

Written submission

House of Commons Health Committee inquiry on public health post-2013: structures, organisation, funding and delivery

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

We welcome the opportunity to submit our views on the impact of the Health and Social Care Act reforms on public health since 2013. We summarised our views on the coalition government's [achievements on public health in May 2015](#) (The King's Fund 2015a). This submission draws on and expands our position, updating it to take into account more recent developments.

Summary

- The transfer of public health functions and staff from the NHS to local authorities appears to have gone relatively smoothly.
- The NHS also has an important role to play in improving public health and needs to go further and faster to realise this.
- The Health and Social Care Act reforms have resulted in a renewed interest in the role of local authorities in improving the health of the populations they serve. The co-location of public health responsibilities with other local authority services represents a real opportunity for localities to take a population health perspective.
- The role of Public Health England needs to be clarified – in particular, in relation to its ability to challenge national government.
- The ability of local authorities to recruit and retain directors of public health continues to be an issue.

- The cuts to the local authority public health grant in 2015/16 and, more recently, those signalled by the Spending Review, make the job of improving the public's health much more difficult.
- With less money devoted specifically to public health, every pound needs to work harder. Local and national government will need to consider using other levers, including regulation, taxation and pricing to support public health objectives.

The current context

1. Since the reforms were implemented in 2013, government has committed more than £5 billion per annum to public health spending in England. Around £2.8 billion of this has been allocated to local authorities, around £2 billion to NHS England (for screening and other functions) and the remainder to Public Health England (for functions such as health protection). Additionally, almost £400 million was transferred from the NHS to local authorities in October this year to fund the first six months of new responsibilities for early years' services.

2. [Our own work](#) (Buck and Maguire 2015), and most recently that of the [Office for National Statistics](#) (2015) and UCL's [Institute of Healthy Equity \(2015\)](#), shows how inequalities in health persist. These are driven in part by the decisions taken by individuals and health and care services, but also by factors within central and local government's control such as poor and inadequate housing, low levels of education, unemployment and deprivations. The [OECD's Health at a glance](#) (2015) also shows how the United Kingdom lags behind similar nations on many health behaviours, particularly on, but not restricted to, obesity.

3. The recent in-year cut to English local authority budgets of £200 million, and the announcement of an average 3.9 per cent real cut every year to local authority allocations throughout the course of this Spending Review period suggests that the government (despite its rhetoric) is not sufficiently committed to the public health agenda.

4. We fundamentally disagree with this course of action and have made this clear in our [Spending Review submission](#) (The King's Fund 2015b) and [elsewhere](#) (Buck 2015). We do not yet know the fate of the Department of Health's allocation to NHS England, or Public Health England's own budget but, given that a significant proportion of allocations to local authorities is spent directly on NHS services, or on pathways intertwined with NHS services, any cuts are likely to lead to a reduction in NHS activity.

5. Local and central government will now be under increased pressure to deliver maximum value from every pound spent on public health. As direct funding will fall significantly, consideration should also be given to how other levers can best be exploited, including looking again at the roles of taxation and pricing. It also raises the issue of whether there is strong enough central co-ordination of policies for health across government. We have previously advocated for this function to be strengthened through the short-lived cabinet sub-committee on public health (see, for example, [our Evidence submission to the Health Committee on Public Health](#) (The King's Fund 2011b)). This is now clearly needed more than ever.

6. Below, we set out our views specifically on the impact of the Health and Social Care Act reforms on public health since 2013. While these are generally positive, they need to be considered within the much more challenging context ahead. The decisions taken in the Spending Review put the maturing and developing public health system at significant risk.

The delivery of public health functions

The transfer to local authorities

7. The transfer of public health functions and staff from the NHS to local authorities appears to have gone, in most cases, smoothly, with directors of public health confident of better health outcomes in the future and [reporting positive experiences of working in local authorities](#) (Association of Directors of Public Health 2015, 2013).

8. Some directors of public health also report feeling that they have appropriate influence across local authority directorates beyond the confines of their own teams, which is critical to [maximising the impact of wider local government actions on health](#) (Buck and Gregory 2013). However, progress is variable, and in some areas [work remains to be done to bridge the cultures of the NHS and local authorities](#) (Mansfield 2013). This includes differences in the understanding, value and use of scientific evidence to determine decision-making and policy; in [one survey](#) of a public health team, almost 60 per cent of respondents answered that decisions were primarily based on political issues rather than 'purely on the evidence base' (Royal Society for Public Health 2015).

The role of the NHS

9. The NHS has an important role to play in public health, though has arguably only belatedly started to refocus on its role in prevention. One sign of this is the fate of Making Every Contact Count, a key policy flowing from the [second phase of the NHS Future Forum](#) in 2012 that encourages all NHS staff to support patients to lead healthier lifestyles (NHS Future Forum 2012). While there has been promising action in some areas, a national action plan 'to improve the NHS contribution to prevention' to be produced 'by March 2015' as part of NHS England's 2014/15 business plan has not yet materialised.

10. More recently, the [NHS five year forward view](#) (Forward View) published in October 2014, argues that 'the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health' (NHS England *et al* 2014). In line with this argument, NHS England has since developed a stronger, and welcome, focus on tackling obesity and diabetes prevention and is also working in broader areas, such as in the Healthy New Towns initiative. However, as set out by NHS England Chief Executive Simon Stevens, the Forward View is predicated on there being [no further cuts to public health](#) (Dunhill 2015), with one of the tests for whether the Spending Review would deliver for the NHS being for [ministers to 'make good on the public health opportunity'](#) (Barnes 2015). On the public health test, it is clear that the 2015 Spending Review has failed.

The future direction of public health

11. One of the prizes on offer as a result of the public health reforms and the way that they dovetail with wider reforms is a move towards [population health systems](#) (Alderwick *et al* 2015).

12. This can be defined as focusing on the broad health of local populations – or ‘the health outcomes of a group of individuals, including the distribution of such outcomes within the group’ (Kindig and Stoddart 2013).

13. As set out in our recent report on achieving this shift in focus, ‘strengthening the role of public health in the NHS, while realising the potential of public health responsibilities being co-located with other local authority services, is critical in order to embed a population health perspective at local level’ (Alderwick *et al* 2015).

14. Recent moves towards [greater devolution](#) (McKenna and Dunn 2015) may act as a spur to place-based action on population health – though, in relation to devolution of health and social care specifically, it currently appears closer to delegation than devolution.

15. The public health reforms have placed directors of public health in the right place at the right time to take advantage of the potentially greater pooling of local budgets, local accountability and influence over local decisions about service provision that we may see as part of the devolution agenda. While this is no guarantee of success, it is an opportunity to hardwire public health into local public service objectives and implementation. Greater Manchester’s [memorandum of understanding](#) is one example, which, if it comes to pass, provides a potential vehicle to achieve this (Manchester City Council 2015).

Public Health England

16. Public Health England was set up as a national executive agency of the Department of Health as part of the reforms. The Public Accounts Committee recently judged that Public Health England ‘has made a good start in its efforts to protect and improve public health’, but that it needs to do more to influence and challenge other central government departments given the extent to which other policies impact on the public’s health (House of Commons Committee of Public Accounts 2015) – a view that we also support.

17. The Public Accounts Committee also called for Public Health England to support local authorities to prioritise the most effective interventions. Since then, Public Health England has invested in additional work on the economics of public health, which is a welcome development.

18. More broadly, there remains a lack of clarity and understanding about Public Health England’s role as an adviser and/or challenger of national government, including when it should speak out, and on what level of evidence. We [highlighted this](#) lack of clarity last year (Buck 2014a) and agreed with the view of the Health Committee that there is a need for the relationship to be clarified, including whether executive agency status is appropriate.

19. While there is still further to go, we welcome the signs that suggest Public Health England is beginning to take this message on board, particularly on its contingent welcome (dependent on future evidence) for the use of e-cigarettes as part of the tobacco harm reduction strategy and the eventual release of its policy review on sugar. We support Public Health England's role in these important policy debates, and its emerging approach of intervening relatively early, informed by evidence while not being constrained by lack of absolute certainty.

20. In November 2012, the government abolished the cross-government Sub-Committee on Public Health – the body it created to see its public health reforms through and that, before coming to power, the Conservatives said would 'send a powerful message that public health is the responsibility of all government departments'. This remains a major gap in the public health reform programme, as it is unclear where this role sits in government and bilateral relationships are not sufficient. Radical improvements in public health depend on co-ordinated action across government based on well-informed evidence and tools. For instance, [research](#) suggests that government spending on social welfare (excluding health) has seven times as much impact on mortality rates as changes in GDP (Stuckler *et al* 2010). Such central co-ordination should include the assessment of major government decisions that affect health and its determinants through Health Impact Assessments and other techniques.

The effectiveness of local authorities in delivering the envisaged improvements to public health

21. The reforms have brought increasing clarity over how local authorities spend their budgets, including how spend is allocated between different aspects of public health in the context of the public health outcomes framework. This should make it easier to assess how spending is related to outcomes and how that differs between areas. While case studies have been published, to our knowledge an overall comprehensive analysis of the impacts of the reforms has not yet been undertaken.

22. However, one of the key opportunities presented by the reforms was the [opportunity for public health professionals to have wider influence over other local authority budgets and functions](#) (Buck and Gregory 2013). Evidence of the influence of directors of public health on the expenditure of other local authority directorates is only just emerging, but [a recent survey](#) found that 10 per cent of respondents answered 'yes, quite a lot' of influence, 54 per cent said 'yes, but not a lot', and 36 per cent said they had no influence (Jenkins *et al* 2015).

The public health workforce

23. This is not an area that has been the focus of The King's Fund's work. However, we note that there were significant concerns about the ability to recruit and retain directors of public health, other key staff and in ensuring the right skills mix, [particularly at the time of transition](#) (Association of Directors of Public Health 2013). While this problem has eased, it [remains an issue in some areas](#) (Association of Directors of Public health 2015).

24. This is critical but the public health workforce extends far beyond the directors of public health and their teams. There are around 130 directors of public health, 1,200 or so public health consultants, 5,000 to 8,000 environmental health officers, and more school nurses and other practitioners – [a total core workforce of around 40,000](#) (Centre for Workforce Intelligence 2014). A focus solely on the directors of public health and their teams means that the wider fate of the workforce does not get the profile and attention that it should.

25. Further, we agree with the [Royal Society for Public Health](#) (RSPH) (2015b) that there is an opportunity to engage millions more in public health activity, including fire and rescue services, allied health professionals, pharmacists and hairdressers. This is ever more important when funding is tight.

Public health spending

26. As originally set out in [our response](#) to the consultation on the public health reforms, it remains our view that the Department of Health should make an estimate of the scale of public health resources required to deliver good services and improve public health outcomes (The King's Fund 2011a). In the light of the Spending Review, it is even more critical that the Department of Health sets out its considered, evidence-based assessment of the quantum of resources required for an effective public health system. We have never seen this assessment. Instead, an assessment has previously been made of what was actually being spent (in what were then primary care trusts and elsewhere) and then used as the baseline for allocations to Public Health England, local authorities and elsewhere.

27. In the first two years following the reforms, the ring-fenced public health allocations to local authorities were relatively generous, with higher real growth in funding than for the NHS. However, [the allocation for 2015/16](#) was the same in cash terms as 2014/15 (Department of Health 2014). Beyond the protected budget, [local authorities have been cutting wider functions](#), such as leisure and park services (Buck 2014b), many of which have an [impact on the public's health](#). [The British Medical Association](#) has suggested that some local authorities have used ring-fenced money to maintain other threatened services (BMA 2015).

28. Earlier this year, an [RSPH survey](#) of public health staff reported that directors of public health did not always have control over public health funds (Royal Society for Public Health 2015a). This finding varied by type of council, with around a third of respondents from unitary authorities saying their director of public health was not in control of the budget. It is important to note that this isn't necessarily a bad thing, particularly where public health funds can be used to help leverage other spending and activity.

29. In early summer 2015 the government made a high-profile in-year cut to local authority budgets on top of the cash standstill budget for public health in 2015/16. This amounted to a flat-rate cut of 6.2 per cent at a time when local authority spending plans for the year had already been made. As we said at the time – in the current environment any significant reduction in public health funding will prove a false economy and

undermine the government's commitments (and those in the Forward View) on prevention.

30. This cut was labelled by HM Treasury as 'non-NHS', but cutting £200 million from local authorities' public health budgets does not mean that the NHS will not be affected. Many of the most significant local authority-funded public health services – including the largest by spend (sexual health, substance misuse, smoking cessation) – and 'NHS' health check services are either intimately intertwined with NHS pathways or are directly commissioned from the NHS.

31. From the initial 'in-year savings' announcement, it took several months for the cuts to be allocated to local authorities, resulting in further planning time being lost. In the end few restrictions were placed on where these cuts would be found, leaving the 'non-NHS' classification meaningless. This also means that local authorities are free to take funds from the (long-planned) transfer of responsibility for young children's services to local authorities; on 30 September these services were categorised as protected NHS spending, on 1 October they were vulnerable to cuts.

32. Further, our work looking at the public health return on investment suggests that, where there are current and future cost savings that flow from local government activity on public health, the principal benefit is reduced demand on the NHS (Buck and Gregory 2013). We would therefore argue that while, most importantly, decisions to cut public health budgets are unwise and damaging, for the reasons above, they will increase pressures on NHS providers.

33. The [Spending Review announcement](#) on cuts to the public health allocation (HM Treasury 2015) – at an average of a 3.9 per cent real cut per year over the course of the Spending Review period – is a false economy. The Forward View is predicated on a radical upgrade in prevention – these reductions in funding are more likely to lead to a downgrade. They are also likely to lead to direct cuts for NHS providers, since local authorities commission the NHS to provide many services.

34. At the time of writing we do not know the wider consequences for NHS England's section 7A agreement with the Department of Health (which funds around £2 billion worth of prevention in the NHS), or the implications for Public Health England's budget and its wider responsibilities. However, there is a question as to whether Public Health England has the right level of resources for its role. We believe that it would be worthwhile for the committee to investigate the likely scope and scale of impact that the reductions to Public Health England's budget will have on its capacity and capability to deliver and support the new public health system.

35. Finally, we note that a consultation is to take place on options to fund local authority public health spending from retained local business rates. While we await any consultation and will give it due consideration, the most immediate concern is that areas less able to raise such income (generally more deprived areas) are also those generally most in need of prevention and public health services. On the face of it, such a move could therefore serve to deepen inequalities in health.

Possible case study issues

36. We believe it may be particularly beneficial for the Health Committee to look into the following issues.

- The impact of the reforms (and spending cuts) on health protection services. This is an area that is far less visible in the public debate but that is critical and deserves further scrutiny.
- A 'deep dive' into how the public health reforms – along with wider reforms – have affected a specific pathway of care. Our suggestion would be sexual health services since these constitute a large proportion of public health budgets and, given the increasingly fragmented provision and commissioning across a range of players, these are where the fault lines of reform are likely to be experienced.
- Much of the focus of public health reform has been on upper-tier local authorities, but we believe there is potential for joining up the dots with other tiers of local government. The [role of district councils in particular](#) deserves attention (Buck and Dunn 2015).
- The impact of the Spending Review on public health functions – in particular, whether Public Health England has sufficient resources to fulfil its role and what is happening to Department of Health funding of NHS England's prevention activity.

Conclusion

37. Evaluating public health policy is complex because so many wider government actions, both local and central, impact on public health. There are also time lags, both in measuring the outcomes of public health policies, and in data release and analysis. Despite these difficulties, The King's Fund has observed some successes: in particular, the process of public health reform has, in most places, been a relatively smooth transition.

38. As part of the reforms, the government transferred ring-fenced resources for public health to local authorities, though recently this was accompanied by a substantial in-year 'non-NHS' cut. We note that this also leaves young children's services – until recently, protected – now open to cuts in funding.

39. Public Health England and local authorities appear to be adapting well to their new roles. But more is expected from Public Health England in its function of challenging the rest of government. Further clarity about Public Health England's role would be welcome.

40. Meanwhile the NHS has made slow progress on Making Every Contact Count, and has only recently started to refocus its role on prevention in line with the Forward View.

41. The co-location of public health with other local authority services creates the potential to embed a population health perspective at local level. Recent moves towards devolution in England may act as a catalyst in achieving this goal.

42. However, the implications of the Spending Review for local authority public health spending, and the potential cuts to the budgets of NHS England and Public Health England, put all of these potential gains in jeopardy. This increases the pressure on

central government to find other ways to improve public health – for example, through regulation, taxation and pricing, as well as stronger co-ordination of policy-making for health across government.

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