PERSPECTIVES ON PUBLIC HEALTH SERIES

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Public Health as a Local Government function

So, the public health function is returning to local government where it all began as local government's oldest profession.

The reality, of course, is that while the heavy duty, statutory powers were transferred to the NHS in 1974, many contributory services to good public health have never left local government. It is arguable whether local government has pulled hard enough on the levers that have remained within its remit. The DoH funded Healthy Communities Programme which pre-dates the present Government, recognised that gap and was seeking to build capacity in local authorities to tackle health inequalities before the emergence of the proposal to transfer the statutory public health function to local government.

However, this article will argue that any expectation of a significant step change in the effectiveness of the public health service and a corresponding reduction in health inequalities, arising merely from the transfer of the function to local government under the Government's proposals, heavily constricted and in full, top down, command and control, NHS mode, are likely to be frustrated. The opportunity for innovation through the freedom of local government to integrate public health into its structures and services is in danger of being strangled at birth.

There is already intense activity by Directors of Public Health and staff, and by NHS managers to plan a transfer that is still nearly 2 years away. What is startling about this activity is the lack of any suggestion or desire that local government itself should take the lead in planning the transfer. This looks increasingly like a defensive strategy on the part of the profession to ensure threatening changes do not occur.

The local authority DPH will, of course, be professionally responsible to the Chief Medical Officer, not the local authority chief executive.

We do not yet know the size of the ring fenced public health budget that will be transferred. We do know that much of it will be commanded by the national public health service. We do now know, though, that the Government will direct the use of some specified and oddly defined activities. Why, for instance, is it necessary to specify particularly sexual health services for funding.

One asks why it is necessary to ring fence the public health budget in local authorities in the first place when this was never done in the NHS. It was ok that much NHS money, and, particularly, funding for "Choosing Health" was diverted to fund PCTs' financial deficits but perish the thought that local government, in its localist way, might do anything so irresponsible.

To a local government eye, the consultation version of the so called Outcomes Framework – more of this later – looks remarkably like an extension of the NHS performance regime.

Worst of all, we await the staff transfer consultation later this year. It seems unlikely that local government will be able to choose its own staff.

Indeed, if the government follows the model adopted for the transfer of Learning and Skills Council staff, we will be told not only who we have to employ but on what salaries. If this occurs questions will need to be asked not only about the Chief Executives' responsibility under s4 of the 1989 Local Government Act to determine the number and grades of staff but also about the relationship of public health staff to painfully constructed local authority job evaluation schemes designed to overcome the long running and expensive equal pay claims that local authorities have suffered. It will not serve public health well to be seen as a "special case" when the rest of local government is undergoing restructurings and reductions in terms and conditions to meet budget constraints.

Meanwhile, the LGA, excessively pleased with itself merely because local government is being given a new responsibility by a hostile government, tippy toes around these issues, perhaps afraid to challenge too strongly lest the Government changes its mind.

Amid all these caveats and constrictions, then, it is perhaps worth asking the question, what are the Government's expectations in making the change; and what exactly is going to change as a result?

It is certainly the case that, in earlier statements, the Secretary of State appeared to recognise the NHS as an illness service and that the excellent services needed by people when the are already ill are different in nature to the services needed to stop them getting ill in the first place. But this radical concept appears to be being stifled under the weight of vested interest and constrictions to ensure local government does not run away with the function.

Merely transferring statutory responsibility to local government is not a magic wand. It will not secure change on its own. As the Chinese say (inscrutably) "Things stay the same unless they change". Running the same service, with the same staff and budget from a different office will not change much. With the current constraints, the worst case scenario is that public health will become a national service hosted by local government, not a fully integrated part of local government itself.

The tortured "Healthy Lives, Healthy People" update and way forward does not offer much hope of any new thinking.

So what should the Government do to clawback its original, radical agenda?

Firstly it should recognise that local government is not the NHS and behaves differently. At top tier level it is in 152 autonomous parts, each with its own democratic mandate. Local government does not respond well to centralised, top down directives which are routine to the NHS. It is the Government's own wish that Councils should be accountable to their own communities not to Ministers. The Government needs to work with local government not seek to direct it. Radical approaches should be supported, lagging Authorities should be encouraged. The Government needs to recognise who its friends are.

Secondly the Government should recognise that standard public health thinking of splitting the problem into specific components – smoking, diet, exercise, mental health, etc – does not achieve step change. This is quite fundamental to a new approach to the problem. Frankly, these services, often clinical in nature, or at least in approach, are better left with the NHS. Is there a man, woman or child left in the country who does not know that smoking damages your health or that five pieces of fruit or vegetables a day is good for it? And yet, unfathomably, people still smoke or eat a deficient diet. Why?

It is said that poverty **causes** ill health, but not everyone in Barnsley dies prematurely, and not everyone in affluent areas like Wokingham or Surrey lives into a long and healthy old age. Something else is in play.

Equally, many public health debates focus on housing and lack of open space as causes, as if damp and unfit Victorian slums are still with us, instead of the Decent Homes programme and modern town planning.

Could it be that, rather than poverty and even poor housing **causing** ill health, that poverty, poor housing and ill-health coincide in the same places caused by another, common factor.

No-one, not even Marmot, has provided a satisfactory causal explanation of the physiological mechanism by which poverty, or today's poorer housing translates into ill health.

I am going to suggest, in areas like Barnsley, that that mechanism has a psychological explanation. Many people have little control over their own lives, they struggle to keep their heads above water, they live in communities beaten up by economic or other forces, they have little economic or political power and they are shoved around by officialdom. As a consequence, they lose mental resilience and self-esteem. They give up. Short term gratification becomes more important than long term well being, and they become less able to nurture their children.

By this explanation, smoking, diet, exercise, educational attainment, anti-social behaviour and even the poor physical condition of neighbourhoods are not separate problems, but the same single problem. But this is a problem that local government, uniquely, can address, albeit that it needs to raise its game in very straitened circumstances over the next 4 years.

The solution lies in dealing with the entrenched dependency culture in these communities. This is perhaps best addressed by giving these people jobs, the dignity of work, but in the absence of jobs, building capacity, confidence and self esteem in individuals and in the community as a whole – big society, even – ceding control to the communities themselves and putting public servants at the disposal of these communities rather than in charge of them. Our experience of personalised budgets for individuals has yielded profound results and solutions not thought possible by professional carers. We need to work the same transformation for communities as a whole.

So, the third thing the Government should do is to ensure its Outcomes Framework reflects, measures and therefore supports this "whole-system" approach and is not limited to simply seeking to measure performance on specific interventions. After all, what is the actual outcome we are seeking? Presumably something akin to the World Health Organisation definition of a general state of well being, rather than an absence of specific illnesses. As I have argued, the mental resilience/capacity of individuals and the community as whole is critical to that outcome. We might even experiment with measures of happiness.

Of course, I recognise the value of indicators underpinning the measurement of achievement of the broad outcome, but these should be good proxies of progress towards the outcome. So, the volume of tranquilliser prescribing or the prevalence of the common "lifestyle" diseases might be good indicators. I doubt that progress with breast feeding initiatives, screening uptakes or rate of hospital admissions for alcohol related harm really cut the mustard as "outcome" indicators. The Outcomes Framework is important but as currently drafted it is really no more than an extension of the NHS's vital signs performance framework.

Fourthly, the Government needs to be more relaxed about the public health budget. After all, can local government do any worse than the NHS? A mechanism does exist to ensure the "local" part of the public health budget is spent appropriately. Under the health reforms every Authority is required to set up a Health and Wellbeing Board. This requirement is, I think, generally welcomed across local government. The Health and Wellbeing Board (HWB) is required to prepare a Joint Strategic Needs Assessment (JSNA) and then approve a Health and Wellbeing Strategy based on the JSNA. I propose therefore that the use of the public health budget should be linked to the delivery of the HWB Strategy. Any expenditure would be legitimate so long as it was justified by the Strategy. Indeed, the Strategy would be the means of setting out the use of the public health budget and by linking them in this way would give the Strategy extra power because it would be, at least partially, funded.

Conclusion

Many pitfalls lie in the paths of a successful transfer of public health responsibilities to local government. The most likely outcome appears to be that public health will become a national service hosted by local government. To prevent this happening, and to reap the benefits of full integration into local government, the Government has to put aside the innate distrust of local government, perhaps by Ministers and civil servants, but certainly by the public health profession, and assert its localist instincts.

In doing so, it needs to embrace a whole-system view of the causes of ill health and health inequalities and adjust the proposed Outcomes Framework to make this clear. But it can perhaps rely on Health and Wellbeing Boards as vehicles, locally, for genuine partnership working and the development of Health and Wellbeing Strategies, based on evidence provided by JSNAs to truly reflect the distinctiveness of the public health problem in different localities.