

Releasing the potential for the public's health



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Foreword

This paper results from the active collaboration of the Local Government Association, the NHS Confederation and the UK Public Health Association, and builds upon our joint response to the Government's public health consultation document, *Choosing health?*

Our purpose in collaborating to develop this paper has been to identify the key principles and the common ground that might underpin a joint vision between our organisations for a new approach to improving and sustaining the public's health. It is not a detailed implementation programme but a high-level consideration of the key drivers for such an initiative, which could be undertaken with confidence by the constituencies that we represent. In the coming months we will continue to develop the proposals set out here.

There has been a major debate about the most effective ways of tackling the health challenges that we face in the 21st century. We are clear that the way forward requires a proper balance to be struck between the responsibility of each of us as individuals for our own health and the responsibility of the state for creating the conditions within which the whole population can achieve its full potential for health.

This unprecedented current level of debate on public health has been driven in part by the

publication of the recent Wanless reports and the widespread acceptance of one of Wanless's key proposals, that prevention is better than cure. However, we must also acknowledge the paradox that while the general public may attach a high priority to tackling public health issues, this has not historically been translated into sustained investment and public health action. Preventing illness and disability, improving health and tackling health inequalities do not command the same level of political priority as the improvement of healthcare and clinical services. Evidence suggests that civil society may be more sympathetic to a prevention-orientated health agenda than national government and communities of experts. We are concerned that unless Government and the other powerful shapers of health policy embrace a public health mindset and ethos, there will be, once again, a faltering of momentum on public health.

We would urge the Government to take our proposals into account as it prepares its new strategy for improving public health. The three organisations presenting this paper will be key to the implementation of future public health policies and practice. Our members will be developing strategies at a local level, and our contribution is based on the knowledge and experience of our members. We look forward to a deepened involvement in securing better health outcomes for all our citizens.



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Introduction

In Government, the media and society at large, health remains one of our major preoccupations. In response to this, and to England's relatively poor health status, spending on health services is increasing. Yet, despite this, improving the public's health remains one of our biggest challenges. The recent Wanless reports^{1,2} are clear in arguing that improving health is the most efficient use of our collective resources and, most significantly, that the public's health is an outcome of all governmental activity. In this context, the Government has consulted on a new public health strategy in *Choosing health? A consultation on action to improve the people's health*.³

The current debate and level of awareness of the state of the public's health has been a welcome consequence of the Wanless reports and the *Choosing health?* consultation. However, many commentators have expressed concern about the emphasis on individual choice explicit in the title of

the consultation document; it is clear that individuals cannot control all the variables influencing health. We believe a strategy that emphasises only individual solutions, choice and competition without a corresponding statement of the responsibilities of Government will be ineffective. Wanless makes it clear that without the fully engaged scenario, in which Government and the public are fully committed to creating and sustaining health rather than to just the treatment of disease and management of disability, there is unlikely to be any reduction in the increasing costs of the NHS and the nation will fail to realise the collective benefits of the investment to date. On the other hand, if full engagement can be achieved, there will be significant relative reductions in future healthcare costs arising out of the prevention and management of chronic disease. In human terms this will mean that many more people will have more years of healthy life and, consequently, a better quality of life.

Summary and recommendations

As we suggest in this paper, it is now time for a clear statement of Government responsibility for public health and for new arrangements for political leadership to achieve it. This requires a fundamental commitment to health as a public not just an individual good, a willingness to end the injustice of intensifying health inequality, investment in local capacity to improve public health, and a strengthening of local governance to improve the health of local communities.

Recommendations

Our recommendations are:

1. The Government should make explicit its commitment to an enhanced model of health that, while recognising the contribution of health services, sets out a comprehensive and cross-cutting agenda of action for improving public health, addressing:

- the range of key drivers of health, including the physical and social environments
- the role of income as a determinant of health
- the interactive and dynamic nature of all of these determinants.

2. The Government should take urgent, precautionary action to strengthen the regulatory framework affecting the public's health, placing the onus of proof on industry, not the public, and establishing an independent, stakeholder-driven process to adjudicate the evidence.

3. In its forthcoming white paper on public health the Government should publicly reiterate its commitment to enabling people to escape from poverty. The white paper should identify further cross-cutting policies and fiscal

measures which tackle the wider determinants of health, including income. It should pinpoint the specific responsibilities of a range of Departments of State in this endeavour.

Moreover, we would want to see the commitment to tackling childhood poverty amplified by a further explicit commitment to tackling poverty in other groups, including pensioners and childless, low-paid adults.

4. The Government should commit itself to the transfer of responsibility for public health from the Department of Health to, or with, other government departments, and consider as a matter of urgency how to ensure the most effective leadership and co-ordination of public health action.

The position of Public Health Minister should become a Cabinet-level post, provided with the resources required to work towards the fully engaged scenario, and its funding should be considered a cross-Governmental responsibility.

5. The Government should review the title, role and remit of the Chief Medical Officer (CMO) to ensure there is proper emphasis on and support for the health agenda as well as health services. For health issues, the CMO should be responsible to the Public Health Minister and have dual accountability to him/her and the Department of Health.

6. The Government must ensure that the policies and programmes of all Departments of State are subjected to a process of health impact assessments and inequality 'proofing', overseen by the new Public Health Minister and his/her team.

7. The Government should ensure that the barriers to mainstreaming proven, effective interventions are removed – this may include

commissioning research into interventions where there is a weak or insufficient evidence base to support wider roll-out. This needs to be backed up by clarification of statutory agencies' responsibilities for mainstreaming effective interventions and for monitoring progress on mainstreaming.

8. The Government's forthcoming public health strategy should outline a range of measures which can ensure that a proper balance is struck between the responsibilities of individuals for their own health and those of Government and local agencies for enabling and supporting individuals in making healthy choices. In particular, we would wish to see the Government make explicit its commitment to developing the public health role and responsibilities of local government and of local voluntary and community agencies, and the allocation of additional resources to localities to develop this potential.

9. The Government should ensure that its public health strategy recognises the vital role local government plays in improving and sustaining public health.

The health scrutiny role of local government should be given the long-term resources and support necessary for the role to be carried out effectively, with less focus on NHS inspection, which may be better carried out by other agencies. We welcome the Centre for Public Scrutiny's three-year programme as a useful start.

10. Primary care trusts (PCTs) need to be supported in their public health role by a new performance framework that prioritises proper health needs assessment, evidence-based preventative strategies accompanied by substantial investment, enhanced community services, and effective strategies for managing acute illness.

11. We welcome the piloting of the new Local Area Agreements (LAAs) which we consider have the potential to enable much greater

autonomy and flexibility at a local level for the NHS and local authorities in partnership. The white paper should encourage PCTs to play a full part in LAAs. Subject to satisfactory evaluation, we would wish to see these agreements or similar mechanisms become the norm.

12. We urge the Government to desist from its command and control tendencies and to be bold enough to trust local agencies to plan and deliver their own services. The next round of Local Public Service Agreements (LPSAs), the development of Local Strategic Partnerships (LSPs) with teeth and LAAs should strengthen the leadership role and democratic accountability of local authorities and empower the development of robust partnership working.

13. The Government should streamline the current number of performance indicators. One of the potential benefits of the concordat between the Healthcare Commission and the Audit Commission and other inspectorates is improved local co-ordination of public health.

14. The boundaries of PCTs and local authorities should be aligned in order to promote and facilitate integrated working. There should also be strong integration of public health teams and skills within PCTs and local authorities – joint appointments are a powerful tool for achieving synergy and collaborative working.

15. The Government should take urgent steps to build public health capacity and bring forward proposals for developing the specialist and non-specialist workforce. This should involve further attention to the development of non-medical public health career pathways.

16. The Government should consider the case for creating a separate investment fund for health improvement, so that initiatives to improve long-term health do not compete for resources with day-to-day service provision.

Our rationale

There are a number of reasons why our organisations have collaborated to set out our strategy for improving and sustaining the public's health.

Firstly, each of the collaborating organisations recognises its own responsibility for contributing to the evolution of national policy on public health and well-being. We will do this by encouraging, evaluating and publicising innovation, and by supporting the efforts of the wide range of specialist and non-specialist staff in local government, the NHS and the non-governmental sector who have a contribution to make to improving and sustaining the public's health.

Secondly, we acknowledge that the partnership working undertaken in the development of this paper exemplifies and promotes the kinds of collaborative, reflective and creative relationships required across Government and between local agencies to tackle the complex factors influencing health.

Thirdly, we are concerned that without urgent action to achieve the fully engaged scenario, the

deepening of inequality in Britain will continue to erode the many gains made in the overall health status of the population. While we acknowledge that in many respects the nation is increasingly healthy and prosperous, there can be no doubt that inequalities in wealth, health and well-being remain stubbornly entrenched and are intensifying. For many people, life chances are determined too much by parental social class and ethnic background.⁴

Finally, we consider it both feasible and timely to consider the actual and potential impact of the modernisation agenda for improving public health. Under the auspices of public sector modernisation, a range of new powers, structures and systems have been introduced in the last five to six years. These developments, though still emerging, have been tested to some extent on the ground, enabling a critical reflection about their strengths and weaknesses. In developing this paper we have considered how these developments might be strengthened to enable more progress towards the fully engaged scenario.

Our shared principles

The Government should set out a clear vision for sustainable public health that includes the following values and principles:

The stewardship role of government

We unequivocally believe that achieving and sustaining the public's health and well-being is the key task of all levels of government, and that all government activities should be devoted to this ultimate goal. Hence, in our view, health improvement is inextricably linked to the concept of public governance.⁵ Recent research demonstrates that 50 per cent of variation in health is due to socio-economic differences, 25 per cent to health services, 15 per cent to biological determinants and 10 per cent to physical environment.⁶ These statistics demonstrate the extent of the impact that government, both central and local, can have.

Health as a public good

We concur with the notion elaborated in the Wanless reports that health should be seen as a public good, to be enjoyed by all to the full limit of their potential, with benefits that then accrue to both individuals and communities. We recognise that we all benefit from good public health and suffer when some groups are excluded from it. We profoundly take issue with the concept of health as a private good from which some are excluded by poverty or other forms of disadvantage.

The concept of health as a public good also obliges us to take into account the increasingly global nature of health. We believe that developed nations such as the UK must support

the public health systems of poor nations in order to address the growing disparities in health and life expectancy between the developed and the developing world. We are committed to the idea of equity as a global public good in itself and that it should be a universal principle of health policy.⁷

A commitment to social justice

We believe that investment in health improvement is more than an economic choice – it is a means of helping to create a better society. We also believe that improvements in the health of all our citizens will be the natural result of policies which help to reduce the significant disparities in wealth and well-being between different groups in the UK. Involving communities more deeply in public health policy will further encourage wider civic and democratic participation.

Effective management of the risks to public health

Managing the risks to public health will be particularly important for the current UK Government, which has committed itself to 'stakeholder regulation'⁸ and has strengthened previous commitments to public health. There is an increasing expectation that government will be seen to be taking proportionate actions to protect public health – particularly when it is the health of children and young people that is at stake. This is underscored by this Government, which acknowledges that in handling risk, 'both opportunity and threat is central to the business of government and [that] this core function needs to be carried out in a context of rising public expectations, declining trust in institutions, declining deference and increased activism.'⁹

Local governance

If we all truly mean business in developing the public's health and achieving the fully engaged scenario, all agencies and all levels of government must be fully committed to the new ways of working.

The concept of local governance is a helpful one in understanding and achieving this aspiration. The development of local strategic partnerships and devolved approaches to neighbourhood management are intended to reinvigorate local democracy and ensure government is more

responsive to local needs. These locally-focused partnership developments offer unprecedented opportunities for constructing new systems of governance in partnership with local people. Local authorities and PCTs are the natural partners and leaders in developing these new compacts, building upon the opportunities arising from current Governmental priorities and creating the foundations for the new public health. However, if these are to fulfil their potential, far more attention needs to be given to issues of organisational and cultural change, capacity building and the hidden costs of implementing these new agendas.^{10,11}

Our vision

A more comprehensive way of thinking about health

The health system in the UK has traditionally reflected a way of thinking about health that focuses primarily on medical care and research directly related to eliminating disease in the individual. While we recognise that this has intrinsic value to each of us, and we are in support of current efforts to enable and encourage individuals to become the co-producers of their own health, we believe that the single focus on healthcare and a fragmented approach to policy and service development has not, up until now, enabled a more comprehensive approach to the health of the population as a whole.

We believe that health is created or, conversely, undermined by a range of social, economic, environmental and biological factors. This complex notion of health entails an equally complex health policy response, requiring the co-ordinated and cross-cutting efforts of central government and local agencies – as well as greater willingness from individuals and the general public to take responsibility for their own health. However, the development of health awareness in the population is also a task for central government and local agencies. We all have a part to play in enabling people to develop a more sophisticated understanding of the consequences of their health choices – and increasing access to more responsive, efficient and flexible services.

Public health and sustainable development

We recognise that our broader vision for the health of the public is dependent upon achieving the social, economic and environmental conditions necessary for healthy living. This has been acknowledged by the commitment of successive

UK Governments (in 1992 and again in 1997) to implement Agenda 21 – the United Nations action plan for sustainable development agreed at the Rio Earth Summit.

Sustainable development is an essential precursor to the achievement of good public health. As the 21st Century unfolds, it is clear that unsustainable development resulting in environmental pollution and climate change poses significant threats to the public's health. Increasingly high levels of persistent organic pollutants from industrial and agricultural activity, together with toxic emissions from vehicle exhausts, are causing higher incidences of respiratory disorders, endocrine disruption and neurological dysfunction. Climate change resulting from global warming and the devastating impacts of flooding and extreme weather events are already beginning to impose severe pressures on the capacity of basic services such as sanitation and clean water supply and are creating intense physical and psychological distress among affected populations.

In this context, we believe that government and the agencies we represent, all have a responsibility to consider how we can promote sustainable

Recommendation 1

The Government should make explicit its commitment to an enhanced model of health that, while recognising the contribution of health services, sets out a comprehensive and cross-cutting action agenda for improving public health, addressing:

- the range of key drivers of health, including the physical and the social environment
- the role of income as a determinant of health
- the interactive and dynamic nature of all of these determinants.

development. Reducing waste, traffic and pollution, looking at energy and water consumption, and taking measures to reduce food miles are all examples of sustainability objectives with obvious connections to health improvement. Almost all have implications for early interventions in managing risks to the health of the population in relation to the root causes of heart disease, cancer and asthma. It's these risks the Government is seeking to address through the *Choosing health?* consultation.

Given the significant interconnection between policies aimed at the promotion of the public's health and policies aimed at achieving sustainable development, we are concerned that a new consultation paper on sustainable development, *Taking it on*,¹² barely mentions health. This exemplifies the narrow view of health and the fragmentation of policy agendas discussed above. We believe it is essential that we see a convergence of these agendas.

Achieving the vision: our proposals

Government leadership

As a result of our belief in the incontestable responsibility of the Government for the stewardship of the public's health, we would wish to see it assume a much stronger leadership role. The Government must seek broad political support for public health values and principles and then plan to ensure the long-term sustainability needed to ensure improvements in the public's health. Practically, this involves:

The Government acting in those areas where only the Government can act

We believe that effective regulation is a vital lever to use in protecting the health of the public. Voluntary self-regulation in this context is wholly inadequate. Evaluation of its effectiveness is predicated on the assumption that the underlying codes of practice adequately protect the public and consumer interests and that there is not an imbalance between protecting and serving the interests of industries and those of the public. There is no evidence of successful self-regulation of public health. In the case of tobacco, self-regulation failed as each voluntary code was circumvented by new marketing strategies outside of the codes. Evidence that this is happening in relation to food has been substantially cited in recent months, not least by the Food Standards Agency.¹³

The National Consumer Council is clear that while self-regulation is perceived to have some advantages over traditional legislation, particularly in terms of its potential flexibility and cost, such advantages are not always achieved in practice. Moreover, there are some circumstances in which self-regulation should not be used. These include:

- where there is a risk to life or health
- when unfair advantage is taken of vulnerable people.¹⁴

Many of the current challenges to public health, including childhood obesity, binge drinking and smoking, have taken place against a liberal regulatory framework that does not provide adequate protection for consumers – particularly children as a uniquely vulnerable group. There are occasions when we need to protect the entire population with regulation and other times when we only need to protect vulnerable groups such as children. This is particularly seen to be the case in relation to environmental protection, the development of sustainable transport systems, health and safety, the nutritional content of foods and the advertising and marketing of food, drink and tobacco to the general public.

We believe there is a prima facie case for the adoption of a precautionary approach to public health protection underpinned by a framework that includes education, information and other supporting resources. The emerging policy framework needs to strike a balance between recognising the individual as co-producer of his or her health and recognising and responding to the differential needs within society, particularly those of the more vulnerable individuals and groups.

Recommendation 2

We recommend that the Government take urgent, precautionary action to strengthen the regulatory framework affecting the public's health, placing the onus of proof on industry and not the public, and establish an independent, stakeholder-driven process to adjudicate the evidence.

Tackling poverty

The Government also has the key role to play in tackling poverty, which has an indisputable impact on health and life chances.¹⁵ While we applaud the

Government's efforts tackling childhood poverty, it remains the case that Britain still has a poor record on child poverty compared with the best performing EU countries.¹⁶ In addition, we consider it unacceptable that, on the basis of the available figures, pensioner poverty has not fallen at all since 1994^{17,18} and that the life conditions of significant numbers of working-age adults, including many from hard-to-reach and excluded groups, remain extremely unfavourable.¹⁹ It has been suggested that, irrespective of the boldness of the Government's pledge to end child poverty, it has been reluctant to make this intention explicit. Given the centrality of this objective to the achievement of public health, we would urge the Government to lead public debate on this issue rather than follow public opinion and to demonstrate across the full range of its activities a more overt and consistent approach to ending poverty.

Recommendation 3

We recommend that in its forthcoming public health white paper the Government publicly reiterates its commitment to enabling people to escape from poverty. The white paper should identify further cross-cutting policies and fiscal measures that tackle the wider determinants of health, including income. It should pinpoint the specific responsibilities of a range of Departments of State in this endeavour.

Moreover, we would want to see the commitment to tackling childhood poverty amplified by a further explicit commitment to tackling poverty in other groups, including pensioners and childless, low-paid adults.

Cross-government co-ordination

New leadership arrangements for public health

The multiplicity of factors involved in the creation and sustaining of the public's health requires the development of an effective mechanism for co-ordinating the vast range of national policies and activities that impact on it. We believe that the retention by the Department of Health of lead

responsibility for public health obscures this cross-cutting dimension and is consequently illogical. Moreover, it perpetuates and reinforces the erroneous view that our present healthcare systems can also deal with the promotion and sustaining of good health and that the choice is between investment in health services today or health improvement services. We are clear that investment in this broader concept of health should become a cross-governmental responsibility. These arguments have been made by many analysts before, in particular by the House of Commons Health Select Committee in its 2001 report on public health. This report outlined a general stance of 'watchful waiting' in order to assess the extent to which the Department of Health could exercise truly effective leadership for public health.²⁰

We believe that the Government should now transfer overall responsibility for public health from the Department of Health and create arrangements for a new and overarching public health entity within the Government. Moreover, we propose that the Public Health Minister should have a seat in Cabinet. This would signal the Government's commitment to public health improvement consistent with the fully engaged scenario and provide the necessary political leadership for its public health strategy. These developments could generate the impetus needed to make real progress on public health improvement.

Recommendation 4

We recommend that the Government commits itself to the transfer or sharing of responsibility for public health from the Department of Health to or with other Government departments, and that it considers as a matter of urgency how to ensure the most effective leadership and co-ordination of public health action.

We further recommend that the position of Minister for Public Health becomes a Cabinet-level post and is provided with the resources required to work towards the fully engaged scenario; its funding should be considered a cross-governmental responsibility.

Maximising the Chief Medical Officer's influence

The Chief Medical Officer's (CMO) department is crucial in promoting action on health inequalities. We are concerned that the current remit of the CMO is too broad, covering as it does the domains of health improvement, health protection and healthcare quality. The breadth of the role is a serious barrier to the post being effective in securing better public health. While retaining medical aspects, preventative work must form the greater part of the role.

We would wish to review and remodel the current CMO arrangements to ensure the role provides key leadership and influence across all Government departments. By becoming a stronger advocate for preventative interventions, the CMO has the power to prioritise this agenda among senior policy makers, managers and clinicians. The position and its supporting team should be redesigned to include a stronger interface with the key public health departments while maintaining the senior status in the Department of Health it currently enjoys. Powerfully, this position could be given dual accountability to the Department of Health and to the non-Department of Health-based, Cabinet-level Minister for Public Health.

Recommendation 5

We recommend that the Government reviews the title, role and remit of the CMO to ensure that there is proper emphasis and support for the health agenda as well as health services. For health issues, the CMO should be responsible to the Minister for Public Health and have dual accountability.

Health impact assessment of policy

We also note that the Health Select Committee recommended that each Government department should 'conduct health audits and health inequality audits of relevant policies.'²¹ We believe that the key role for Government is to audit all of its policies to ensure they complement and

encompass the public health agenda. Without this systematic mechanism for assessing the impact of policy, we are unlikely to achieve the required policy synergy.

Recommendation 6

We recommend that the Government ensures that the policies and programmes of all Departments of State are subjected to a process of health impact assessment and inequality 'proofing', overseen by the new public health minister and his/her team.

Mainstreaming

We would argue that the existing 'health gap' between different population groups and areas will not be successfully tackled without recognition that services to address health inequalities must be mainstreamed. This will give a better chance that they will be designed to ensure they support health improvements in disadvantaged groups.

While useful learning can emerge from innovative and effective short-term projects, piecemeal funding encourages the thinking that spending on tackling deprivation is a separately resourced problem. Replacing this with a long-term approach that mobilises the whole range of public sector resources is crucial to breaking the cycle of deprivation.

Recommendation 7

We recommend the Government ensures that the barriers to mainstreaming proven effective interventions are removed – this may include commissioning research into interventions where there is a weak or insufficient evidence base to support wider roll-out. This needs to be backed up by clarification of statutory agencies' responsibilities for mainstreaming effective interventions and for monitoring progress on mainstreaming.

Releasing the potential of communities

We recognise that having a sense of control over one's life is important for health and that, unless individuals perceive that they have autonomy, their capacity to make healthy choices is highly constrained. We would wish to enable people to become more effective at keeping themselves healthy for longer, whether through the development of services and information that can enable them to make healthy choices and respond to their individual needs or through the empowerment of communities, particularly in areas of high disadvantage.

This is particularly important if we are to reduce health inequalities. Decision-making which does not take effective targeting into account or does not involve the active participation of local people in designing services, opens up the risk that inequalities will continue to intensify. This will require a new culture within local service networks, embracing the need to serve the public with services which respond effectively to needs, and the development of new skills for engaging and sharing power with local people. This new culture is necessary if new services are to be developed which can

effectively respond to the diversity of needs inherent in local communities, but also to address the decline in civic participation and the growing loss of trust in institutions, particularly evident in areas of high deprivation.²²

Releasing the potential of local government

Local government functions and services

In our vision for public health we recognise the crucial role local government plays in supporting and influencing the wide range of agencies and organisations that make up civil society. We also recognise the legitimate mandate local government has in representing the interests of local people and acting in response to demand for social action at a local level.

Local government's diverse services and regulatory functions have a major impact on people's lives and it is often the major employer in its locality. The list of local government functions and services that act to improve the health and well-being of the local population exceeds that of any other public body. Local government has the capacity to tackle public health in the following ways:

- as an employer
- through the services it commissions and delivers
- through its regulatory powers
- through community leadership – democratic localism
- through the well-being power.

However, this vital role has been both obscured and undermined by the policy fragmentation which has separated policy on healthcare from the wide range of policies determining the conditions in which health can be sustained. These latter policies have not enjoyed the same political salience as policies affecting healthcare. We would urge the Government to challenge this policy hierarchy once and for all in its forthcoming public health strategy and make explicit its commitment to supporting and extending the role of local

Recommendation 8

We recommend that the forthcoming public health strategy outlines a range of measures which can ensure that a proper balance is struck between the responsibilities of individuals for their own health and those of government and local agencies for enabling and supporting individuals in making healthy choices. In particular, we would wish to see the Government make explicit its commitment to developing the public health role and responsibilities of local government and of local voluntary and community agencies. The Government should also make explicit the allocation of additional resources to localities to develop this potential.

government in promoting and sustaining the people's health within the new balanced framework.

Community leadership

Community leadership empowers and enables councils to work together with other partnerships to make a real difference to the well-being of local communities. Many authorities are using this power to look beyond traditional service boundaries towards their wider responsibilities for the economic, social and environmental well-being of their areas. As the examples below describe, the Local Government Act 2000 is being used by local authorities in many different ways, although a hallmark of success has more often than not entailed working closely with local partners through the Local Community Strategy and local strategic partnerships.

Case study

Hastings has used the well-being power to promote safer sun bathing. The council has worked with a local manufacturer to give out free suntan lotion bottles on the beach. Last year, the council went one stage further in selling over 2,000 bottles of the lotion at half the normal retail price. The council has not made any profit from the partnership as the 80 pence from every bottle sold has been used to cover the costs of the promotion. The project has received very good coverage in the local, regional and national press, helping to promote Hastings as an attractive place to go on holiday.

Scrutiny

In this regard, we consider the power of health scrutiny to be vital and that local authorities should be given the resources and support they need to undertake it effectively. Health scrutiny can be used to enable agencies to become more responsive to the health needs of their communities by considering the effectiveness of strategies and actions designed to address local health needs. To

have a lasting impact, health scrutiny must also be more than just the inspection of local NHS hospital services. Health scrutiny should also focus on public health issues in the widest sense and come up with realistic, practical ways forward that can be acted upon by local individuals, communities and organisations. Health scrutiny, within a much simplified framework, potentially provides a real opportunity to think outside the box and instigate novel or interesting proposals that may achieve alternative concrete scenarios.

Case study

Cornwall's scrutiny committee recently looked at ways of preventing Type 2 diabetes through the promotion of healthy lifestyles. Research has shown that the incidence of Type 2 diabetes is rising even though it is largely preventable. The increase has been attributed to changes in lifestyles and diets. The committee felt that there needed to be a concerted effort by all those involved in public health to stem the increase and it listed 36 recommendations for local action. Taken together, they call for a more joined-up, strategic approach to tackling this increasingly prevalent disease.

Recommendation 9

We recommend that the Government ensures its public health strategy recognises the vital role local government plays in improving and sustaining public health.

We further recommend that the health scrutiny role of local government be given the resources and support needed for the role to be carried out effectively, with less focus on NHS inspection which may be better carried out by other agencies. While we welcome the Centre for Public Scrutiny's three-year programme as a useful start, we recommend that health scrutiny be given the long-term resources and support it needs to be carried out effectively.

Releasing the potential of the NHS

A recent poll by The NHS Confederation²³ has shown that 52 per cent of NHS chief executives consider public health to be the most important current health issue. Nevertheless, the current expectations and performance regime can make it difficult for organisations to deliver the vision or give the degree of personal leadership that they would wish. While the Wanless Report is clear that no single agency can take responsibility for tackling health inequalities, recent national reports remark on the achievement of and scope for the NHS, particularly primary care, engaging in preventative programmes and targeting vulnerable and excluded communities. We agree that the requirement for PCTs to improve the health of their populations as part of their core business provides enormous scope to engage in sustained preventative programmes and dynamic partnerships at the heart of their communities. However, if PCTs are to fulfil this potential, several things have to change to enable them to operate effectively in partnership with local government and the private and voluntary sectors.

Commissioning for health

Firstly, PCTs need to be enabled to commission for health as well as healthcare. Health services need to be commissioned within a framework that explicitly links investment with the health strategy. These two components must be seen to be inextricably linked. This requires a radical shift in the performance framework to give as much priority as possible to the proper assessment of health needs, the development of evidence-based preventative strategies backed by real investment, the enhancement of community services, as well as effective strategies for managing acute illness. This change would enable shifts to be made both culturally and in the skills base of the workforce.

PCTs need additional public health capacity to deliver public health programmes and the public health intelligence skills necessary to understand and work effectively with local communities. Local Delivery Plans (LDPs) and health equity audits are

essential tools. These and the emerging data need to be fully exploited. In line with other workforce modernisation, the public health workforce requires redesign, including enhanced managerial and leadership skills, to meet the needs of an effective and high-quality public health organisation.

Changing ways of working

The new contracts for GPs, pharmacists, dentists and optometrists provide an opportunity to mainstream a public health approach by incentivising new ways of working. The provision of enhanced services under the new General Medical Services contract offers huge potential to invest in, for example, sexual health, smoking cessation and services for the homeless. In addition, the GP contract and Agenda for Change have the potential to radically refocus the professional roles of nurses, midwives and health visitors, and maximise their public health contribution.

Managing care

At the heart of Wanless's recommendations is an emphasis on changing the way that individuals interact with health services. If patients and the public are to take control over their health they must be given better information and be equipped with the necessary confidence to support this shift. This is a major challenge in relation to the most disempowered, excluded and disengaged groups and individuals. The onus is therefore on government and statutory bodies, in partnership with the voluntary sector, to address this. The fully engaged scenario also requires a change in relationships with professionals and the targeting of behaviour before people become active users of services. Sure Start exemplifies the approach required. These methodologies need to be extended to work with other groups. It is acknowledged that this is being adopted by new chronic disease and case management programmes, which involve a more systematic and personalised approach to service delivery, putting the patient's specific needs at the heart of the care plan. The training of all health and social care professionals needs to include these perspectives and capabilities.

The NHS as employer

As with local government, the NHS is a key employer of large numbers of people, many in manual groups and from many diverse ethnic backgrounds. This provides important opportunities to improve the health of large numbers of people through training, education, occupational health programmes and the development of new kinds of services, including the development of community enterprises. Moreover, the NHS has a role to play in promoting local environmental health through its policies and practices in transport, recycling, food sourcing, waste disposal, utilisation of energy and building design. These potentials have been identified systematically in a range of publications in recent

years; however, these considerations are very marginal or non-existent within the pressing business agendas of hard-pressed trusts. It is our view that the responsibilities of the NHS in this area need to be clarified and prioritised.

Recommendation 10

PCTs need to be supported in their public health role by a performance framework which prioritises proper health needs assessment. This needs to be accompanied by evidence-based preventative strategies, substantial investment, enhanced community services and effective strategies for managing acute illness.

Partnership

Beyond the rhetoric

The concept of partnership has become a cornerstone of a range of recent policy shifts aimed at modernising institutions across the whole field of civil and public life. One of the main influences reflects the growing recognition that there are links between policies on health and those, for example, on housing, the physical environment, employment and other functional areas. There is also a

recognition that issues such as urban deprivation must be tackled in a co-ordinated way. This approach holds out the prospect of tackling the longstanding, interconnected problems affecting the public's health – and in particular of reducing the health gap between social groups and tackling social exclusion – more successfully than discrete policies in specific, functional areas.

Local Area Agreements

In this regard, the imminent piloting of Local Area Agreements (LAAs) is welcome. Under LAAs, local authorities, the NHS and other relevant partners will be able to negotiate with central government clear targets and outcomes for their areas, but will have the autonomy and flexibility to decide locally how best to achieve them. This new form of national/local agreement will also simplify funding streams into one pot and act as a strong inducement to joined-up working. Furthermore, Local Public Service Agreements will be an integral part of the LAAs, offering financial rewards for high performance. LAAs represent a way forward in that they will establish a more mature relationship between the Government and local bodies, based on mutual trust and delegated responsibilities.

Case study

The South Warwickshire health and social care community is proposing to develop a foundation health community, integrating all the major partners in the economy – South Warwickshire PCT, the County Council and the local acute trusts, two of which are expected to become foundations by 2006. The proposal aims to maximise the individual strengths of local government and the NHS and to work in partnership where this will have a beneficial impact for the population. It will integrate current and impending policy initiatives, such as chronic disease management, choice and payment by results, LSPs, and National Service Frameworks, to maximise the health gains for the local population. Particular emphasis is being put on targeting health inequalities and mainstreaming preventative action, for example:

- providing GPs and other primary care providers with incentives to actively manage the health of their registered population
- including prevention within PCT commissioning and informing it with a sound evidence base of both the effectiveness and cost-effectiveness of public health interventions.

Recommendation 11

We welcome the piloting of the new Local Area Agreements, which we consider have the potential to enable much greater autonomy and flexibility at a local level for the NHS and local authorities in partnership. The public health white paper should encourage PCTs to play a full part in Local Area Agreements. Subject to satisfactory evaluation, we would wish to see these agreements or similar mechanisms become the norm.

Making local partnerships work

Our vision is fundamentally one of a partnership model. We recognise that tackling the multiple factors involved in health requires profound cultural change to drive forward co-ordinated efforts, unified targets and funding streams, incentives and a common performance framework. We discuss these in turn below.

Incentives

A performance management framework which prioritises action on inequalities will be a powerful lever for change. The allocation of resources to PCTs and local authorities also needs to be revisited to build in protected social capital investment to ensure sustained funding for long-term health programmes. This would need an accompanying joint audit tool to quantify progress.

Case study

The Healthy Settings Unit at the University of Central Lancashire has developed a work programme which Salford PCT is helping to implement. The PCT has funded a post in the Economic Development Unit of the City Council, the post holder ensuring that the measures taken will complement the work of the City Council in its plans to regenerate Salford. The primary focus of the work is to develop the willingness and capacity of directorates across the PCT and City Council to do business in a way that has benefits for the health of local people. Early activities undertaken include a review of recruitment processes to encourage local people to apply for jobs, schemes to ensure local suppliers are considered for providing goods, and incentives to encourage cycling.

Unified targets

In the first round of Local Public Service Agreements (LPSAs) each authority and its partners had on average three health/social care targets, representing 25 per cent of the total number of targets. The first round of LPSAs led to improved

partnership working at a local level as well as greater dialogue and engagement between local authorities and the Department of Health.

Case studies

In Stockton-on-Tees the target for reducing local drug use has been achieved through the use of pooled budgets to support a specialist GP service, a young person's community drugs team and the redeployment of the Addictive Behaviour Service into primary care settings.

An LPSA target on food poverty was met by the setting up of the Coventry Community Nutrition Service. There, a team of nutritional experts works directly with families, individuals and the community to encourage healthier lifestyle choices by promoting the link between good food and health, improving people's cooking skills as well as their budgeting, shopping and preparation skills.

Recommendation 12

We urge the Government to desist from its command and control tendencies and to be bold enough to trust local agencies to plan and deliver their own services. The next round of Local Public Service Agreements, the development of Local Strategic Partnerships with teeth and Local Area Agreements should strengthen the leadership role and democratic accountability of local authorities and empower the development of robust partnership working.

Joint performance monitoring

In the last five years, performance assessment has become an industry in itself. This, in our view, has diverted performance assessment away from its main objective of helping localities improve local services. In addition, there has been an escalation in the number of targets, inspections and controls. For example, there are currently over 17 significant inspectorates in local government.

We are interested in the joint work being developed by the Healthcare Commission and Audit Commission stemming from the concordat between them and other inspectorates.²⁴ Hopefully, this will result in much more joined-up inspection and local development arrangements. However, the key to achieving this will be a commitment by Government to simplify as well as join things up, in parallel with a truly collaborative approach between inspectors and meaningful partnership at a local level between key organisations.

We call for a performance assessment framework for localities which is more streamlined, proportionate to risk and focused on what matters locally. Such a framework should focus on public health outcomes and not on institutions or service silo outputs and processes. We believe that a performance assessment framework that prioritises action on inequalities will be a powerful lever for change. Furthermore, the audit and inspection system should be seen as part of a wider range of tools to help drive improvement – tools that could increasingly shift to more internally-driven processes such as self, peer and even user assessment/challenge.

Recommendation 13

The Government should streamline the current number of performance indicators. One of the potential benefits of the concordat between the Healthcare Commission, the Audit Commission and other inspectorates is improved local co-ordination of public health.

Coterminosity and joint appointments

One of the obstacles to integrated working at local level on public health is the absence in very many areas of coterminosity between health and local government organisation. While we recognise that this is not an absolute deterrent to effective working, we believe a commitment to bringing the boundaries of PCTs into alignment with those of local authorities would be welcome.

In keeping with this, we believe that closely integrated PCT and local authority public health departments are essential. The skills of the director of public health (DPH) and the public health team should be available to both the PCT and the local authority and should be applied flexibly in order to maximise the benefits locally. The model of joint PCT–local authority appointments provides an ideal basis for this. We would wish to see the DPH role become more completely that of the public health advocate for the community it serves.

Recommendation 14

We recommend that the boundaries of PCTs and local authorities be aligned in order to promote and facilitate integrated working.

We further recommend that there should be strong integration of public health teams and skills in PCTs and local authorities – joint appointments are a powerful tool for achieving synergy and collaborative working.

Enhanced capacity at local level to address local health

One consequence of focusing energies on healthcare rather than on public health has been the relative lack of development of the public health workforce. Yet, as discussed in Wanless and acknowledged in *Choosing health?*, the last few years have seen a massive rise in demand for the expertise of public health specialists to tackle the challenges which we face, including the rise in sexually transmitted diseases, the obesity epidemic, resilience planning against terrorist attack, and the impact of tobacco use and pollution.

Since 2001, there have been massive changes in public health structures in the UK. The creation of the Health Protection Agency and primary care trusts has led to a shortage of specialists in the field as these are drawn into management positions. In addition, there are a significant number of vacancies for directors of public health in PCTs.

Hardly surprising therefore that the morale of public health workers is low.

In some areas, public health networks, observatories and academic departments are providing some capacity, but this is patchy and if they are to work effectively they need to be managed and resourced properly. The arrival of environmental health, nursing, dental and other staff onto the field is welcomed, but access to training for these groups is very poor and career paths are not developed. Wanless was especially critical of the fragmented and overstretched nature of the public health workforce.

The Faculty of Public Health has recently made a series of recommendations to the Government on ways of addressing the current shortage of capacity. We support the general thrust of its recommendations which outline a strategic approach to long-term workforce planning for the specialist workforce. The agenda needs to engage and involve the whole workforce. We would also want to see greater emphasis on the development of education and training pathways for the broad non-specialist workforce in both the NHS and local government, including the development of non-medical career pathways and skills escalators. This is key to the development of the public health

mindset, itself an essential underpinning of sustained strategic change. The management and administration of public health also needs to be honed and developed in order to equip services for the modern challenge.

Recommendation 15

We recommend that the Government takes urgent steps to build public health capacity and brings forward proposals on developing the specialist and non-specialist workforce. This should involve further attention to the development of non-medical public health career pathways.

Recommendation 16

We also need to examine how we fund programmes to tackle health inequalities so that money is not diverted into more immediate areas of the health service. There is a case for creating a separate investment fund for health improvement so that initiatives to improve long-term health do not compete for resources with day-to-day service provision.

Conclusions

The vision for public health and the recommendations set out in this paper have been developed in a context of increasing public health challenge and increased concern at all levels of society. Up until now, the policy focus on the needs and performance of the healthcare system has pushed public health, long-term health promotion and health improvement schemes onto the back-burner. Moreover, there has been little awareness of the interconnectedness of policies on health and other policies. Hence, there has been a lack of co-ordination of effort to tackle the joint problems.

As a consequence, we potentially face a crisis in public health as we move further into the 21st Century. This will be immeasurably damaging to the nation as a whole; in recognition of this there is a new policy focus on public health. We welcome this but believe that it is fragile. Its growth cannot be left to chance or to the short-term interests of government: the stakes for the future health and prosperity of the nation are too high. In this paper we have set out proposals which we believe will nurture and consolidate the public's health through the generation of sustained political commitment and the development of a workforce that is both skilled and passionate about its purpose.

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Cover photographs courtesy of Jon Walter at Third Avenue.

The collaborating organisations

The **Local Government Association** represents over 400 local authorities in England and Wales and exists to promote better local government, enabling local people to shape a distinctive and better future for their communities. It aims to put local councils at the heart of the drive for better public services, working with Government to secure that objective.

The **NHS Confederation** brings together the organisations that make up the modern NHS across the UK. Working with our members, we are an independent driving force to transform health services and health by influencing policy

and the wider public debate and connecting health leaders through networking and information sharing.

The **United Kingdom Public Health Association** is an independent voluntary organisation bringing together individuals and organisations from all sectors who share a common commitment to promoting the public's health. It seeks to promote the development of healthy public policy at all levels of government and across all sectors, acting as an information platform and aiming to support those working in public health, both professionally or in a voluntary capacity.

Releasing the potential for the public's health

It is time for a fundamental political commitment to health as a public not just an individual good, a willingness to end the injustice of intensifying health inequality, investment in local capacity to improve public health and a strengthening of local governance to improve the health of local communities.

This paper, the result of the active collaboration of the Local Government Association, the NHS Confederation and the UK Public Health Association, makes a number of key recommendations. These include: transferring the

responsibility for public health from the Department of Health to, or with, other Government Departments; making the position of Public Health Minister a Cabinet-level post; making the Chief Medical Officer jointly accountable, for health issues, to the Public Health Minister and the Department of Health; strengthening primary care trusts and local authorities in their public health roles through a more streamlined performance management framework; and aligning the boundaries of primary care trusts and local authorities and integrating their public health teams and skills.



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