PERSPECTIVES ON PUBLIC HEALTH SERIES

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The mood music surrounding the government's public health proposals has detectably changed and, for those keen to see public health return to its natural home in local government, the sounds are shrill and discordant. The widespread enthusiasm which greeted the public health white paper's two central messages when it appeared in November 2010 – that public health should become the responsibility of local government, and that the Department of Health should focus on health rather than ill-health – has largely evaporated in some quarters to be replaced by a much more guarded and cautious response. At one level, the shift reflects a regrouping of vested interests and a growing defensiveness in the face of what many fear may result from the changes were they to proceed as intended.

Amidst the continuing delay and uncertainty over much of the detail of the proposed changes, and possibly aimed at allaying fears over the 'bold vision' for reform set out in the white paper in November 2010 becoming blurred, the government published a policy statement in mid-July 2011 by way of an update on the way forward.[1]

Maybe it was naïve to expect a smooth ride for the original proposals, especially when many of those who have raised doubts about the transfer of much of the public health function have been charged with making the transition work. Is there not a lesson here, namely, that if you want to disturb the status quo it makes little sense to entrust the task to those who either consider themselves to be at risk or who stand to lose most from the changes. 'Disruptive innovation' was never likely to find favour among certain groups in public health – largely, though not exclusively, those with a clinical background – who, with few exceptions, are cautious, risk averse and have always been suspicious of local government.[2] Even those within the specialty who earlier professed their support for the return of public health to local government and for the Secretary of State for Health to live up to the title, having sensed a change in wind direction are now insisting on certain safeguards being put in place to prevent what they fear will be the fragmentation of the public health workforce and its withdrawal from the NHS where there remains important work to be done. While the government's July 2011 policy statement and update endeavours to take the heat out of the situation and restore confidence in the original policy direction, it is very much a case of 'work in progress' with a raft of knotty issues still to be sorted over the coming months. At the same time, there have been a few notable changes resulting from the negative response to some of the original proposals and from the recommendations of the NHS Future Forum. The case against the original proposals was made most cogently and persuasively by a group of public health academics whose critique appeared in that widely respected organ of the medical establishment, *The Lancet*.[3] Their anxieties centred on the following: a perceived loss of independence if public health goes into local government and also into Public Health England (PHE) if located within the Department of Health; insufficient status and political support locally; a fear that public health budgets, even if protected for a time, will be at risk from cash-strapped local authorities; and worries that the new arrangements will be insufficiently attractive to attract and retain high-quality staff.

In modified proposals which attracted the support of the Faculty of Public Health, Association of Directors of Public Health, and the British Medical Association, McKee et al suggested that PHE should be located outside the Department of Health to ensure its independence, and that the existing NHS-based public health workforce would be transferred to PHE and contracted to local authorities as required. The authors acknowledged that their proposals 'might reduce the sense of ownership of public health by some local authorities'. Surely this strikes at the heart of the matter. If local government is merely to host a function that to all intents and purposes is accountable to, and run from, a central body then the whole purpose and spirit of the original proposals aimed at integrating the function with local government will be lost. This, of course, is the authors' primary intention in order to ensure, in the words of one of the contributors to this collection, 'that local government does not run away with the

function'. For many in public health that is the nightmare scenario. It has also given Department of Health ministers and officials a headache they had not anticipated. The government's response to the various concerns expressed is a mix of capitulation on the one hand and commitment to holding the line on the other. So, while Public Health England will now be an executive agency with its own distinct identity quite separate from the Department of Health, Directors of Public Health (DsPH) and their teams will move to local authorities as proposed back in November 2010. Whether these developments and shifts will be sufficient to satisfy the critics is unclear and will probably not be known for sure for some time. As ever in these situations, the devil is in the detail and much of this remains to be worked through.

Reviewing the contributions to this LGID publication, it is striking how pervasive the more cautious and grudging welcome for the white paper changes is. A broad, if rather lukewarm, welcome for the main thrust of the changes is accompanied by wariness about some aspects of them and a concern that the alleged strengths of public health, as it has evolved within the NHS since 1974, may be put at serious risk. Apart from the concern over a fragmented workforce, are worries that the training of the public health workforce may become similarly fragmented. The government's policy statement, reporting similar feedback from the consultation exercise following the public health white paper, does little to reassure on these points since matters affecting the workforce are to be dealt with in a separate document due in the autumn.

Coppard, in his contribution, makes an important observation when he states that despite the intense activity by Directors of Public Health (DsPH), their staff, and NHS managers, 'what is startling…is the lack of any suggestion or desire that local government itself should take the lead in planning the transfer'. He puts this down to the 'defensive strategy' being orchestrated by the profession 'to ensure threatening changes do not occur'. The dilemma for public health if it insists on being treated as a special case (something it never achieved within the NHS) is that if it succeeds it will not be in its long-term best interests. Moreover, as Coppard warns, the opportunities offered by the proposals to local government are 'in danger of being strangled at birth'.

Not helping the cause of those who support the thrust of the proposals are the serious flaws and fault-lines running through both the white paper and the now emasculated Health and Social Care Bill whose fate remains surrounded by continuing uncertainty. Although there is greater clarity around some aspects of PHE's role and functions, there remain issues of potential concern. Unless, or until, these are addressed, it is hard to have confidence that the transfer of public health locally will be welcomed by local government or regarded more as a poisoned chalice. All the enthusiasm on display for Health and Wellbeing Boards (HWBs), the JSNA, and health and wellbeing strategies will count for nothing if local government ends up merely hosting a function over which it has minimal influence or control. Such an outcome must surely be unacceptable to the local government community. To be fair, the government seems to acknowledge this when it states on several occasions in its policy statement and update that giving the public health role to local government 'opens new opportunities for community engagement and to develop holistic solutions to health and wellbeing embracing the full range of local services'.[1]

Yet, at the same time, PHE is intended to be a powerful and influential force – 'a global leader in translating evidence into practice, and…tackling hitherto intractable problems'. In discharging its functions to ensure that best evidence is heeded, that interventions which work are deployed, and that improvements in health outcomes occur, it will operate at different levels including, somewhat ominously, 'having a local presence'. So much for localism and the trust to be placed in local government. Getting the balance right between

what is best done centrally and the application of the subsidiarity principle will be a major challenge and will determine how far local government truly becomes a public health leader. Earlier worries about the dual accountability of the DPH to their local authority employer as well as to the Secretary of State for Health appear to have been heeded insofar as the policy statement is eerily silent on the subject. But has the vexed issue gone away or has it simply been fudged for the time being? DsPH will be employed by local authorities with the appointment process being joint with PHE to ensure that only qualified individuals are appointed and, presumably intended to avoid the local rat-catcher, or worse, being promoted to DPH. On the matter of health protection, much is made of the 'clear line of sight down to the frontline' but what the implications of this are in the event of the Secretary of State not taking kindly to what that clear line of sight might reveal is no longer mentioned as a potential sacking offence. In short, under what circumstances might the frontline become the firing line?

Linking fears over accountability and governance is the constant reference to the three domains that have come to dominate discussion of the public health function in the UK: health protection, health improvement, health service quality.[4] It has become the default position of critics of the current proposals since it provides a convenient framework and set of reasons for not moving public health out of the NHS since to do so might put at risk at least one of the domains – health service quality – that would remain the responsibility of the NHS. The government's policy statement reaffirms the commitment to these domains, noting in particular the importance of the NHS to public health.

The concerns expressed by many critics of the proposals, and noted above, reveal a number of interesting assumptions. Most notable is the assumption that public health as it has developed in the NHS since 1974 has, by and large, been an unmitigated success. But those who have long favoured returning the function to local government start from the premise that public health has singularly failed to make significant headway in respect of tackling health inequalities or improving public health. Many, including some of the contributors to this publication, have criticised the medical model underpinning much of what still happens in public health and its failure to move beyond descriptions of the problem to finding and implementing solutions to them and being held to account for their achievement. Such failures have been well documented by numerous inquiries conducted by, among others, the House of Commons Health Committee,[5,6] the Public Accounts Committee,[7] the Audit Commission,[8] and the National Audit Office.[9]

The logic of the fears expressed over the proposed changes, regardless of whether they may be justified or not, is to avoid taking full advantage of the move of public health to local government and to see the changes as demanding a damage limitation exercise – a case of tolerating the changes through gritted teeth while simultaneously ensuring that nothing much happens so that it is pretty much 'business as usual'. To be fair, the government's policy statement avoids adopting such a negative stance, referring instead to 'the bold vision' put forward in the November 2010 white paper and to the 'real enthusiasm for a new approach to public health' which greeted the original proposals. The government therefore wishes to 'maintain this momentum' and to encourage local authorities and public health professionals to get on with it.

The mixed mood music with its increasingly syncopated rhythms is a dilemma facing public health since, not for the first time in its history , it stands at a crossroads. There is a real opportunity to shape the future in new and different ways as opposed to expending energy and effort on preserving as much of the status quo as possible. The government seems to be trying to sell this as the narrative of choice. But real risks remain in terms of where the detail to be resolved might lead. If it leads to an all-powerful role for PHE and the

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Department of Health effectively overseeing, and even overshadowing, what local government does, then local government will either walk away or, at best, remain (or become) lukewarm about the proposals. The opportunity to renew and reinvigorate public health will then be lost.

If victory is to be snatched from the jaws of defeat, where might one look for a possible solution? Many of the contributors rightly point to the importance of leadership. Arguably, until very recently, leadership has been lacking in public health especially leadership embracing the whole public health system and crossing organisational and professional boundaries. Initiatives to strengthen public health leadership have been supported by the LGID's Healthy Communities programme and by the Department of Health and these have been aimed not just at officers and managers but, importantly, at elected members, too. Central to the aims of such programmes has been a focus on the whole system and on viewing public health problems and challenges as complex and 'wicked', requiring attention by all those agencies engaged in improving health. Key to success is the importance of partnership working, especially across the NHS, local government and third sector. Yet, despite numerous attempts to reinvent and strengthen partnerships over the years, their record and impact have been patchy and generally poor.[10] Such weaknesses are acknowledged by Harrison in his contribution and he quotes one board member of an NHS Care Trust as saying she would 'throw herself out the window' if the proposed HWBs ended up focused on structures or turned out like the Local Strategic Partnership they are to replace. HWBs have been strengthened following the work of the NHS Future Forum listening exercise but there remains unease that the pathfinders will get locked into the structural mind trap which has plagued previous partnerships.

Too much emphasis has been placed on process issues and on getting the structures right and too little attention has been given to what the partnerships have been tasked to do and whether they have been given the wherewithal to deliver. This might include support from senior managers, clarity over objectives, ensuring appropriate accountability arrangements are in place to track progress, and requiring that the different cultures in the partnership are both understood and respected. Skills in effective partnership working remain undeveloped and while merely shifting the public health function from the NHS to local government is no guarantee that such weaknesses will be addressed, it is just possible that for local government public health will assume a greater significance than it has done in the NHS since 1974.

How confident can one be that such an outcome is likely? Reviewing the contributions comprising this publication gives grounds for some optimism. For instance, moving from a largely medical model of public health that has persisted in the NHS to a social model that addresses the wider health determinants has a greater chance of success in local government where most of what it does impacts on the public's health and wellbeing. There is also a greater receptiveness to an assets approach in local government in contrast to an NHS grounded in a medical model with its emphasis on disease and deficits. But perhaps the most persuasive argument for transferring public health to local government is that it holds out the prospect of removing public health from the stranglehold of the NHS and moving it towards those parts of the wider system that affect health. The experience of joint posts has not been systematically or independently evaluated but anecdotal accounts, including impressions from some of the contributors to this collection, suggest that they have been widely variable. The case for giving local government the lead public health role may therefore be persuasive although the challenge facing DsPH in what for many will be a very different culture cannot be overestimated.

Conclusion

The way forward remains unclear at the time of writing although some known unknowns, notably what PHE might look like and do, are less of a mystery. To ensure that the government's proposals for public health do succeed, there needs to be agreement reached on the optimal balance between central and local control, on the rationale (if any) for having ring-fenced budgets, on the location of the public health specialist workforce, and on the role and function of HWBs to ensure they do not repeat the mistakes of previous partnerships. If there is to be a fresh start in public health, there cannot be an implicit assumption that a state of 'business as usual' will prevail. If that is all DsPH and others aspire to, not only do the changes deserve to fail but we might as well opt for the status quo and stick to the Devil we know.

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