow-form Public Health England	
Start to set up working arrangements with local authorities, including matching of PCT DsPH to local authority areas	During 2011
PHE will take on full responsibilities Publish shadow public health ring-fenced allocations to local authorities	April 2012
Local health improvement functions transferred to local authorities, with ring-fenced grant	April 2013

Comment

Significant parts of this white paper will be strongly supported by local government. The recognition of the role of local government in improving health and tackling the underlying social and economic causes of ill health is translated into major reform which puts local authorities at the heart of the new public health system. Indeed, the reforms could be seen as taking local government back to the role it had historically, even if the context is now very different.

The LGiU welcomes the commitment to bridging the health inequality gap and to building on the Marmot Review's work. Previous reports into health inequalities, notably the 1980 Black report, have been abandoned when a new government has come to power – this is clearly not going to happen to Marmot.

'All's well that ends well?' was published by the LGiU in November 2010. Commissioned by the Department of Health, it considered the role of councils in health improvement and analysed the proposed reforms that were set out in the health white paper from the perspective of local government. Many of the points we raised are reflected in the public health white paper. We particularly support the white paper's emphasis on prevention and early intervention; the plans for statutory health and wellbeing boards; the need for much more robust evidence about 'what works'; and the vision of integrating public health much more closely to areas such as social care. transport, leisure, planning and housing.

There are, naturally, areas where we think the government could have been more radical – such as in relation to developing new national models that incentivise public sector bodies to invest in programmes that prevent ill health and deliver financial benefits elsewhere over

time, providing financial rewards for councils investing in early intervention models, such as family intervention that produces, for example, savings down the line to the NHS.

Although local government will support the thrust of the white paper, there will, of course, be concerns about how it will be implemented.

Local government had called for the local public health grant not to be ring-fenced. We argued that the contribution of local authorities to improving the health of their residents and to tackling the health inequalities gap is made largely through their mainstream activities and ring-fencing the budget would constrict what councils can do. However, it is clear that it will be ring-fenced and local government must now forcefully argue for maximum funding discretion, in accordance with the principles of localism, to facilitate efficiencies, joint working and commissioning and pooled budgets.

It is not yet clear what the scope or scale of the budget is going to be, nor what it will have to cover in relation to new staffing responsibilities. The transfer of the DsPH and, presumably, parts of the public health workforce must be adequately funded.

The LGiU welcomes the health premium in principle, but it will clearly be very difficult to develop a system of reward that is both fair and understandable, There is also the wider danger that the outcomes framework will be too centralised and prevent innovation and local flexibility.

The position of the DsPH is of some concern. There seems to be confused accountabilities here, and the case has not been robustly made by the government for the joint accountability proposed.

There are bound to be tensions over the relative roles and powers of local government and PHE (and indeed between local government, the department of health and the NHS). Local government will want to see as much devolution as possible to the local level and for councils to take on a wider, lead commissioning role for services such as mental health. There needs to be continuing debate about the most appropriate split between councils and PHE for commissioning public health services. There also needs to be more thought given by the government to how district councils, that have an essential role in improving wellbeing, can be properly incorporated into the new regime.

All's well that ends well highlighted the major challenges facing local authorities in the transition to the new system and beyond. These challenges remain. Local government and health are facing major structural changes at the same time as unprecedented spending cuts; there are huge policy challenges, particularly tackling health inequalities; and new relationships need to be developed and partnerships redesigned. The white paper says little about the cultural change that will be needed, especially to ensure that councils can work effectively with the new GP consortia. It is recognised that GPs will need to work closely with local authorities and the DH says that it will work to strengthen the public health role of GPs. One of the few specific questions asked in the consultation is whether there are additional ways in which the DH can ensure that GPs and GP practices will continue to play a key role in areas for which PHE will take responsibility?

Although local government clearly faces big challenges, the reforms do offer very significant potential benefits for local government and communities. They should strengthen democratic accountability of local health and public health services. Local authorities collectively could take the lead in supporting health improvement locally and managing performance. This could be a unique opportunity to shift the policy and public emphasis from the focus on the medical model of health to health and wellbeing. The new framework for public health should more effectively bring together the work that councils do to influence health and wellbeing through their core services and leadership role with the more traditional public health and health improvement focus.