The King's Fund submission to the Health Select Committee Inquiry into Public Health

June 2011

1. **The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.**

2. This submission sets out our views on the key principles of the reforms under the Committee's core questions. It does not address detailed organisational issues, such as the regulation of the workforce.

3. Much of this submission is drawn from our consultation response (The King's Fund 2011) to the White Paper *Healthy Lives, Healthy People* (Department of Health 2010a) in which we made 40 recommendations to the government on how it could improve its proposals.

Summary

4. We welcome the government's intentions to increase the involvement of local government in public health. However, we have major concerns about several aspects of the proposed reforms. In particular:

    - **the level and proposed allocation of resources for public health**
    - **the balance of accountabilities, incentives and levers in the new system.** Too much confidence is being placed in the health premium to incentivise performance. There is a risk that without penalties or stronger accountability, performance will decline
    - **the lack of responsibility for population health of GP consortia**. There is a risk that primary care's role in public health will be marginalised
    - **the challenges of co-ordinating local commissioning and supporting data flows** as a result of multiple commissioning routes and loss of co-terminosity between local government and primary care trusts
    - **the need for improved alignment between the NHS and local authorities with regards to duties to reduce inequalities in health**
    - **the timing of the reforms** in the context of major organisational change in the NHS and local government and severe budgetary pressure.

The inquiry's key issues

The creation of Public Health England within the Department of Health

5. We feel Public Health England (PHE) needs to be part of government to maximise influence over the actions of central departments that affect public health. However, there are good arguments for some functions to be independent of government to secure public trust, particularly its information, intelligence and evidence functions. The Chief Medical Officer's unique position as a professional, independent voice needs to be retained. But further independent assessment of PHE's activities will help to reassure those that fear the independence of public health advice to government is at risk.

- *PHE should have a charter setting out clearly its objectives, including the explicit reduction of inequalities in health*. Its performance should be independently assessed and reported on annually.

The public health role of the Secretary of State

6. The Sub-Committee on Public Health could be a powerful mechanism at the heart of government. Radical improvements in public health depend on co-ordinated action across government based on well-informed evidence and tools. For instance, recent research suggests that government spending on social welfare (excluding health) has seven times as much impact on mortality rates as changes in GDP (Stuckler *et al* 2010).

- *The Sub-Committee on Public Health should be a more powerful, formal decision-making body*, assessing major government decisions that affect health and its determinants through Health Impact Assessments (HIAs) and other techniques.

- *PHE should develop the tools to support the Sub-Committee, local authorities and others to assess the impacts of their actions on health and inequalities in health*. This should include quantitative and qualitative approaches and explore the use of equity weights in standard techniques such as cost-benefit and cost-effectiveness analysis of health-related interventions.

- *The Secretary of State should set up a mechanism through the Sub-Committee to monitor health inequalities*. He should commission and publish a report on the public health impacts of budget changes.

The future role of local government in health

7. We welcome the intention to give local authorities the role of leading health improvement and to create statutory health and wellbeing boards. This will help to ensure that public health is better aligned with health, social care and other local services.

8. However, we are concerned that they will not the power to drive local public health strategy and to ensure that all partners play their full role. They could easily become 'talking shops' rather than bodies with system leadership and accountability at their core.

9. We are particularly concerned about whether the boards will have sufficient engagement and influence with GP commissioners (The King's Fund 2010a). It is not clear, for example, whether decisions made by the boards following joint strategic needs assessments (JSNA) will influence GP consortia's allocation of resources.

- *The government should place a duty on GP consortia to promote the health of their local population* and to base their plans on the local JSNA and health and wellbeing strategy. This will ensure closer engagement with health and wellbeing boards.

- *The experience of early implementer sites should be documented and evaluated* so that governance issues in the local public health system are worked through before the reforms go live.

Arrangements for public health involvement in the commissioning of NHS services

10. Public health specialists have a unique combination of skills combined with in-depth clinical knowledge. These include interpreting scientific evidence and research, improving and redesigning services, providing independent and objective advice on treatment and funding decisions, and ensuring that decisions are based on the needs of the whole population and on best available evidence.

11. These skills need to be accessible to GP consortia. There is a danger that the transfer of responsibility to local authorities and the formation of a large number of variably sized GP consortia will spread these skills too thinly. It may be appropriate and efficient for input on public health commissioning to be provided from a 'cluster' of public health specialists.

12. Current proposals mean that the prime commissioning responsibility for primary health improvement services such as smoking, alcohol and obesity control will sit with local authorities, though the NHS will be expected to deliver some related brief interventions in primary care. It is not clear whether these primary care interventions will be commissioned through PHE, the NHS Commissioning Board (NHSCB) or local authorities or how this will, or should, differ by area.

13. There is a risk of fragmentation. For example, GPs may not fully engage with their role in preventive public health; the full breadth of the population may not be covered by public health services in areas where there are multiple and complex commissioning routes for public health services; and opportunities for jointly commissioning and co-ordinating service redesign and integrated pathways may not be realised. Ultimately, the government's view may be that these are local decisions, but if so it needs to be clear how this relates to public accountability for outcomes through the Public Health Outcomes Framework (PHOF) and through health and wellbeing boards, PHE or the NHS Commissioning Board (NHSCB).

- *The Department needs to set out a coherent structured approach to how specialist public health skills will be available to the NHS*, in particular to GP commissioners.

The future of the Public Health Observatories

14. Without accurate, up-to-date information on public health trends and outcomes, the system will not function. PHE can provide information, evidence and benchmarking from the centre. However, local intelligence functions are also critical. Absorbing Public Health Observatories (PHOs) into PHE may save the centre some money in the short term but it risks creating a less effective local public health intelligence network and significantly higher overall costs as directors of public health (DPHs) each seek to replace the lost capability in their own patches.

15. One of the achievements of the previous government was to move towards more co-terminous boundaries and data flows between local authorities (LAs) and PCTs. The 'free' clustering of GPs into consortia means that their boundaries do not align with local

authority boundaries in many cases, presenting massive challenges to the use of information to support accountability and governance in the new system.

- *The Department should reconsider the decision to absorb the functions of PHOs into PHE* in terms of independence, regional intelligence and the economies of scale and scope that 10 PHOs bring compared to 150 DPHs (and GP consortia) commissioning local intelligence separately.

- *The government needs to prioritise the mapping of data from GP consortia boundaries to local authorities* to ensure that the public health intelligence function supporting health and wellbeing boards, GP consortia and the delivery of the PHOF are fit for purpose.

<u>The structure and purpose of the Public Health Outcomes Framework</u>

16. We support the proposed domains within the PHOF of health protection through to the wider determinants of health, behaviour change and the final outcomes in terms of morbidity, quality of life, life expectancy and infant mortality.

17. However, we have consistently recommended (The King's Fund 2010b) that the Department should use an integrated outcomes framework across social care, public health and the NHS. The NHS has a greater role in public health, prevention and tackling health inequalities than indicated by the PHOF.

18. The number of indicators in the PHOF are to be reduced. This runs counter to the declared intention for more public transparency of outcomes. Local areas should have access to the widest array of information the centre can provide, from which they can choose their priorities and understand how they compare with others.

19. There is a presumption that accountability will flow purely from public transparency of the PHOF. This is flawed. There are no plans for PHE to have any role in overall performance. No-one is therefore, in the end, accountable for the outcomes that are expected from the billions of pounds of taxpayers' money that will be given to local authorities for public health. This is in stark contrast to how GP consortia will be held to account for their contribution to the NHS Outcomes Framework through the Commissioning Outcomes Framework (COF) with strong accountability to the NHSCB. This imbalance in accountability for outcomes is potentially damaging to public health.

20. The Department needs to learn from the experience of the previous government's public health and inequalities targets. It is widely accepted that the inequalities and public health targets have helped to foster local action. The Committee recommended the former be continued (Health Select Committee 2009).

21. We remain extremely concerned that in a system with no clear accountabilities, public transparency of information and small incentives payments will not be strong enough to deliver improved public health and reduce inequalities.

- *The Department needs to integrate the PHOF with the NHS and social care outcomes frameworks* to incentivise the proper care for patients and public health.

- If the PHOF continues as a separate framework*, more of the indicators in domain 3 and 4 of the PHOF need to be represented in the NHS outcomes framework and there should be no limit set on the number of indicators*. This will help to: ensure that GPs fully contribute

to public health outcomes, reduce the risk of fragmentation, and ensure that local areas have the best information from which to prioritise.

- *PHE needs to develop accountability and commissioning frameworks for public health* learning from its experience with the previous public health and inequalities targets. It should not rely solely on the health premium to deliver results.

Arrangements for funding public health services (including the health premium)

22. The Department has attempted to measure how much is currently spent on public health in order to transfer that amount to local authorities. Given the scale of the public health challenge, outlined in the evidence paper (Department of Health 2010b) published alongside *Healthy Lives, Healthy People*, we are concerned that public health will be underfunded at the outset.

23. The local public health budget will be dwarfed by the local NHS budget. The NHS budget needs to adequately reflect the role of the NHS in public health and inequalities reduction. In recent years the Advisory Council on Resource Allocation (ACRA) has been asked to reflect that one of the core objectives of the NHS is tackling preventable inequalities in health. This objective will remain if the Health and Social Care Bill retains – and, as we argue below, extends – the duty on the NHSCB and consortia to tackle inequalities.

24. In 2010/11 the NHS formula included a weighting of 15 per cent for health inequalities; this will be reduced to 10 per cent in 2011/12 (Gainsbury 2011). This decision is arguably more significant than anything that happens to public health budgets.

25. The allocation system for the public health budget will be new. It needs to adequately reflect the distribution of inequalities in health, within local authorities as well as between them.

26. The current intention seems to be for the formula to be based on a 'one-shot' strategy and for all future changes in allocations (beyond up-rating for prices) to be based on achievements rewarded through the health premium. This is far too crude and risks consigning parts of the country to a vicious spiral of chronic underfunding.

- *The Department needs to set the public health budget on a proper assessment of need* and not solely on basis of estimates of what is currently being spent. This needs to be closely aligned with an assessment by the Department for Communities and Local Government on how much local authorities are currently spending on health improvement and broader activities so there is a good understanding of local baselines before resources are transferred.

- *We urge the Department to fully assess the impact on public health and inequalities of the decision to reduce the weight on deprivation in the NHS allocation formulae*.

- *The public health allocation formula needs to reflect inequalities in health outcomes both within and between areas*.

- *The Department should revise its current position of only up-rating allocations for prices.* It must also include broader elements outside the control of local authorities, such as population churn, so that areas are appropriately funded for public health.

27. The current model for the health premium is for a payment based on relative performance between areas on a small number of indicators in the PHOF, with larger payments for more disadvantaged local authorities. This is transparent and recognises that local

authorities with high deprivation have further to go and will find it more costly and harder to make changes.

28. However, it runs the risk that local authorities will hit the qualifying criteria by focusing on the 'easy wins', helping people from wealthier areas who are easier and cheaper to reach, rather than those in poorer areas where social norms are harder to address. It also incentivises making short-term gains, rather than investing in the wider determinants of health. It could therefore simultaneously improve population health and widen inequalities within local authorities.

29. Local authorities need to be stretched. The premium should be designed so that they are not incentivised to do the minimum to meet the payment threshold in-year. Population health churn also needs to be taken into account to reduce the likelihood of misattribution of rewards to actions.

- *The premium's design needs to focus on a combination of within-area inequality reduction in final outcomes and short-run shifts in the known major causes of inequalities that the local authority can influence.* Within-area life expectancy and within-area smoking rates are the leading candidates for inclusion in a relatively simple formula.

- *The premium needs to be piloted*, due to the evident complexities and high chance of perverse outcomes.

How the government is responding to the Marmot Review on health inequalities

30. The commitment to duties on the NHSCB and GP consortia to tackle inequalities in health is a major step forward. However, they are not strong or comprehensive enough.

31. The duties refer only to the role of the health care system as a provider of patient care. The proposed duties on inequalities ignore the vast potential the NHS has to affect public health and inequalities through the intelligent and directed use of its economic power in local communities.

32. There is no matching duty in the Bill for local authorities to tackle inequalities in health.

33. The PHOF includes a domain for the wider determinants of health which is consistent with the emphasis on wider determinants from the Marmot Review. The government could strengthen its response to the review and signal its commitment to reducing inequalities reduction by including the 'Marmot indicators' (London Health Observatory 2011) in the PHOF.

- *The government should widen the duty on inequalities to include the contribution of the NHS to broader health outcomes* beyond inequalities in access to care and outcomes from that care as currently in the Bill.

- *The government needs to be more explicit in the Bill about the role and expectations of local authorities around tackling inequalities in health* and align them with the expanded duties we suggest for the NHS Commissioning Board and GP consortia.

- *The Department of Health should include the Marmot inequality indicators developed by the London Health Observatory in the PHOF*, or be explicit why it is not doing so.

Annex: References

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