

The
BOW
GROUP

Target Paper



**‘Healthy Lives, Healthy People: Our Strategy
for Public Health in England’ – Opportunities
and Challenges**

The Bow Group Health & Education Policy Committee

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The Bow Group was founded in February 1951 as an association of Conservative graduates, set up by a number of students who wanted to carry on discussing policy and ideas after they had left university. They were also concerned by the monopoly which socialist ideas had in intellectual university circles. It originally met at Bow, East London, from which it takes its name.

Geoffrey Howe, William Rees-Mogg and Norman St John Stevas were among those attending the first meeting. From the start, the Group attracted top-flight graduates and quickly drew the attention of a number of government ministers, notably Harold Macmillan. In the intervening time, Michael Howard, Norman Lamont and Peter Lilley have all held the Bow Group chairmanship. Christopher Bland, the current Chairman of BT, was Bow Group chairman in 1969. In the recent General Election five recent members of the Bow Group Council were elected to the Commons.

Since its foundation the Bow Group has been a great source of policy ideas, and many of its papers have had a direct influence on government policy and the life of the nation. Although it has no corporate view, it has at times been associated with views both of left and right - always within the broad beliefs of the Conservative Party.

The Bow Group (BG) has four clear objectives:

- To contribute to the formation of Conservative Party policy
- To publish members' work and policy committee research
- To arrange meetings, debates and conferences
- To stimulate and promote fresh thinking in the Conservative Party

Recent publications include (all available at www.bowgroup.org):

'Putting the Health Back in Education', Tracey Bleakley, Stuart Carroll & Ross Carroll with a foreword from Charlotte Leslie MP (BG Health & Education Committee), **February 2011**

'Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health'
Ross Carroll, Mike Hewitson & Stuart Carroll with a foreword from Baroness Cumberlege (BG Health & Education Committee) **September 2010**

'Equity and Excellence: Liberating the NHS' – Opportunities and Challenges
Stuart Carroll & Gary Jones (BG Health & Education Committee) **August 2010**

The Case for Energy Crops: How Developing Countries can Help Themselves & Boost UK Energy Security
Tony Lodge (BG Transport & Energy Committee) **July 2010**

The Enterprise Nation? Developing Northern Ireland into an Enterprise Zone
Ross Carroll with a foreword by Lord Trimble (BG Economics Committee) **April 2010**

The Right Track – Delivering the Conservatives' Vision for High Speed Rail
Tony Lodge with a foreword by Lord Heseltine (BG Transport & Energy Committee) **January 2010**

"People Power: Reforming QUANGOs" – Is this Applicable to Health Agencies?
Stuart Carroll & Nick Hoile (BG Health & Education Committee) including contributions from Sir Andrew Dillon, Dr. Richard Barker and Dr. Bill Moyes **November 2009**

More for Less: Cutting Public Spending, Protecting Public Services
The Rt. Hon John Redwood MP & Carl Thomson (BG Economics Committee) **November 2009**

Doing Veterans Justice: Conversations with the Forgotten Fighters
Ross Carroll, Stuart Carroll and Julien Rey (BG Health & Education Committee) including contributions from Simon Weston OBE and Captain Surgeon Morgan O'Connell **June 2009**



A Report by the Health & Education Policy Committee of the Bow Group

March 29th 2011

**Stuart Carroll, Gary Jones, Ross Carroll, Nick Hoile,
Jennifer White, Thomas Kelley & Michael Hewitson**

Bow Group Health & Education Policy Committee

The Health & Education Policy Committee is committed to researching and analysing the issues and challenges facing the NHS, wider healthcare sector and the education system as a result of Government policies. The Committee regularly meets to discuss new research projects and how it can support viable, sustainable and effective policies to improve the provision and delivery of healthcare services, and the education system.

Chairman – Stuart Carroll

For more information, please contact Stuart Carroll on health.policy@thebowgroup.org.

From the Research Secretary

Ultimately, effective policy is all about results rather than rhetoric. This is the clear message that comes out of this response by the Bow Group's Health and Education Policy Committee to the Coalition Government's White Paper on public health, *'Healthy Lives, Healthy People: Our Strategy for Public Health in England'*.

While the Labour Government from 1997-2010 made a great deal of noise about addressing this country's serious long-term health problems – including the highest levels of obesity in Europe and widening health inequalities between the rich and the poor – little of any real substance was achieved. There was a great deal of activity, but much of it was unfocused and consequently squandered. This is apparent in the spate of initiatives that were launched and bodies created with direct responsibility for public health, including Overview and Scrutiny Committees (OSCs), Health Action Zones (HAZs) and Health Improvement Partnerships (HImps). If the current Government is to be successful in improving public health, it will have to bring cohesion to this tangle of bodies with overlapping jurisdictions and responsibilities. The role of Health and Wellbeing Boards (HWBs) will be crucial in achieving this objective and this paper makes it clear that these bodies must be given teeth if they are to be successful.

The other theme that comes out of this paper is the need for preventative healthcare to play a role in reducing the enormous cost of poor health to the country. With escalating costs and practically limitless demand for healthcare, something different has to be done. The need to contain the growth in spending has been given greater urgency by the Government's programme of austerity. Meanwhile, measures to encourage members of the public to take greater responsibility for their health tread a fine line between a gentle 'nudge' and the full-blown paternalism of the nanny state.

The Government has much to prove. If they are to succeed, there will be a need for clarity and precision in the policies, smooth implementation and, crucially, effective follow-up. The White Paper is a start, but there is still a great deal to be done before we can genuinely say that things will be different this time.

Luke Powell
Bow Group Research Secretary
March 2011

Executive Summary

- On 30th November 2010, the Coalition Government published its eagerly anticipated White Paper on public health, *'Healthy Lives, Healthy People: Our Strategy for Public Health in England'*
- While some of the policy proposals and rhetoric contained within the document have been advanced by previous governments, the public health White Paper signifies an important and serious statement of intent of how the Coalition Government wants to fundamentally change the way health policy is understood and implemented.
- The Bow Group supports the motives and rationale behind the creation of Public Health England, which if properly implemented will help support people in maintaining their health, mainly at a community level through local councils, whilst keeping a firm national grip on national public health issues such as flu pandemics at a national level.
- The Government's plan to give Local Authorities more power and responsibility of their population's health can be seen as a positive step and consistent with the wider vision to devolve healthcare decision-making to the local level. However, more detail is needed to explain how the plans will be implemented and how responsibilities will be allocated. At this point, the Government has only postulated a broad framework for implementation and important detail is missing.
- We agree with the Government's assessment that the so-called "nanny state" has gone too far and has been largely ineffective in dealing with the UK's public health challenges. A new approach focused on "nudging" rather than "pushing" is needed. It is also clear that for the UK to see a marked improvement in health outcomes individuals must take greater responsibility for their own health.
- The Bow Group welcomes much of the radical blueprint to promote public health and wellbeing across the country. The Government should be congratulated for its commitment to tackle the causes of premature death and ill health, which continue to undermine health outcomes and compare poorly to many other European countries.
- However, the success of the Government's public health initiatives will be highly dependent on its ability not only to effectively implement its strategy, but also its ability to effectively communicate and disseminate its key policy messages to the public as a whole.

Technical Acronyms and Abbreviations

CMO	Chief Medical Officer
DH	UK Department of Health
DPH	Directors of Public Health
DWP	UK Department of Work and Pensions
GP	General Practitioner
HAZ	Health Action Zone
HImp	Health Improvement Programme
HPA	Health Protection Agency
HWB	Health Wellbeing Board
JSNA	Joint Strategic Needs Assessments
LAA	Local Area Agreement
LA	Local Authority
LSP	Local Strategic Partnership
LTC	Long-Term Condition
MoD	Ministry of Defence
MP	Member of Parliament
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
OSC	Overview and Scrutiny Committee
QOF	Quality and Outcomes Framework
PLC	Public Limited Company
PSHE	Personal, social and health education
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UK	United Kingdom

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1.0 Introduction

On 30th November 2010, the Coalition Government published its eagerly anticipated White Paper on public health, *'Healthy Lives, Healthy People: Our Strategy for Public Health in England'*.¹ The near 100 page document – significantly more bulky and lengthy than the Government's first offering, *'Equity and Excellence: Liberating the NHS'*² – outlines the Coalition's vision for a public health revolution; an NHS that instinctively lives and breathes preventative healthcare; and a new Public Health Service entirely dedicated to help achieved better health outcomes across England. While some of the policy proposals and rhetoric contained within the document have been advanced by previous governments, the public health White Paper signifies an important and serious statement of intent on how the Coalition Government wants to fundamentally change the way health policy is understood and implemented.

As with most clichés, the aphorism “prevention is better than cure” has much truth contained within it. This is as true for primary prevention as it is for secondary prevention; both absolutely crucial for achieving optimal health outcomes. There is little doubt the UK has significant public health problems as demonstrated by the highest levels of obesity in Europe and amongst the highest rates of sexually transmitted diseases (STD) such as genital warts and Chlamydia. Smoking and alcohol related illness remains high, whilst health inequalities between the rich and poor have widened.

Public health is also an increasing economic imperative should the NHS be placed on an affordable and sustainable financial footing. Indeed, the basic health economic problem of optimising the NHS budget constraint against infinite healthcare needs necessarily demands a new approach to tackle a mounting cost burden hitting an already over-stretched NHS. It is from this perspective that avoiding preventable illness and disease is critical from both a health outcomes and health economics point of view.

But is all this talk of public health really that new? A cursory glance over the last 30 years shows that almost all Government's, both Conservative and Labour, have looked to address the issue of public health. Most recently, the previous Labour Government released a wide range of policy papers designed to address public health, including amongst others, *'Smoking Kills'*; *'The Acheson Report; Saving Lives'*; *'Our Healthier Nation'*; *'A Programme for Action'*; *'Securing Good Health for the Population'*; *'Healthy Weight Healthy Lives'*; *'Choosing Health'*; and *'Our Health, our care, our say'*.

Despite this increased policy focus on public health and health inequalities, progress has generally been intransigent and inconsistent, with clear problems associated with implementation and strategic direction. Indeed, a recent report by the Public Accounts Committee on health inequalities highlighted that in 2004 the Labour Government set the Department of Health (DH) the target of reducing the gap in life expectancy between 70 “spearhead” local authorities with high deprivation and the population as a whole by 10% by 2010. The report concluded that “the Department has not met this target and has been exceptionally slow to tackle health inequalities.” There are plenty more examples of Labour's doubtful record.

So how can the Coalition Government reverse this trend? Some critics have argued that the Conservative Governments of the 1980s and 1990s paid little attention to the wider determinants of health and health inequalities – something fundamental to public health – as

highlighted by the Government response to ‘*The Black Report*’ in 1980 and critical reviews of ‘*Health of the Nation*’ in 1992.

So whilst the Bow Group welcomes the high profile and clear emphasis being placed on public health by the Coalition Government, one very simple but important question needs to be answered: what is going to be different this time to ensure public health policy is a genuine success? How far does this White Paper challenge conventional wisdom and propose a new course? It is the purpose of this short paper to explore the opportunities and challenges in ‘*Healthy Lives, Healthy People*’.

2.0 Structure of Paper

The public health White Paper touches on many important aspects of health and social policy. For the purposes of this paper, we focus on the following key areas:

- 1) The role of GPs and ‘Equity and Excellence’;
- 2) Public Health England;
- 3) Local government arrangements and ring-fenced budgets;
- 4) The role of pharmacy;
- 5) Tackling obesity, alcohol and drug addiction;
- 6) Mental health and sexual health;
- 7) Vaccination and health protection;
- 8) Educating healthcare professionals;
- 9) Health inequalities and outcomes; and,
- 10) UK PLC and the wider UK economy.

Each area is discussed and examined in detail in the following sections. At the end of each section, we provide a summary of what we consider to be the key opportunities and challenges for each area discussed.

3.0 The Role of GPs and ‘Equity and Excellence’

An important practical policy consideration concerns the degree of cohesion that will exist between ‘*Healthy Lives, Healthy People*’ and the Government’s wider vision for the NHS as outlined in ‘*Equity and Excellence*’. It is important to understand how exactly the two sets of reforms in both White Papers will fit together and complement one another in practice.

“Public health is everybody’s business” is clearly stated in the foreword of the White Paper by Andrew Lansley. Given that the “big idea” for the NHS is GP-led commissioning through local consortia, it is inconceivable that the Government’s public health aspirations could be realised without GPs playing a central and constructive role both as commissioners of care, and in their traditional clinical role as the local healthcare professional with whom most patients typically first come into contact. To this end, the advent of Health and Wellbeing Boards (HWBs) (see section 5.3) are a welcome development that will enable GPs to combine their roles as patient advocate, commissioners of care and public health proponents in an integrated and coherent manner.

As clinicians, GPs often come into contact with individuals that have long-term conditions (LTCs). Whilst public health is sometimes thought of as preventing ill health through diet, exercise and wider lifestyle choices, many people develop LTCs which can not necessarily be

prevented through lifestyle choices alone. Secondary prevention is therefore equally important for people with LTCs; that is, preventing avoidable worsening of LTCs that may see a decline in health outcomes and an increased cost to the NHS through avoidable GP consultations or increased utilisation of secondary or tertiary care services. It is therefore encouraging to see LTCs mentioned within both the White Paper and the Public Health Outcomes Framework. We encourage the Government to continue to consider secondary prevention alongside primary prevention.

It is our view that GPs as clinicians can play a huge role in improving the public health outcomes of the country. As the “gatekeepers” of healthcare, who are often the first port of call for patients, GPs should play a central role in taking measures to promote public health improvements within local communities. With this in mind, the Bow Group believes that there are three key areas that are essential to ensuring GP consortia support and advance the Government’s public health drive. These are: 1) The Quality and Outcomes Framework (QOF); 2) Health and Wellbeing Boards (HWBs); and 3) Outcomes Frameworks.

3.1. The Quality and Outcomes Framework (QOF)

The Bow Group welcomes the proposal that a sum of at least the equivalent to 15% of the current value of the QOF points tally and weighting will be devoted to evidence-based public health and primary prevention indicators from 2013. We believe this is important given that recent evidence has indicated that the QOF has resulted in GPs focusing too narrowly on certain conditions to the detriment of their wider public health role. Such changes to the QOF should therefore help to incentivise GPs to consider more widely the importance of public health interventions as clinicians and commissioners.

We also believe the Government should actively consider the merits of a parallel but complementary pharmacy QOF, which would include public health indicators, and help support the work of GPs and local consortia. The Bow Group’s recent policy paper on the role of pharmacy highlighted the improvements pharmacy can deliver, and is delivering, in public health, and sets out the rationale and level of support for a complementary pharmacy QOF.¹ As part of its consultation, the Government should take advantage of the opportunity to further its thinking and challenge conventional wisdom on the QOF.

3.2. Health and Wellbeing Boards (HWBs)

Effective and coherent commissioning decisions made by GP consortia will be critical to achieving not just the Government’s NHS outcomes objectives, but also their public health objectives. As well as commissioning NHS care, there is also provision in *‘Healthy Lives, Healthy People’* for GP consortia to commission on behalf of Public Health England. To this end, HWBs will be vital in order to enable close working between local health partners such as GP commissioners, local authority leaders, Directors of Public Health, social care leads, HealthWatch and others. HWBs will also be important for integrating Joint Strategic Needs Assessments (JSNA) and joining up commissioning decisions based upon the JSNA for local populations.

¹ Ross Carroll, Mike Hewitson & Stuart Carroll with a foreword from Baroness Julia Cumberlege, ‘Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health and Long-Term Conditions’, The Bow Group, September 2010.

Whilst the Bow Group welcomes the concept of HWBs, it will be important that such boards are not simply “talking shops” that local stakeholders merely pay lip service to, but rather are authoritative decision-making bodies that have a clarity of purpose to join up public health, primary, secondary and social care. Engagement of GP consortia, given their central role in the “new NHS”, will be vital if HWBs are to be a success.

The Government therefore needs to assess the successes and failures – and the associated reasons for relative success versus failure – of the raft of initiatives advanced under the previous Labour Government from 1997 – 2010. This includes looking carefully at bodies and initiatives such as Overview and Scrutiny Committees (OSC), Health Action Zones (HAZ), Health Improvement Programmes (HImPs), Local Strategic Partnerships (LSPs) and Local Area Agreements (LAA). Learning the lessons and applying that knowledge moving forward will be invaluable. This is particularly relevant when considering the future role of GPs in public health.

Whilst the purpose of these bodies differed slightly to what is being proposed for HWBs, their overarching aims were to either bring together local decision makers such as NHS bodies, local authorities and others to promote collaboration (and in the case of HAZs to bring together pooled budgets; something proposed in ‘Healthy Lives, Healthy People’) or to advance improved outcomes in public health. Some successes were seen as a result of these initiatives, but these successes were by no means universal. Criticisms have included a lack of consultation by the NHS and an unwillingness to share information by bodies such as OSCs; confusion as to the role of LAAs; and a huge variability in the ability to build partnerships particularly in HAZs. If HWBs are to avoid a similar fate, the Secretary of State must be clear from the outset why these problems existed and provide solutions to avoid making the same mistakes again.

It is important that every HWB operates to a baseline level of effectiveness across all areas of the country. Otherwise, similar problems to those highlighted above will occur, with pockets of excellence contrasted by pockets of apathy. This will in turn affect the overall quality of commissioning and care, and potentially lead to variability in quality and standards.

The Government should therefore consider penalties for GP consortia, Directors of Public Health, social care leads, Local HealthWatch and Local Authorities for unsatisfactory attendance at HWB meetings so as to provide appropriate incentives at inception to garner participation and engagement. Allied to this point, HWBs should aim to meet at the appropriate stages of the GP commissioning cycle so as to learn from past commissioning decisions and to inform future actions around public health.

Whilst provision currently exists for pooled budgets across areas that can impact public health, we hope that fully implemented and robust HWBs will provide an increased momentum for combining budgets across sectors that can impact public health outcomes where appropriate, and to breakdown silos that can often exist despite what is best for patients.

3.3. Outcomes Frameworks

In addition to proposed amendments to the QOF, the Bow Group also welcomes the rationale behind the Public Health Outcomes Framework. This should help provide clarity and focus

on the key issues of importance in public health for those involved in the provision and commissioning of public health interventions.

GPs can play a vital role in achieving good outcomes against all of the proposed domains within the Public Health Outcomes Framework, and therefore the amended QOF should be indexed to the Public Health Outcomes Framework to ensure coherence.

The Bow Group welcomes the Government's aim to promote confluence where possible between the NHS Outcomes Framework and the Public Health Outcomes Framework. This will promote a more joined up approach to commissioning, and will likely lead to a situation where public health is seen as a top priority by local GP commissioning consortia.

Finally, we call for enforcement of a national standard for public health interventions. Whilst NICE guidelines are extremely useful, they are exactly that – only guidelines and, regardless of the reality, most providers tend to claim they are compliant. By linking a national standard for public health services providers with the NHS Outcomes Framework and the Public Health Outcomes Framework, greater scrutiny on intervention quality would be possible and in turn lead to better outcomes and value for money. This is a current area of weakness in the White Paper and something the Government should think about further as part of its consultation.

3.4. Summary of key opportunities and challenges

Opportunities

- “Public health is everybody’s business” and it is therefore inconceivable that the Government’s reforms can be realised without GPs.
- HWBs are a welcome development and should enable GPs to combine their roles as patient advocate, commissioners of care and public health proponents in an integrated and coherent manner.
- The proposal that a sum of at least the equivalent to 15% of the current value of the QOF points tally and weighting will be devoted to evidence-based public health and primary prevention indicators from 2013 is a positive and welcome development.

Challenges

- HWBs must not simply be “talking shops” that local stakeholders merely pay lip service to, but must be authoritative decision-making bodies that have clarity of purpose to join up public health.
- The Government should actively consider the merits of a parallel but complementary pharmacy QOF, which would include public health indicators, and help support the work of GPs and local consortia.
- We call for enforcement of a national standard for public health interventions linked to the NHS Outcomes Framework and the Public Health Outcomes Framework.

4.0 Public Health England

A central part of the White Paper concerns the creation of a new public health service called Public Health England. Operating within the DH, Public Health England will oversee national public health programmes in areas such as vaccination, screening, health visitors and family nurses. The new service will set outcome measures for public health and a new health

premium will be awarded in areas based on progress. The organisation will also be the repository of best practice and evidence, and negotiate the new responsibility deal on public health between different partners including charities and industry.

4.1. Specific roles and responsibilities

Public Health England will also directly commission, or provide, some services at the central level such as national public health campaigns or other health protection functions currently carried out by the Health Protection Agency (HPA). Some specialist services may be carried out at sub-national or supra-local level such as services for victims of sexual violence. Although there will be no formal structure, sub-national commissioning arrangements could be established as part of Public Health England or alternatively local authorities could adopt supra-local arrangements for one authority to lead on behalf of others.

The new arrangements will see money allocated from the NHS budget and ring-fenced for public health. One part will be used by Public Health England for population-wide issues; another will provide a ring-fenced budget to local authorities. The burden for the majority of public health provision will fall on councils who will commission services from their ring-fenced budget.

The Bow Group supports the motives and rationale behind the creation of Public Health England, which if properly implemented will help support people in maintaining their health, mainly at a community level through local councils, whilst keeping a firm national grip on national public health issues such as flu pandemics at a national level. In principle, it should help to provide a focal point for prioritising an overall improvement in public health. Public Health England should also provide an excellent opportunity to coordinate health, social and other services which currently often work in isolation. The critical challenge will be implementation and explaining to people within the NHS and outside how exactly this new part of the wider healthcare system will function and operate; a difficult challenge the Government is already confronting with its wider NHS reform programme.

4.2. Funding of Public Health England

The White Paper confirms that a ring-fenced funding pot of at least £4 billion will be handed over for tackling public health issues. Part of this money will be spent by local councils and the rest will be used by Public Health England.

The Bow Group is pleased with this development and believes this will go some way to ensure that public health budget will no longer be “raided” by the NHS to cover deficits. However, in future it will be essential that Public Health England is funded adequately to undertake its important role. This cannot be a one-shot measure or an easy target for spending cuts when the going gets tough. The White Paper is less convincing and reassuring in this regard.

It is concerning that there is increasing evidence already that the £4 billion expected to be allocated to Public Health England might lead to an underfunded system in the future. For example, Health England data from 2009 showed a £3.7 billion spend on public health and health improvement in 2006-07, increasing to £5 billion if some categories of medication were included. The same report identified a further £1.3 billion when environmental health services, food safety measures and health visiting services were factored in.³ A new public

health service will only work with proper funding, and there is an immediate worry that this part of the equation has not been fully thought through.

In addition, it has been reported that the two QUANGOs being pulled into Public Health England (the National Treatment Agency and the HPA) risk losing around 15-20% funding over the next year adding more pressure to the proposed budget⁴. In the case of the HPA, a breakdown of its accounts shows the agency to be largely self-sufficient in many areas of its *modus operandi* due to international research grants and other external funding, which does not cost the beleaguered taxpayer a single penny. This is primarily due to the HPA's strong international reputation – arguably an “asset” rather than a “liability” in financial and economic terms.

With this in mind and given the Government's rationale for cutting the size of the QUANGO state, i.e. to reduce costs and deliver economic efficiencies, the abolition of the HPA and its integration into a new Public Health Service would seem odd and counter-intuitive. A simple cost-benefit analysis would suggest the Government's decision has little to do with economics and more to do with politics, namely the need for Andrew Lansley to show the Treasury and Cabinet Office that the DH is making its own contribution to the QUANGO cull. It is therefore difficult to defend the decision to get rid of the HPA, and we call for the Government even at this late stage to think again. One other viable option is to make the HPA an “executive agency”, which would be politically acceptable but ensure critical functions are not jettisoned or messily merged into the DH itself.

The DH is currently consulting on how the proposed funding arrangements will be implemented. We urge the Government to set out at the earliest opportunity how the funding structure for public health will precisely work and how this will be sustained over time. There is a real need to challenge conventional thinking in this regard. Otherwise, there is a real danger that the important work of Public Health England could be undermined from the start due to a lack of financial backing and sustainable funding.

4.3. Structure of Public Health England

There is also a clear need for more detail on how exactly Public Health England will be configured, organised and structured. This is particularly important given that the new Public Health Service will be assuming critical roles and responsibilities.

As discussed above, one such example is health protection where the functions of the soon to be abolished HPA will soon be transferred to Public Health England. The HPA's current responsibilities are by no means trivial, covering highly skilled and intricate areas such as preparedness and protection against health hazards, infectious disease, and hazardous chemical, poisons and radiation. In the extreme sense, the HPA has responsibility for advising the Ministry of Defence (MoD) on issues to do with chemical and biological warfare. How will Public Health England subsume such critical, and in extreme cases “life and death”, responsibilities without undermining current arrangements and ongoing research work?

With all such functions, there is a big question mark as to how these responsibilities will be effectively transferred ensuring that independence in assessment is retained (per the original “arms length body” rationale) – something seminal to the credibility of health protection both domestically and internationally – without undue political interference and/or Whitehall

obstruction. The Government needs to urgently provide clarity on the practical details of its proposed new structure, not least given that these reforms are all directly tied up with the larger reorganisation of the NHS.

4.4. Summary of key opportunities and challenges

Opportunities

- There is a strong rationale behind the creation of Public Health England, which if properly implemented will help support people in maintaining their health and provide a focal point for public health.
- It is pleasing that a ring-fenced funding pot of at least £4 billion will be handed over for tackling public health issues and this will go some way to ensure that public health budget will no longer be “raided” by the NHS to cover deficits.
- Public Health England should provide a repository of best practice and evidence, and negotiate the new responsibility deal on public health between different partners including charities and industry.

Challenges

- In future, it will be essential that Public Health England is funded adequately to undertake its important role. This cannot be a one-shot measure or an easy target for spending cuts when the going gets tough. We urge the Government to set out at the earliest opportunity how the funding structure for public health will precisely work and how this will be sustained over time.
- There is a clear need for more detail on how exactly Public Health England will be configured, organised and structured. This is particularly important given that the new service will be assuming critical roles and responsibilities.
- It is difficult to defend the decision to get rid of the HPA as currently proposed, and we call for the Government even at this late stage to think again.

5.0 Local Government Arrangements and Ring-Fenced Budgets

A critical part of the White Paper concerns the involvement of local government and ring-fenced budgets to advance the Government’s key policy proposals. Some experts argued that the strategy outlined in the last Conservative Government’s public health White Paper, *‘Health of the Nation’*, conferred a missed opportunity because it failed to make provision for the proper involvements of local authorities. It is clear that this is one area of policy the Coalition Government is keen to change through its proposals to devolve responsibility for public health to local government.

Indeed, the Government’s plan to give Local Authorities (LAs) more power and responsibility of their population’s health can be seen as a positive step and consistent with the wider vision to devolve healthcare decision-making to the local level. However, more detail is needed to explain how the plans will be implemented and how responsibilities will be allocated. At this point, the Government has only postulated a broad framework for implementation, which in isolation is not really sufficient.

Moreover, there are political risks associated with these reforms. By devolving public health to a local level, the Government is also devolving control for the overall success of this policy and is essentially placing its destiny in the hands of local decision-makers. As with all things of this nature, the Government may no longer be directly responsible, but this will not

stop the public from pointing the finger of blame if success is perceived to be elusive. Thinking through the “communications strategy” and likely threats is therefore important.

5.1. Local Government

The White Paper sets out the framework for how the new Public Health service will operate through Public Health England in the DH down to GP consortia and Directors of Public Health (DPH) at the local level. It is the implementation of this framework that will decide whether this is a radical success or a demonstration in good intentions not translating into practice. Importantly, this new framework will be locally driven and therefore has a greater potential to be in line with local needs.

Arguably the most controversial aspect of this new policy approach concerns the amount of power being handed to LAs. It is stated very clearly that the Government intends to “keep to a minimum the constraints” on how LAs will fulfil the public health role and spend budgets. This is what the Government sees as giving freedom to LAs to make decisions that are appropriate to their populations needs.

A likely criticism from the Labour Opposition relates to the so-called potential for vast differences in levels of service developing between different parts of the country. We are told the Health and Social Care Bill will give LAs a “duty to take steps to improve the health of their population”. What those steps are is not clear. Nor are the consequences for any LA which is deemed to have not fulfilled that duty. It is here that the detail will determine the scope for smooth implementation and the likely success of a fundamentally sound policy. To fend off populist criticism from Ed Miliband et al, the Coalition Government would do well to carefully and forensically think through this part of its public health plan.

5.2. Directors of Public Health (DPH)

The White Paper outlines an increased role for DPH. This can be considered a sound decision that should help to ensure that there is a visible figure directly responsible for the improvement of local public health. Furthermore, since DPH are accountable to the Chief Medical Officer (CMO) and will be jointly appointed by the LAs and Public Health England the issue of accountability should not be a problem as some have precipitously suggested. This should foster a certain level of ‘quality-control’ between different areas, and avoid too much potential for DPH to go too far in one direction without proper checks and balances as to whether this aligns with national imperatives.

5.3. Health and Wellbeing Boards (HWBs)

As touched upon in section 3, the creation of HWBs is a philosophical shift that bravely challenges the previous Labour Government’s ethos of centralisation. This is true even when considering the minutiae of policy implementation. It allows those in local government to demonstrate their talents and makes decisions in accordance with local needs. Although we are supportive of more local and therefore responsive decision-making, any such philosophical shift does confer potential problems. There is no guarantee that each LA will be capable of taking on and successfully carrying out the vast range of responsibilities. It is therefore imperative the DH is not an idle spectator on the touchlines, but rather a leader and promoter of good practice where needed.

The Government's proposed framework of HWBs should help to bring together those local bodies responsible for the improvement of local population health. The weaving together of these different bodies into a statutory body ought to result in effective joint working. These boards will bring together GP consortia, DPH, Social Care, Children Services, and make them all accountable for the public health needs of the local population. These boards will, like DPH, provide a visible body to ensure accountability. We strongly advise that local HealthWatch, as part of minimum membership requirements, guarantee the involvement of local charity and patient groups in HWBs. This would help to ensure that local people who are not directly involved in public health have an opportunity to be represented and engaged in the process from the outset.

In line with the more general theme of "centralisation doesn't work", this proposed structure puts responsibility for success squarely in the hands of local bodies. This is what has been called for by local health representatives for many years if not decades. It remains to be seen whether those at a local level with the responsibility to promote public health will be as able and as willing as historical rhetoric implies. Again, this is an area the DH must keep a close eye on as the reforms progress and early performance indicators come through.

5.4. Ring-Fenced Budgets

"There will be ring-fenced budgets for upper tier and unitary local authorities and a new health premium to reward them for progress made against elements of the proposed new public health outcomes framework."⁵

Ring-fenced budgets are low-hanging fruit in the world of quick political wins; translating the policy into a funding reality is much harder. At a time when LAs are facing cuts to their budgets across the board, a ring-fenced budget for public health is good and warrants a big "thumbs up". It should mean the public's health is not secondary to other financial pressures, and keeping the public healthy is of course a long-term financial saving.

It is short-term pressures that will make this ring-fenced pledge something of a financial challenge. Just as important, what is the mechanism to stop any attempt by a LA to use the budget for something other than public health using loose justification via the classic "wider determinants of health" argument? Moreover, at a time when local facilities are being cut and reduced how easy will it be to justify keeping this budget ring-fenced? Given that public health is about many different local services working together (including social services and mental health services), what can be done to ensure the funds are used to support all these public health services and are not siphoned into politically advantageous schemes for individual authorities? The Government needs to answer these important questions as part of its consultation.

5.5. Health Premium

The White Paper describes the health premium as policy to improve the health of the poorest, fastest. Through a simple formula, LAs will be rewarded for improvements to the local populations' health based on the public health outcomes framework. Those areas with the worst health outcomes will receive an "incentive" payment. It is not clear whether those LAs deemed to have good public health when measured against the public health outcomes framework will receive any incentive to make additional improvements.

It is difficult to argue with the principle of improving the health of the poorest with priority, but once again the devil is in the detail. This could potentially leave the Government open to accusations that LAs who already have a good level of local public health or do not make any progress in improving their public health will face cuts. The latter is actually recognised in the White Paper, “Potentially an area that makes no progress might receive no growth in funding for these services.” The key to this are the words “potentially” and “might”. This formula is being developed with unidentified “key partners” and so we do not yet know how this premium will function in detail.

There is no timescale for when the detailed model will be available as it is clearly stated “we will only set out a detailed model when we have established the baseline and potential scale of the premium clearly, and have agreement about the outcomes we will use.” This is somewhat frustrating given it was first raised in *Equity and Excellence* in July 2010. If the health premium is successfully delivered, it will be a truly progressive reform. It will ensure that those areas facing the greatest challenges achieving real outcomes in improving health (rather than hitting targets) will be rewarded. Until we can assess how this premium will be formulated, it is only possible at this stage to speculate on its potential rather than comment on detail on its likely success.

5.6. Summary of key opportunities and challenges

Opportunities

- If successfully delivered, the health premium will be a truly progressive reform. It will ensure that those areas facing the greatest challenges achieving real outcomes in improving health (rather than hitting targets) will be rewarded.

Challenges

- More information is needed to be published on how the health premium would work in practice. Until we can assess how this premium will be formulated, it is only possible to speculate on its potential.

6.0 The Role of Pharmacy

For the Government’s public health drive to be a success, it will be important that the skills and expertise of all healthcare professionals across the NHS are fully utilised and maximised. As a Bow Group paper published in September 2010 highlightedⁱⁱ, this is particularly pertinent in the case of pharmacy, not least when considering the innate potential in the community pharmacy network. We believe the Government must further consider the potential role for pharmacy as part of its consultation and ongoing deliberations.

6.1. Local Pharmacy

Across the UK, in every town, suburb and city centre, the UK’s traditional network of more than 10,000 community pharmacies see millions of people every day. Crucially, pharmacy has the unique capacity of often seeing people when they are well, before they are sick or develop LTCs. There is also growing evidence that pharmacies may be able to reach some

ⁱⁱ Ross Carroll, Mike Hewitson & Stuart Carroll with a foreword from Baroness Julia Cumberlege, ‘Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health and Long-Term Conditions’, The Bow Group, September 2010.

difficult to reach patient groups such as working age adults and minorities. It is from this perspective that pharmacy already plays an important preventative and public health role.

Allied to this point, pharmacists are in many ways the most accessible healthcare professional across the NHS, available for extended hours in most places and where 99% of the population can gain access⁶. Moreover, pharmacists already have a significant heritage in public health as exemplified by long standing initiatives to encourage smoking cessation; prevent unwanted pregnancies; and provide essential services to problem drug users. It is arguable that there is huge latent potential within this network, which is largely embedded at the heart of local communities.

The White Paper offers some recognition of the unique potential of community pharmacies. Section 4.52 of *Healthy Lives* directs Public Health England to “influence the development of the community pharmacy contractual framework”. Whilst dovetailing public health into the existing pharmacy work scheme is a low risk option, there is potential that community pharmacy becomes detached from the new public health service – with parallel services commissioned via Public Health England leading to duplication of effort which may fail to assimilate the benefits inherent in a network that reaches up to 1.8 million people each day. It is vital that Public Health England look to integrate community pharmacy at every stage as a key asset in the fight for a healthier nation. To that end, when commissioning pharmacy-based services, the new arrangements should seek specialist commissioning knowledge to give every chance of success and optimising service provision.

6.2. Pharmacy and Public Health

NHS smoking cessation services are a prime example of the potential benefits of pharmacy in public health. In some areas, such services are also good examples of how not to commission a successful service. When in Opposition, Andrew Lansley said: “Under the pharmacy contract there was intended to be much greater access to [stop smoking] services through pharmacy that would reach people who were not presenting to their GP...we need to use the pharmacy sector more for these kinds of services”.

In Scotland, 56% of all quit attempts in 2009 were made through pharmacies. However, in England around a quarter of all pharmacies are not even commissioned to provide a smoking cessation service. *Healthy Lives* highlights the scale of the challenge: “The NHS spends over £2.7bn a year on smoking-related illness, but less than £150m on smoking cessation”. Large-scale investment in a national programme of pharmacy-based stop-smoking services is a sound financial strategy to protect the long-term interests of UK taxpayers and promote public health. The abovementioned Bow Group policy paper on community pharmacy made a number of recommendations about improving the quality and coverage of enhanced services such as smoking cessation activities. A national service specification would give greater quality assurance and provide an opportunity to benchmark providers on a fair basis for ongoing improvement.

As part of the national prevention strategy, we welcome the announcement that the NHS Health Checks programme will continue for those 40-74 years, and that community pharmacies should be included as an important point of access for this service. The roll-out of the Health Checks programme through pharmacy should be considered as part of a wider platform, starting with basic interventions such as alcohol brief interventions; weight management advice and support; and smoking cessation. The Healthy Living Pharmacy

(HLP) programme in Portsmouth is a good example of high quality public health services delivered in a pharmacy setting. Early outcomes from the 10 HLPs show a 140% increase in smoking cessation compared to the previous year. The inclusion of the HLP model in *'Healthy Lives, Healthy People'* chimes with the Bow Group's recommendations for pharmacy enhanced services and the notion that pharmacy can offer an effective and scaleable model for high quality and targeted public health interventions.

A natural extension of Healthy Living Pharmacies, which already helps to empower people to take responsibility and action to live healthier lives, could be the provision of wellness incentives. The Nuffield Council on Bioethics (referenced on page 30 of *Healthy Lives, Healthy People*) details the ladder of interventions which can be used to lead to better public health. Pharmacy has the potential to own the so-called 'wellness agenda', as it already does in schemes operating in the US, guiding choice through the provision of incentives. An example of this model could be the provision of discounted gym memberships or sports equipment to people who have stopped smoking and continue to remain abstinent. While this could be controversial, there is a sound financial strategy for taxpayers, provided there are adequate checks and balances built in to prevent abuse.

'Healthy Lives, Healthy People' supports a wider role for the community pharmacy network in reducing health inequalities and improving health and wellbeing. We support this aspiration, and urge the Coalition Government to ensure that all providers are commissioned equitably, with proportionate oversight to guarantee fairness. GP Commissioners should seek to make better use of their local pharmacies that may already be providing a range of Public Health services, before they begin to create their own systems of Public Health Interventions, which could potentially duplicate existing services. The model of pharmacy based public health interventions is strong and cost-effective, and must be fully integrated with the programme of Public Health England.

6.3. Summary of key opportunities and challenges

Opportunities

- As part of the national prevention strategy, we welcome the announcement that the NHS Health Checks programme will continue for those 40-74 years, and that community pharmacies should be included as an important point of access for this service.

Challenges

- We call for the Government to introduce a national programme of pharmacy-based stop-smoking services. This would be a sound financial strategy to protect the long-term interests of UK taxpayers and promote public health

7.0 Tackling Obesity, Alcohol and Drug Addiction

The Government has rightly identified that the causes of premature death are dominated by lifestyle choices, with smoking, unhealthy diets, excess alcohol consumption and sedentary lifestyles being major contributory factors. For far too long, the UK has focussed on the treatment of such diseases rather than emphasising the importance of preventative action for tackling public health problems, and the resulting health inequalities, facing the UK.

There are four key areas that underpin the White Paper response to tackling obesity, alcohol, tobacco, and drug addiction. These are: 1) individual responsibility, 2) localism, 3) society, and 4) children and adolescents.

7.1. Individual responsibility

Many would agree with the Government's assessment that the so-called "nanny state" has gone too far and has been largely ineffective in dealing with the UK's public health challenges. A new approach focused on "nudging" rather than "pushing" is needed. It is also clear that for the UK to see a marked improvement in health outcomes individuals must take greater responsibility for their own health. This is particularly important when looking at risk factors for killer diseases.

The leading causes of death across all ages are circulatory disease, cancer and respiratory disease. All such diseases have strong links with lifestyle and are therefore to some extent controllable by individuals. However, it is important to realise that different people, and different groups in society, require differing levels of help, support and guidance to successfully appreciate and accept individual responsibility. These are concepts that the White Paper largely embraces. Nudging people in the right direction, and doing more to improve the outcomes of those families in need of more intensive support (for example doubling the capacity of the family nurse partnership programme) go a long way to illustrate the Government's commitment to support those in greatest need.

However, as the paper highlights, it is vital that society seeks to put individuals in the driving seat so they can best control their health, wellbeing and care. Furthermore, more integrated and innovative ways are needed to empower people and communities to make healthier life choices. We support this approach and look forward to seeing these innovative ideas being developed.

7.2. Localism

A key feature of the Coalition Government has been the policy of localism; something central to the Government's plans for better public health.

The "one size fits all" approach has been a familiar feature of recent government policy in the UK. It is pleasing to see the Coalition Government realise that different areas of the UK face different health challenges and thus the need to advance local solutions to tackle local problems. For example, evidence shows that low income and deprivation tend to be strongly associated with higher levels of obesity, smoking and harm arising from drug and alcohol misuse. We therefore fully agree with the Government's proposal that there is a clear need for local government to play a direct and active role in the promotion and delivery of public health.

7.3. Society

The society in which we live inescapably plays a pivotal role in our health. Good wellbeing (a positive physical, social and mental state) brings a wide range of benefits. We are all strongly influenced by the people around us: our families, the communities in which we live, the quality of these communities (for example pollution, air quality, open spaces) and social norms. As the White Paper correctly identifies, improving the environment in which people live can make healthy lifestyles easier.

It should be acknowledged that wider factors influencing the health and wellbeing of individuals, families and local communities, such as education, employment and the environment, need to be addressed. Allied to many of the ideas put forward by Iain Duncan-Smith at the Department for Work and Pensions (DWP), the Government must aim to create a nation of people who want to work and who enjoy work. Not only does this have enormous benefits for the wider economy, but it also helps to improve people's health and general wellbeing. The Government's efforts to get people into work and their efforts in partnership with employers to improve health at work are to be applauded.

Furthermore, we fully support the pledge to encourage partnership working and opportunities for providers from all sectors to offer relevant services. The protection of green spaces and support of local communities in the ownership of public spaces are initiatives likely to improve levels of participation in exercise and in turn levels of wellbeing. Creating environments that encourage "healthy" behaviour is also crucial to "nudging" people in the right direction, and therefore the Government's aim of fostering environments that discourage ill-health and help bring about cultural change is something we highly commend.

7.4. Children and Adolescents

The Government is right to point out that we have a duty to ensure that the foundations are laid during childhood for a healthy adult life. The White Paper recognises that tackling maternal obesity and maternal smoking will reduce infant mortality. Currently more than 1 in 5 children are obese by the age of 3, and 1 in 5 young adults say they have recently taken drugs. These are startling figures and the Government is right to recognise the urgency with which these problems need to be tackled.

Increased numbers of health visitors delivering the healthy child programme; continuing with free nursery care each week; refocusing Sure Start children's centres; support in schools to improve the content of the PSHE curriculum; and local freedom for teachers to deliver the content as they think it should be delivered are excellent policy features of the White Paper. Public health funding will rightly be made available so that local communities can develop tailored approaches to ensure easy access healthcare facilities are available for young people. Physical education must remain a focus in schools and there should be greater encouragement for participation in competitive sports. We support these policies, which have national direction but local freedom to ensure that healthcare develops to match the needs of the local population.

7.5. Summary of key opportunities and challenges

Opportunities

- Nudging people in the right direction, and doing more to improve the outcomes of those families in need of more intensive support, will go a long way to illustrate the Government's commitment to support those in greatest need.
- We fully agree with the Government's proposal that there is a clear need for local government to play a direct and active role in the promotion and delivery of public health.

Challenges

- It is important to realise that different people, and different groups in society, require differing levels of help, support and guidance to successfully appreciate and accept individual responsibility. Although these are concepts that the White Paper largely embraces, the Government must ensure a multi-dimensional strategy is adopted where needed to meet this imperative.

8.0 Mental Health and Sexual Health

In addition to obesity, alcohol consumption and smoking, other key public health challenges are mental and sexual health. The White Paper also makes direct reference to these two imperatives.

8.1. Mental Health

The DH has recently published a new public mental health strategy, '*No Health Without Mental Health*', which the Minister for Care Services has indicated will "reshape mental health strategy to set clear outcomes and offer a roadmap for delivering them".^{7,8} The White Paper therefore does not outline specific public mental health policies, but gives an indication of how public mental health services will be provided within the context of the new public health system.

The rhetoric of the White Paper, which makes a compelling case for improving public mental health and provides an assessment of the human and economic costs of inaction, is to be welcomed. However, the key test for the implementation of the new mental health strategy will be whether it fulfils the White Paper's ambitious commitment to adopt a new approach that "gets to the root cause of people's circumstances and behaviour, and integrates mental and physical health".⁹

Due to the complexity of the different determinants of mental health, the Government's ability to tackle the "root cause" of poor mental health is dependent on a coherent cross-governmental policy framework including education, housing, welfare, employment, and justice policy. With this in mind, the implementation of the new mental health strategy must not be rooted solely in the DH. Critically, its implementation must not be the exclusive responsibility of health services, but must also be integrated within a broader strategy facilitating service-delivery at a central and local level.

As many of the determinants of mental health are linked to poverty and social exclusion, it will be particularly important to integrate the new mental health strategy with the Government's broader social justice and social mobility agenda. There is a strong evidence-base for the need to linking poverty-fighting with initiatives to improve mental health on a population level, and Frank Field MP's recent analysis of poverty also identified good parental mental health as a key factor in improving the life outcomes of children and ending inter-generational cycles of poverty.^{10,11}

Overall responsibility for public mental health will inevitably fall to the DH. To achieve the aspirations of the White Paper, the DH will need to promote fundamental reform of the NHS mental health budgets to foster appropriate local resource allocation. In 2009/10, the NHS spent just £3 million of its £6.3 billion mental health budget on mental health promotion, concentrating spending instead on services to treat rather than prevent mental health problems.¹² If the human and economic costs of poor mental health are to be reduced, local

services should be encouraged to shift spending as far as possible from crisis services to those promoting mental health and preventing mental illness.

At the same time as redirecting mental health spending, there will be a need for commissioners in the new public health system to work to reduce the stigma and discrimination experienced by people with mental health problems, building on the success of campaigns such as *'Time To Change'*, which sought to shift public attitudes towards mental health problems.¹³ The DH's research indicates that significant improvements can still be made to shift the public perception of people suffering with mental health problems, and there is an ongoing need to address these issues. This need for improvement must not be lost in the shift to the new commissioning and service provision arrangements.¹⁴

The White Paper's commitment to integrate mental health and physical health is welcome and any new strategies on mental health, diet, exercise, smoking, and other factors will need to be carefully coordinated to ensure an integrated approach.

8.2. Sexual Health

As with mental health, the White Paper commits to the publication of a sexual health strategy in spring 2011, and makes a powerful rhetorical case for the need to reduce the country's high rates of sexually transmitted infections (STIs) and teenage pregnancy.

We welcome the Government's commitment to publish the results of its evidence review for sexual health, and its ongoing funding of pilots of interventions on alcohol misuse and sexual health risks. The results of the evidence review will be particularly helpful in developing targeted interventions for at-risk groups. Whilst the sexual health strategy should be targeted at the most at-risk groups in society, it will be critical to ensure that interventions are not stigmatising, and that some population-level health promotion strategies continue to promote sexual wellbeing amongst the wider population. We welcome the proposed sexual health indicators in the outcomes framework as a mechanism to improve overall public sexual health.¹⁵

The White Paper's commitment to provide open-access, confidential, and non-judgemental services is also welcome. Given the need to target the most at-risk groups and the socially and cultural sensitivities around sexual health, representatives of these groups should be involved in the commissioning and service-provision processes. Where possible services should be co-produced by commissioners and service users to maximise their uptake and reduce the stigma associated with their use.

The ongoing consultation on the commissioning of public health services indicates that sexual health activity funded by the public health budget will include contraception, testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, outreach and prevention. All these services will be commissioned by LAs except contraception services, which will be commissioned in primary care by the NHS Commissioning Board and in other settings by LAs. There is a need to ensure that this dual route for the commissioning of contraceptive services does not lead to fragmented or uneven service provision, and that there is no "wrong door" for access to contraceptives.¹⁶ Similarly, the commissioning of testing services for sexually transmitted infections will need to be carefully managed in partnership with GP consortia to ensure the uptake of opportunistic screening in primary care.¹⁷

Within educational settings, the Government's commitment to review the non-statutory personal, social and health education (PSHE) framework is welcome both as a means of reducing the human and economic cost of STIs and as a means of reducing the number of accidental teenage pregnancies that can result in poorer life outcomes for parents and children.¹⁸ As a recent Bow Group report into health education found, there is a clear need for a new evidence-based approach to sex education that focuses on outcomes and the responsibility agenda.ⁱⁱⁱ This view has been supported by the Centre for Social Justice that has argued that PSHE should provide an evidence-based curriculum including information on successful relationship formation and maintenance, including the importance of commitment and marriage.¹⁹

The White Paper's commitment to "work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services (including sexually transmitted infections, contraception, abortion, health promotion and prevention)" has provoked criticism from some pro-life groups.²⁰ Following the Science and Technology Committee's 2007 analysis of scientific developments relating to abortion, relevant legislation should be kept under review to ensure it reflects ongoing medical and scientific developments.²¹

8.3. Summary of key opportunities and challenges

Opportunities

- It is welcome that the White Paper makes a compelling case for improving public mental health and provides an assessment of the human and economic costs of inaction.
- The White Paper's commitment to integrate mental health and physical health is positive and any new strategies on mental health, diet, exercise, smoking, and other factors will need to be carefully coordinated to ensure an integrated approach.
- We support the Government's commitment to publish the results of its evidence review for sexual health, and its ongoing funding of pilots of interventions on alcohol misuse and sexual health risks.

Challenges

- The key test for the implementation of the new mental health strategy will be whether the Government fulfils the White Paper's ambitious commitment to adopt a new approach that "gets to the root cause of people's circumstances and behaviour, and integrates mental and physical health".
- There is a clear need to ensure health education is utilised to better deal with mental and sexual health challenges.

9.0 Vaccination and Health Protection

A key area of public health is the role of vaccination and health protection. Although these imperatives may sometimes be less visible and politically fashionable than the topical issues of obesity, binge drinking and drug addiction, their importance cannot and should not be underestimated. This has been exemplified by the recent flu outbreak where the importance, value and central role of vaccination were all clearly accentuated. Moreover, polio

ⁱⁱⁱ Tracey Bleakley, Stuart Carroll & Ross Carroll with a foreword from Charlotte Leslie MP, 'Putting the Health Back in Education', Bow Group Policy Paper, February 2011.

vaccination has resulted in the near eradication of the disease across the developed world, and thus demonstrates the far-reaching potential of effective immunisation.

It is certainly fair to say that the UK has enjoyed a successful vaccination policy as demonstrated by the implementation of the national vaccination schedule and associated higher uptake and coverage rates. However, if the Government is genuinely serious about public health – and thus the “better to prevent rather than cure” ethos – it is absolutely critical that the Government does not fall into the trap of thinking UK vaccination policy is a ticked box and there is nothing left to do. As the White Paper itself acknowledges, “Infectious diseases now account for only 1 in 50 deaths. However, tuberculosis and STIs are rising, and pandemic flu remains a threat”. *‘Healthy Lives, Healthy People’* goes some way to confirming and consolidating the important role of vaccination, but arguably not as far as it could do or should do.

Indeed, there is more that can be done. This is true in terms of recommending and introducing new vaccinations. A simple comparison of UK and international schedules highlights differences in global vaccination policy indicating that the UK arguably lags “behind the curve” of many other developed countries, most notably in the wider use of vaccines against varicella and rotavirus (as used in the US and Australia). On a different note, the DH arguably needs to be more active in communicating and disseminating targeted information to dispel popular myths about vaccination, not least in the light of the contemptible and abominable MMR Wakefield saga. There is a clear opportunity for the DH to work more closely and effectively with the pharmaceutical industry in this respect.

Moreover, it is important the Government fosters an approach whereby the evaluation and assessment of vaccinations is placed with a wider context accounting for economic and business imperatives and the UK’s industrial policy, complementing the important work of the Office of Life Sciences (OLS) and the Department of Business, Skills and Innovation (BIS). There should be little doubt that vaccination confers huge economic value through the prevention of disease, and thus offers the potential for significant cost offsets to the NHS and wider economy from illnesses and diseases avoided. This is important in terms of opportunity costs and resource savings, which in turn allows the Treasury and DH to budget with greater confidence and predictability – after all, it is easier to budget the upfront costs of vaccination rather than the reactive and curative treatment costs of illness and disease.

Allied to this important economic point, it is also important that optimal decisions are made when choosing between competing vaccines, with a strong emphasis on value-based criteria rather than merely cost or price. The current processes and procedures informing the evaluation, particularly economic evaluation, of vaccines through the Joint Committee for Vaccination and Immunisation (JCVI), soon to be abolished HPA (who is responsible for a lot of the infectious disease and economic modelling to inform JCVI/DH decisions) and the DH procurements pathways lack the clarity, clearness and certainty of the current NICE appraisal process as used for the evaluation of drugs and medicines.

There is also arguably a greater role for pharmacies in helping to deliver vaccination programmes. Pharmacies already play a role in health protection by the provision of services such as needle exchange, which help to keep the public safe from the harm caused by needle-stick injuries. It is right that the White Paper recognises the value of these schemes to wider society. In the future, pharmacies could play an even greater role in protecting the public, as they did during the 2009/10 swine flu pandemic. The great capacity available in the

pharmacy network, and the general accessibility of local pharmacy services to the wider general public, should be utilised for preparedness to abate future pandemics, not only to provide access to antiviral medicines, but also as a platform to mass vaccination.

9.1. Summary of key opportunities and challenges

Opportunities

- The Government is right to recognise the importance and value of vaccination as part of its public health drive.

Challenges

- If the Government is genuinely serious about public health – and thus the “better to prevent rather than cure” ethos – it is absolutely critical that the Government does not fall into the trap of thinking UK vaccination policy is a ticked box and there is nothing left to do.
- The current processes and procedures informing the evaluation, particularly economic evaluation, of vaccines through the Joint Committee for Vaccination and Immunisation (JCVI), soon to be abolished HPA (who is responsible for a lot of the infectious disease and economic modelling to inform JCVI/DH decisions) and the DH procurements pathways lack the clarity, clearness and certainty of the current NICE appraisal process as used for the evaluation of drugs and medicines.

10.0 Educating Healthcare Professionals

In the White Paper, the Government rightly acknowledges the importance of maintaining a well-trained and highly motivated public health workforce that utilises an evidence-based approach to clinical practice. Importantly, it is recognised that clinicians and other professionals have an essential role to play in improving and protecting population health. This is undoubtedly an area that has been undervalued by previous Governments of all persuasions, but nonetheless constitutes a critical piece of the public health jigsaw. If the Government’s ambitious public health reforms are to have a chance of success, it is essential that all healthcare professionals, from the student to the consultant, from the nurse to the dietician, are trained, skilled and motivated to practice preventative medicine. There is a long way to go.

Unfortunately, the White Paper makes no mention of undergraduate medical and dental education, and similarly undergraduate health education. At present, medical training and education around public health and the management of conditions like obesity, drug and alcohol addiction receives little if, in some cases, any attention at all. This has to change and change quickly – a massive piece of the jigsaw missing from the public health White Paper.

It is from this perspective that the Bow Group calls on the Government to overhaul public health education across the healthcare sector particularly at the undergraduate level. Innovative, engaging teaching styles are needed to educate our future healthcare professionals in a vitally important area of medicine. This is one of the key determinants in securing the future health of our nation. After all, if our healthcare professionals are not properly skilled and equipped to tackle head on the public health challenges of today and tomorrow, what chance have the rest of us got?

10.1. Summary of key opportunities and challenges

Opportunities

- The Government rightly acknowledges the importance of maintaining a well-trained and highly motivated public health workforce that utilises an evidence-based approach to clinical practice.

Challenges

- The White Paper makes no mention of undergraduate medical and dental education, and similarly undergraduate health education.
- At present, medical training and education around public health and the management of conditions like obesity, drug and alcohol addiction receives little if, in some cases, any attention at all. This has to change and change quickly.

11.0 Health Inequalities and Outcomes

The White Paper set out plans for Public Health England to work with the NICE and the DH to set indicators for the QOF. Public Health England and the new NHS commissioning board will also be charged with working collaboratively to ensure GP consortia “maximise their impact on improving population health and reducing health inequalities”.

The Bow Group sees this as a positive step and will aid developments towards a QOF which will do more to encourage GPs to help patients to achieve key public health targets, such as weight loss, smoking cessation and reduced alcohol consumption.

Alongside this development, the Bow Group is pleased that the White Paper confirmed plans for at least 15% of all QOF funding will be assigned to public health and primary prevention indicators from 2013. This idea was originally mooted by the DH after the Lord Darzi Review. As a report published by the Bow Group in 2010 proposed, a greater proportion of the framework dedicated to public health “would help to potentially shape a culture that is more consciously focused on prevention rather than the traditional and prevailing model of reactive/curative healthcare”.²²

Following on the seminal work of the Marmot Review, it is promising that the Coalition Government are committed to reducing health inequalities, noting that these have got worse over recent years. The White Paper rightly identifies that health inequalities are determined by a plethora of factors, ranging from early years care to social policies. In order for the proposals to reduce health inequalities to work, it will require departments across government to implement effective social policies which foster a focus on equity right from the outset. Despite the fiscal constraints and the reality of Government departments facing significant cuts, it will be crucial that the Government invest in making this a reality.

As mentioned above, the role of GPs in tackling health inequalities should not be underestimated. GPs are normally the first point of medical contact within the NHS and they play a vital role in preventive care, which typically involves diagnostic screening and providing advice on how to lead a healthy lifestyle. The Bow Group has previously argued that in its current form the QOF has not been designed effectively enough to address health inequalities. The Coalition Government should urgently look into the possibility of introducing new incentives for GPs in deprived areas with a view to improving services for patients in those areas.

11.1. Summary of key opportunities and challenges

Opportunities

- The Bow Group backs plans for Public Health England and the new NHS commissioning board that will be charged with working collaboratively to ensure GP consortia “maximise their impact on improving population health and reducing health inequalities”.
- The White Paper rightly identifies that health inequalities are determined by a plethora of factors, ranging from early years care to social policies. In order for the proposals to reduce health inequalities to work, it will require departments across government to implement effective social policies which foster a focus on equity right from the outset.

Challenges

- The Coalition Government should urgently look into the possibility of introducing new incentives for GPs in deprived areas with a view to improving services for patients in those areas.

12.0 UK PLC and the Economy

Public health is not just a health imperative. It is also an economic imperative. This is particularly important against the backdrop of the UK’s yawning budget deficit and the current economic climate. Although the argument surrounding the “politics of prevention” has largely been won – after all, it would be extraordinary to see a politician argue in favour of the 10 pints a day, 20 fags in the back pocket and donor kebab with extra chilli sauce in the evening lifestyle – the truth is that the argument in favour of the “economics of prevention” has yet to be convincingly won. This is arguably a consequence of hitherto Treasury and Whitehall thinking about the need for short-term gains to fit the political and parliamentary cycle. It should be clear that if the UK is serious about public health it needs to invest (not just financially, but also politically and conceptually) and be committed to that investment over the long-term and not just the short-term.

In the midst of the UK’s deficit reduction plan, cutting overall public spending is an unavoidable reality bequeathed by the previous Labour Government. All Government departments must also seek to extract maximum value from their budgets to optimise the quality of public spending decisions. Despite being “ring-fenced”, the NHS budget is by no means immune or exempt with the NHS having to find £20 billion of savings over the next four years. Successful public health outcomes can help reduce the burden on the NHS and in turn alleviate resource pressures on a financially stretched healthcare system. It is from this perspective that the Government’s policies for improved public health confer an important economic reality.

This economic reality is true in a number of ways. It is important in the sense that, although healthcare should primarily focus on the health of an individual, it should also look to provide wider societal benefits to individuals and communities. When taxpayer money is spent on higher education, it has the benefit of educating individuals, but it also has the benefit of up-skilling the workforce so as to benefit business and to attract investment. When taxpayer money is spent on transport, it helps connect people but it also improves business linkages and therefore productivity and efficiency for the wider economy.

Successful public health interventions can help improve the health of the nation at large. This is inherently good for individual wellbeing, but it is also good for society. If people are healthier and fitter, they are less likely to lose their jobs through ill health and more likely to be able to enter the workplace if out of work. They are also more likely to deliver greater productivity in the work place. All of this is good for the economy and for business, particularly in the current economic climate and given that the UK needs to maximise “injections” rather than “withdrawals”. The work of Dame Carol Black, Professor Steve Boorman and The Work Foundation to name but a few, makes a clear economic case for better public health and preventative healthcare. It is this value-based argument that Andrew Lansley and co must continue to make to their Treasury colleagues to ensure public health is given appropriate financial backing.

Furthermore, it is well-documented that the UK population is aging. It is therefore vital that we “age well” so that the NHS does not become overburdened, particularly in times of economic austerity. Good public health outcomes can prevent this scenario from arising and help foster a more financially affordable and sustainable NHS.

This will also aid the “Big Society” concept, as retired and elderly individuals often constitute the most active group of volunteers, given they have more time to invest into such activities than those active in the work place. A fitter and healthier retired population may be able to yield a greater wave of volunteering within the “Big Society”, whilst improved public health outcomes across the population is likely to be reflected in the Prime Minister’s “happiness index” designed to capture non-economic quality of life measures.

12.1. Summary of key opportunities and challenges

Opportunities

- Public health is not just a health imperative, but also an economic imperative. The White Paper is right to acknowledge this key point.
- Better public health can also aid the “Big Society” concept as retired and elderly people tend to constitute the most active group of volunteers.

Challenges

- There is a need across Government to challenge prevailing Treasury and Whitehall thinking about the need for short-term gains to fit the political and parliamentary cycle. If taken seriously, public health requires patience, investment and a long-term strategy including long-term funding.

13.0 Concluding Thoughts

The Bow Group welcomes much of the radical blueprint to promote public health and wellbeing across the country. The Government should be congratulated for its commitment to tackle the causes of premature death and ill health, which continue to undermine health outcomes and compare poorly to many other European countries. The White Paper is also right to conclude that public health is a cross-cutting imperative that transcends the boundaries of the NHS and health policy, and actually incorporates a variety of areas including the environment, poverty, education and housing.

There is also much merit in the Government's broader approach to "nudge" rather than "nanny". The former is entirely consistent with Conservative principles and the latter has been empirically discredited despite the previous Labour Government's pertinacious attempts. There is little doubt that public health is a pressing imperative, but as with all things political and policy orientated it is essential an appropriate balance is struck between advancing the need for better health outcomes, and individual life chances regardless of background, income and social status, and the need to ensure people are not lectured, patronised and bombarded with misplaced and inaccessible information.

It is from this perspective that the success of the Government's public health initiatives will be highly dependent on its ability not only to effectively implement its strategy, but also its ability to effectively communicate and disseminate its key policy messages to the public as a whole. As we are currently seeing with the Government's wider plans for the "new NHS" as detailed in *'Equity and Excellence'*, this communication and implementation challenge can be considerable and unrelenting. Ultimately, reforms of this scale require confidence – the confidence of politicians, policymakers, the NHS and the wider general public. Without it, policy success (perceived or real) can quickly become elusive.

It is against this backdrop that, whilst it is important to reiterate the Bow Group's admiration for the Government's laudable attempts to place public health at the heart of the healthcare system, a strong emphasis on detailed implementation and accountability for outcomes must accompany the wider concept and prevailing rhetoric. As the DH continues to consult, there is an opportunity to refine and prepare the plan for a successful public health legacy. This is central to ensuring 'Healthy Lives' and 'Healthy People', and moreover the Government achieving greater lasting success than the panoply of White Papers, strategies and initiatives over the last 30 years. Otherwise, people will continue to ask one basic question: what is different this time? And an apathetic and disillusioned public will get the Government nowhere.

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