PUBLIC HEALTH WHITE PAPER REPORT

By:	Meradin Peachey, Kent Director of Public Health
To:	Corporate Management Team, 7 December 2010
Subject:	Public Health White Paper – Healthy Lives, Healthy People
Classification:	Unrestricted

Recommendations

1. CMT are asked to note the contents of the public health white paper *Healthy Lives, Healthy People* and to endorse the proposal for progressing KCC's response to the consultation.

Summary

2. (1) *Healthy Lives Healthy People* is the new White paper for public health, the first since Choosing Health was issued in 2004 and intends to develop a "wellness service" alongside the NHS. It has been widely trailed since the coalition government came to power and many of its proposals were also presaged within the NHS White Paper Equity and Excellence. *Healthy Lives Healthy People* therefore builds on the contents of the NHS white paper concerning public health. (A report to CMT on the public health aspects of the NHS white paper was presented on 26/10/10). *Healthy Lives, Healthy People* is designed to complement *A Vision for Adult Social Care: Capable Communities and Active Citizens.* The White Paper was issued alongside *Our Health and Wellbeing Today* an analysis of the current state of health of the nation.

(2) *Healthy Lives, Healthy People* also articulates the government's response to the report into health inequalities by Sir Michael Marmot *Fair Society Healthy Lives* published earlier this year. It therefore needs to be considered alongside the Marmot Report, as successfully tackling health inequalities will require concentrated action across a wide-range of activity. (Reports to CMT and Cabinet on the Marmot report and its implications have also recently been taken).

(3) *Healthy Lives, Healthy People* concentrates on the structural and philosophical changes the government believes are necessary to meet the public health challenges we face. There are fundamental changes to responsibilities for public health and the structures to deliver it.

(4) Philosophically the White Paper signals a movement to "nudge" not "nag" or "nanny". Helping people to make healthier choices rather than telling them what to do is the principle objective. The white paper champions localism; greater understanding of people's behaviour and what motivates change; and promotes better mental health and wellbeing as a key element.

Introduction

3 (1) *"In the new vision, each local authority and their individual director of public health will act as strategic public health leaders for their local population. They will lead discussions about how their ring-fenced money should be spent to improve outcomes for people's health and well-being locally. They should be in a position to ensure public health is always considered when local authorities, GP consortia and the NHS make decisions.*

(2) The white paper is based on the concept of:

- Reach across and reach out – addressing the root causes of poor health and wellbeing, reaching out to the individuals and families who need the most support – and be:
  - Responsive – owned by communities and shaped by their needs
  - Resourced – with ring-fenced funding and incentives to improve
  - Rigorous – professionally led, focussed on evidence, efficient, effective: and
  - Resilient – strengthening protection against current and future threats to health

Public Health England

4 (1) The headline issue for the White Paper is the establishing of Public Health England (PHE) as the new body responsible for public health nationally, independent from the NHS but responsible to the Department of Health. PHE will be established through the Health and Social Care Bill by April 2012.

(2) "Public Health England will:

- *integrate leading expertise, advice and influence, into one organisation by combining experts from a range of public health bodies such as the Health Protection Agency, the National Treatment Agency for Substance Misuse and the Department of Health.*
- *be established within the Department of Health in April 2012, and will set the overall outcomes framework for public health.*
- *will focus on national resilience against health threats such as flu pandemics, and will act as a 'knowledge bank' for the best and most up-to-date evidence on what we know works to improve the public's health.*
- *provide the resources, ideas, and the funding to support local strategies."*

(3) PHE will also be responsible for funding health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, child health promotion and other functions which will be consulted upon in due course.

(4) Public health will be incorporated into the NHS National Commissioning Board's mandate and the Chief Medical Officer will be the major advocate for public health nationally "within, across and beyond government".

(5) To tackle health inequalities a Health Inclusion Board will be established to address issues for those who do not access health care services. Professor Steve Field, former Chair of the Royal College of GPs, will head up this board which will include GPs, nurses, and charities. The Board will advocate for the vulnerable and socially excluded in society such as homeless people, drug users, refugees and asylum seekers, young people who have recently left care, and those not in education, employment and training.

Local Authority Public Health

5 (1) Locally public health will become the responsibility of local authorities (upper tier or unitary) with Directors of Public Health being jointly appointed between the PHE and the local authority. This change in responsibility resonates with Michael Marmot's findings and his assertion that the solutions to health inequalities are social not medical.

(2) "Local public health leadership, and responsibility, will be returned to local government. Health and well-being boards, based in local authorities, will provide a forum to bring together NHS commissioners, councils and elected councillors with patient champions, to join up the public health agenda with the wider work of the NHS, social care and children's services."

(3) A ringfenced budget of c. £4 billion – the 4% of the NHS budget currently considered to be devoted to preventative health and health promotion – will be given to local authorities to promote public health in their areas. In Kent this could equate to c £80m if it is 4% of existing PCT budgets. Allocations will be weighted to take account of local inequalities and deprivation.

(4) The LGA and some local authorities are arguing that the ring-fencing requirement should be removed in recognition that virtually all local authority activity contributes to health and wellbeing to some degree and that ringfencing will reinforce a silo mentality to public health. Whilst the recognition of local authority activity towards public health is well put, the argument that funding will be siloed if ring-fenced is somewhat spurious. Without robust safeguards around what is in effect the only growth area of local authority budgets over the next four years it is difficult to see how the money will be properly directed for public health purposes. The government is also keen to avoid public health funding being raided because of shortfalls elsewhere as has frequently been the case within the NHS.

(5) Funding will be transferred under s31 of the Local Government Act 2003 from April 2013. Shadow allocations will be made in 2012/13.

Health Premium

6 (1) In order to provide incentive to tackle inequalities a premium payment will apply to part of the budget for health improvement if progress in improving health outcomes is achieved.

(2) "Responding to the challenges set out in Professor Sir Michael Marmot's powerful Fair Society, Healthy Lives report, this White Paper includes a proposal for a new, and simple, health premium that will reward progress on specific public health outcomes.

(3) *Driven by a formula to be developed together with key partners, the premium will represent a new approach to fighting health inequalities. The intention is for the formula to recognise that disadvantaged areas face the greatest challenges, and will therefore receive a greater premium for progress made."*

(4) The Health Premium aims to reward success in improving public health against a set of outcomes. The premium for communities will be adjusted to reflect existing health inequalities so that the highest payments will go to the most disadvantaged communities with the poorest health outcomes.

(5) The type of success measurement could include reduction to childhood and adult obesity; increases in physical activity levels; reducing incidence of alcohol-related diseases; reducing illegal drug use prevalence; reducing prevalence of teenage smokers, reducing teenage pregnancy rates etc.

(6) Further detail is expected in the outcomes framework and funding and commissioning papers to be issued by the DH.

Outcomes framework

7 (1) There is little said in the White Paper about the outcomes that the new system will be expected to deliver. Much more detail will be contained in an Outcomes Framework ancillary paper expected early next year which will be focused on five domains:

1. Health protection and resilience; protecting people from major health emergencies and serious harm to health

2. Tackling the wider determinants of ill-health; addressing factors that affect health and wellbeing

3. Health improvement; positively promoting the adoption of "healthy" lifestyles

4. Prevention of ill-health; reducing the number of people living with preventable ill-health: and

5. Healthy life expectancy and preventable mortality; preventing people from dying prematurely

The Director of Public Health

8 (1) The role of the Director of Public Health (DPH) is further refined. The DPH is expected to be responsible for the public health budget and to become the primary source of advice and information on health matters to the local authority.

(2) *"In the new vision, each local authority and their individual director of public health will act as strategic public health leaders for their local population. They will lead discussions about how their ring-fenced money should be spent to improve outcomes for people's health and well-being locally. They should be in a position to ensure public health is always considered when local authorities, GP consortia and the NHS make decisions*

(3) DPH responsibilities will include:

- Promoting health and wellbeing within local government
- Providing and using evidence relating to health and wellbeing
- Advising and supporting GP consortia on the population aspects of NHS services
- Developing an approach to improving health and wellbeing locally including promoting equalities and tackling health inequalities
- Working closely with Public Health England health protection units to provide health protection as directed by the Secretary of State
- Collaborating with local partners on improving health and wellbeing including GP consortia, other local DsPH, local; businesses and others

(4) The DPH is to be directly accountable to the Secretary of State for Health and professionally to the Chief Medical Officer.

(5) Although separate from the NHS the PHE will obviously need to retain strong links and working arrangements with the health service. At local level this will be through the Health and Wellbeing Board where the commissioning of health services in accordance with the Joint Strategic Health Assessments will be monitored. Preventative services will obviously play a major role in managing the demand for health services and this may well involve GP consortia and others in their commissioning.

Health and Wellbeing Board

9 *(1) "Local public health leadership, and responsibility, will be returned to local government. Health and well-being boards, based in local authorities, will provide a forum to bring together NHS commissioners, councils and elected councillors with patient champions, to join up the public health agenda with the wider work of the NHS, social care and children's services."*

(2) Although the PHE will be separate from the NHS it will still be essential for the two agencies to work closely together. Locally this will be through the Health and Wellbeing Boards announced in *Equity and Excellence.* The DPH will play a key role in ensuring that PHE and NHS work well together to promote health and wellbeing.

(3) The work of the Health and Wellbeing Boards will be guided by the Joint Strategic Needs Assessments. To assist the provision of high quality intelligence, information and analysis new agencies will be established – the National Institute for Health Research school for Public Health Research and a Policy Research Unit on Behaviour and Health.

The New Philosophy

10 (1) The new approach signalled by *Healthy Lives, Healthy People* rejects the target driven emphasis of the previous government's Choosing Health programme. It seeks to recognise that many of the behaviours that can lead to ill-health are difficult to change and for many people their circumstances preclude their ability to take up opportunities that are offered. *Healthy Lives, Healthy People* therefore attempts to both improve people's overall lifestyle and to give people realistic and attainable choices to live in a healthier way that do not require immediate drastic change but can add up to significant improvements over time. To this end an emphasis on Social Marketing is to be retained.

(2) The new philosophy is incorporated in the 4 R's (see above) and the Nuffield Foundation's "Ladder of Change".

(3) *"Drawing on a model called the Nuffield Council of Bioethics Ladder of Interventions; the Government intends to 'stay out' of people's everyday lives wherever possible.*

(4) *The Nuffield interventions range from the least intrusive actions: such as providing information to allow people to make their own choices; through guiding choices; to the most intrusive: eliminating people's choice through legislation, for example the introduction of compulsory seat belts.*

(5) *Where the case for central action is justified, the aim will be to use the least intrusive approach necessary to achieve the desired effect, focusing on enabling and guiding people's choices wherever possible.*

(6) *The intention is to make healthy lifestyles easier, for example through access to public exercise facilities, cycle paths, or safe playgrounds. Government's focus will be on protecting the public from health threats and improving the healthy life expectancy of the population, improving the health of the poorest, fastest. There are currently gaps of up to 7-years in life expectancy between those living in the richest and poorest areas."*

(7) In other words the approach will be to find the least coercive and most supportive ways to help people attain better health.

(8) The priority given to least intrusive engagement is reflected in the Responsibility Deals with the private and voluntary sectors and government that are being brokered to redefine the roles and responsibilities of the third sector and business towards promoting good health. These are highly controversial and it remains to be seen whether organisations such as Coca Cola and McDonalds are able to shift their emphasis towards promoting healthier lifestyles and away from high sugar and fat products.

Other issues

11 (1) *Healthy Lives Healthy People* is important for what it does not contain as well as what it does. References to funding, beyond the crude c£4 billion national figure, and how the commissioning process for public health will work are largely absent. Whilst the white paper addresses five of Sir Michael Marmot's recommendations any reference to the sixth – the need for a standard of living that enables everyone to afford to be healthy - is absent. Michael Marmot himself has said that the econonomic sufficiency recommendation is not in itself a necessary precondition for the other five, but it will need to be addressed somewhere of health inequalities to be tackled successfully.

(2) Tobacco control proposals designed to dissuade young people from starting smoking such as plain packaging for cigarettes, removing point of sale displays and vending machines are not included in the white paper but are to be subject to further consultation pending a national Tobacco Control White Paper to be issued early next year. If the new public health system is to be serious about tackling health inequalities the attitude of the government towards smoking and tobacco control will be a litmus test of its commitment.

Transition timetable

12 (1) Responsibility for public health transfers to local authorities in April 2013. To assist this process a series of planning letters will be issued by the DH throughout 2011. Further papers will be issued thus:

- Winter 2010/11 Consultation on:

  Health Visitors
  Mental Health
  Tobacco Control

- By early 2011:

  A detailed roadmap for the system as a whole – NHS, PHE and DH for the years ahead
  Further consultation including Public Health Outcomes Framework and Funding and Commissioning
  Human Resources framework (including arrangements for staff transferring from NHS to local authorities)
  Health and Social Care Bill
  NHS Operating Framework and PCT 11/12 allocations

- Spring 2011:

  Public Health Responsibility Deal
  Obesity
  Physical Activity
  Social Marketing
  Sexual health and teenage pregnancy
  Pandemic flu

- Autumn 2011:

  Health Protection, emergency preparedness and response

- Through 2011/12:

  Detailed policy and operational design

- April 2012 PHE established within DH

White Paper Consultation Process

13 (1) The White Paper consultation runs until 08/03/11.

(2) Further consideration of Healthy Lives, Healthy People and the responses to the consultation questions it contains is proposed to be through a working group chaired by the Head of Public Health Policy with the KCC Directorate representatives from the Public Health Board. This group will report to CMT and Cabinet to determine the KCC consultation response.

Meradin Peachey
Director of Public Health

Tel: 01622 694293