Clinical Medicine 2011, Vol 11, No 5: 430–3

Healthy people, healthy lives. The English public health white paper: risks and challenges for a new public health system

John Middleton

The English public health system is set to undergo a radical overhaul for the first time in nearly 40 years. The white paper, *Healthy people, healthy lives* is a response, the government says, to policy failures in public health which mean that:

- Britain has among the worst levels of obesity in the world
- smoking claims over 80,000 lives a year
- 1.6 million people are dependent on alcohol
- over half a million new sexually transmitted infections were diagnosed last year, and one in 10 people getting an infection will be reinfected within a year
- poor mental health is estimated to be responsible for nearly a quarter of the overall burden of long-standing poor health
- people in the poorest areas expect to live up to seven years less than people in richer ones.[1]

The UK Faculty of Public Health definition of public health is used, namely: 'the science and art of the protection and promotion of health and wellbeing, the prevention of disease and the prolongation of life, through the organised efforts of society.'[2]

The main proposals include: a life course approach to tackling health inequalities, following the lead of the Marmot Report[3]; a new public health system founded on Public Health England (PHE) and public health directors based in local authorities; a ring-fenced budget for public health taken from the NHS budget and redistributed to PHE and local authorities; an outcomes framework and a health premium recognising the degree of difficulty in local public health problems and rewarding good progress; revitalised health and wellbeing boards led by local authorities and general practice commissioning consortia; and an increased role for industry in health improvement and health in the workplace.

The strategy wants integration, partnership and evidence-based practice. It acknowledges a place for government regulation and taxation but it is light on government intervention, despite the fact that major improvements in health have been brought about through legislation such as compulsory seat belts in cars and the ban on smoking in public places, and through fiscal means like alcohol and tobacco taxation.[4] Its line is very much about shifting responsibility and action to local communities and to individuals. All government departments are to be engaged and a cabinet subcommittee has been created to do that.

John Middleton, director of public health, Sandwell Primary Care Trust and Sandwell Metropolitan Borough Council; vice president, UK Faculty of Public Health

A new service, PHE, created within the Department of Health, will pull together functions such as the Health Protection Agency, the National (Drugs) Treatment Agency, and the regional public health teams and observatories. PHE will oversee the allocation of ring-fenced budgets to local authorities, and delegate commissioning of health service public health tasks, such as immunisation and screening, to the NHS Commissioning Board. Local authorities will be given increased powers and responsibilities for health strategy, for public involvement (through the Healthwatch) and for public health improvement. Directors of public health (DsPH) will be appointed and will be accountable both to the local authority and, through PHE, to the chief medical officer (CMO) and to the secretary of state for health. Their teams will deliver health needs analysis, health protection and health improvement programmes, managed either by the team or commissioned from a range of health and care services, voluntary and community providers and other agencies.

Local authorities will hold a ring-fenced public health budget and this will need to be deployed to achieve a series of public health outcomes. A health premium will be available for areas with the greatest health inequalities, with rewards for achievement and otherwise. Health and wellbeing boards will be set up to review local needs, based on the independent annual report by their DsPH and the joint strategic needs analysis.

Public health in the UK

The idea of the collective need for protection of the public goes back at least to medieval times,[5] but modern public health was born into local authorities in the UK in the Victorian sanitary revolution.[6–8] Sir John Simon, the first CMO, said famously that 'the interests of health and the interests of common physical comfort and convenience are in various cases identical'.[6] This idea subsequently became enshrined in the World Health Organization's (WHO's) *Health for all* strategy as the 'prerequisites for health': clean water and sanitation, adequate shelter and food, education, employment, a safe environment and peace.[9] Marmot's two reports on social determinants of health and reducing inequalities globally[10] and nationally[3] pick up these themes. The growth of public health paralleled the growth of collective social provision through local authorities. New sewers and clean water provision accompanied the first council housing and the first non-religious, non-private collective education. New services, such as social work, district nursing, environmental health protection and health visiting, were born in the office of the medical officer for health of the local authority. By

© Royal College of Physicians, 2011. All rights reserved.

the 1930s, local authorities increasingly came to provide health clinics, ambulances and hospitals.[11]

The NHS took away the dread of becoming ill and being financially ruined.[12] Public health protection remained in the province of the local authority medical officers of health until the NHS reorganisation of 1974. By that time, their empire was beginning to crumble: social work, district nursing and health visiting were robust professions in their own right. The independent medical officer of health had become an anachronism and antagonistic to local democracy.[13] The role of the public health doctor in the new health authorities was cast differently – the new community physician who would span the worlds of local authority and the new NHS – the doctor, making a diagnosis of the ills of the community and proposing the remedies for collective improvement.[14] Epidemiology would be applied to assess the effectiveness and efficiency of healthcare.[15] Tudor Hart added the notion of inverse care law – that the poor people in need of the most and best healthcare tended to get the least and the worst.[16] Later, the Black Report showed how 30 years of the NHS had seen widening health inequalities.[17]

The new public health movement of the 1980s reopened the local authority role in health.[18] The European WHO proposed 38 targets for health for all by the year 2000, bringing relevance to affluent and industrialised countries for HFA strategy.[19]

Acheson reclaimed the term public health[20] and reestablished the primacy of the director of public health as an executive officer of the health authority producing an annual report from which health and health service planning should emanate. The consultant for communicable disease control was also reinvented.

Most recently, public health has addressed diseases of behaviour and addiction, inactivity and over consumption, under the looming realisation of climate chaos, major global environmental and economic catastrophe.[21–25] The coalition government has committed to radical austerity measures which are punishing the poorest even further, and threatening to create wider health inequality.

The Health Bill[26] proposes the legislation for the health system structures proposed in the NHS, the public health and the social care white papers – the NHS Commissioning Board, general practice commissioning consortia, Monitor, Healthwatch, PHE and local authority public health. It confirms duties of engagement, partnership, quality, and reducing inequalities, on NHS commissioners and public health. It confirms PHE under the Department of Health, and DsPH jointly appointed by the secretary of state and local authorities, but employed by councils.

UK responses to the public health white paper

UK public health lobbyists, including the Faculty of Public Health, have broadly welcomed the government's increased focus on population health, the commitment to the Marmot Report's findings on health inequalities, and the evidence-based, professional approach to tackle them. The approach to outcomes, evidence, expertise, transparency and to new resources for national public health research has also been welcomed. However, it remains to be seen which 'evidence base' will be politically acceptable. The government has steadfastly resisted calls for minimum pricing of alcohol for which the evidence base is strong, and supported industry involvement in the responsibility deals to address problems of over consumption, for which there is little evidence.[27] The strategy claims to adopt the Marmot Report's recommendations but ignores the key recommendations to reduce inequalities in income across the social gradient, by reducing inequalities in income.[3]

The emphasis on town planning for healthier built environment, transport and improving mental and physical public health is encouraged and so it is surprising that the government has suspended the National Institute for Health and Clinical Excellence's public health guideline on healthy town planning.

The return of public health to English local authorities is also welcomed in principle, which brings England back where most non-UK public health departments are based; the European Healthy Cities movement is based on city government action – budgets, agreements and partnerships.[28]

The changes come at a time of immense turmoil in all aspects of public sector life. The budgets of local authorities are being cut by nearly one third. The modus operandi of local authorities is changing from big civic service delivery to smaller democratically accountable intelligent bodies able to commission services from a range of public, community and private providers. They want the localism and the public health budget that the government offers but do not want to be told what professionals to employ or what to spend the money on.[29]

The UK public health service has evolved with critical appraisal skills in epidemiology residing at local level, the ability to inform local health needs assessments, advocate effective intervention and monitor outcomes. It has led critical analysis of the affordability and effectiveness of high-cost clinical interventions at local level. And it has led to critical recognition of the inverse care law that people in poor areas get poor services.[16] The major population health services, screening and immunisation have also benefited massively from the leadership of public health specialists within the health service. More recently there has been recognition of the need for preventive services to complement clinical care, for instance in smoking cessation services, health trainers, community development and food and fitness workers. For these reasons we must protect health services public health.[31–34]

The Scally Report recommends statutory regulation of public health professionals for the protection of the public[35]; government favours voluntary regulation. It is invidious that medically qualified public health professionals are statutorily registered and regulated but other public health specialists are not [36]

The white paper expresses the desire to protect the public health workforce through this period of change. In all previous health service reorganisations, public health expertise has been lost and the current risks seem greater. Complex consultation documents on the funding and commissioning arrangements for public health and the public health outcomes framework have been issued concurrently.[38,39] These demonstrate the

© Royal College of Physicians, 2011. All rights reserved.

enormity of the bureaucratic challenge, and financial risks inherent in trying to unravel complex policy and commissioning functions which have evolved over 40 years in the NHS. Custom and practice, and goodwill need to be replaced by explicit funding regimes and due diligence, where previously they had been undertaken largely through sound inter-professional alliances and light-touch NHS financial transactions. While NHS professionals may understand the operational requirements of screening programmes and immunisation, for instance, little of this work would be formally described as 'commissioned'.

The future of the public health reforms

Academic responses to the health reforms have included those that are stridently against the reforms because they present the end of the NHS in all but a logo.[43,44] Others merely continue to lament the absence of an evidence base that will show health service redisorganisation will save lives or save money.[45–47] The strong health professional response to the NHS proposals has led to the 'period of reflection' through a further public and professional consultation led by Professor Steve Field. The public health reforms, initially welcomed, have proved more problematic in the detail. Support is not unconditional – there is a strong expectation for: an independent and robust PHE which is capable of providing a coherent career and training structure for public health specialists in health protection, health improvement and health services public health; protection of terms and conditions of staff into the new system; DsPH reporting to chief executives of councils; clarity in the size and applications of the ring-fenced budget and professional regulation for all public health professionals and a protected and rapidly expanding ring-fenced budget. The lack of enthusiasm for the reforms from the local government group does not auger well. The prize in the reforms would be for councils to embrace their life-saving and life-enhancing role, taking public health as a matter of civic pride for which they are responsible. Sadly, in the current financial austerity, a mindset of saving money prevails over the public sector, which is greater than the political will and the need to protect and save lives. The risk is that a generation of public health professionals will be disenfranchised and lost from the health system and the population perspective they bring to saving lives will be lost for a very long time.

Postscript

At the time of going to press (August 2011) the government has responded to the NHS Futures Forum report, ostensibly agreeing to all its major recommendations. These included that the secretary of state should remain accountable for the NHS, that patient choice and safety considerations override those competition, and that there should be greater clinician, patient and local political involvement in health and wellbeing boards and clinical commissioning groups. The amended health bill, now almost impenetrable to any but the most committed observers, will be subject to renewed parliamentary scrutiny in September and still risks rejection. The government has produced their response and way forward document on the public health white paper consultation. They have accepted Public Health England should be an executive agency of the Department of Health to preserve its scientific independence and enable it to continue to attract major research contracts and generate income from vaccine and biomedical product sales. They have made the strongest statement yet about the chief officer status of the director of public health in the local authority, but are not committing this to statute. Neither have they accepted the case for statutory regulation of all public health professionals.

Acknowledgements

Dr Middleton is funded by the National Institute for Health Research (NIHR) through the Collaborations for Leadership in Applied Health Research and Care for Birmingham and Black Country (CLAHRC-BBC) programme. This paper has been prepared under the auspices of the CLAHRC-BBC knowledge management programme. The views expressed are not necessarily those of the NIHR or the Department of Health.

References

1. Department of Health. *Healthy lives, healthy people: our strategy for public health in England*. London: DH, 2010.
2. Davies L. The new public health strategy for England. *BMJ* 2010;341:c7049.
3. Marmot M. *Fair society, healthy lives: strategic review of health inequalities in England post-2010*. London: The Marmot Review, 2010. www.marmotreview.org.
4. Nuffield Council on Bioethics. *Public health: ethical issues*. London: Nuffield Council on Bioethics, 2007. www.nuffieldbioethics.org/go/ourwork/publichealth/introduction
5. Ruffhead, O. *The statutes at large from Magna Charta to the twenty-fifth year of the reign of King George the Third, inclusive*. London: Eyre and Strachan, 1786. http://nrs.harvard.edu/urn-3:hul.ebookbatch.ECCO_batch:T134763
6. Muir Gray JA. *Man against disease: preventive medicine*. New York: Oxford University Press, 1979.
7. Rosen G. *The history of public health*. Baltimore: Johns Hopkins University Press, 1993.
8. Lambert T. England in the 19th century, 2008. www.localhistories.org/19thcentengland.html
9. World Health Organization. *Report on the international conference on primary health care*. Geneva: WHO, 1978.
10. Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008. www.who.int/social_determinants/thecommission/finalreport/en/index.html
11. Webster C. Local government and health care: the historical perspective. *BMJ*. 1995:310:1584.
12. Bevan A. A free health service. In: *In place of fear*. Wakefield: EP Publishing, 1976:98–121.
13. Lewis J. *What price community medicine? The philosophy practice and politics of public health since 1919*. London: Wheatsheaf, 1986.
14. Morris J. Tomorrow's community physician. *Lancet* 1969;ii:811–16.
15. Cochrane AL. *Effectiveness and efficiency: random reflections on health services*. Oxford: Nuffield Provincial Hospitals Trust, 1972.
16. Tudor Hart J. The inverse care law. *Lancet* 1971;1;405–12.

© Royal College of Physicians, 2011. All rights reserved.

17 Department of Health and Social Security. *Inequalities in health*. London: DHSS, 1980.
18 Ashton J, Seymour H. *The new public health*. Milton Keynes: Open University Press, 1990.
19 World Health Organization. *Targets for health for all in the European region*. Copenhagen: WHO, 1984.
20 Department of Health. *Public health in England. The report of the Committee of Inquiry into the Future Development of the Public Health Function*. London: HMSO, 1988.
21 Stott R. *The ecology of health*. Dartington: Green Books, 2000.
22 Middleton J. Environmental health, climate chaos and resilience. *Medicine Conflict and Survival SHOES* 2008;24(suppl 1).
23 Macpherson K, Marsh T, Brown M. *Tackling obesities: future choices –modelling future trends in obesity and the impact on health*, 2nd edition. London: Department of Business and Innovation and Science, 2008. www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities/reports-and-publications/quantitative-erratum
24 Audit Commission. *When it comes to the crunch*. London: Audit Commission, 2009. www.audit-commission.gov.uk/localgov/national-studies/Pages/whenitcomestothecrunch12aug2009_copy.aspx
25 Torjeson I. Primary care: recession medicine. *BMJ* 2010;340.
26 English Health and Social Care Bill 2011. London: Department of Health, 2011.
27 O'Dowd, A. Government's public health responsibility deal is met with skepticism. *BMJ* 2011;342:d1702
28 WHOEURO. Healthy cities movement. www.euro.who.int/en/what-we-do/health-topics/environmental-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network
29 Local Government Group. *Local Government Group on the day briefing: Healthy lives, healthy people: our strategy for public health in England*. www.lga.gov.uk/lga/core/page.do?pageId=15313144
30 Middleton J. What does the public health white paper hold for local authorities? *Municipal J* 2010;13.
31 Faculty of Public Health. *Response to the public health white paper, Healthy lives, healthy people*. London: Faculty of Public Health, 2011.
32 British Medical Association. *Response to the public health white paper, Healthy lives, healthy people*. London: BMA, 2011. www.bma.org.uk/healthcare_policy/public_health_white_paper/index.jsp
33 Association of Directors of Public Health. *Response to the public health white paper, Healthy lives, healthy people*. Cambridge: ADPH, 2011.
34 British Medical Association joint statement of GP consultative committee consultants in public health medicine. *Public health support for GP commissioning*. London: BMA, 2010. www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/resources-1/commissioning-support-for-ltc/PH-Support-for-GP-Commissioning.pdf/view Alliance, Solutions for Public Health
35 Department of Health. *Review of the regulation of public health professionals*. London: DH, 2011. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122089
36 Faculty of Public Health. *Response to the consultation paper on the professional regulation of public health professionals*. London: Faculty of Public Health, 2011.
37 McKee M, Hurst L, Aldridge R *et al*. Public health in England: an option for the way forward? *Lancet* 2011;378:536–9.
38 Public Health Development Unit. *Healthy lives, healthy people: transparency in outcomes, proposals for a public health outcomes framework*. A consultation document. London: Department of Health, 2010.
39 Public Health Development Unit. *Healthy lives, healthy people: consultation on the funding and commissioning routes for public health*. London: Department of Health, 2010.
40 Faculty of Public Health. *Response to Healthy lives, healthy people: transparency in outcomes: proposals for a public health outcomes framework*. A consultation document. London: Faculty of Public Health, 2011.
41 Faculty of Public Health. *Response to Healthy lives, healthy people consultation on the funding and commissioning routes for public health*. London: Faculty of Public Health, 2011.
42 Middleton J. Public health can't survive on £4 billion. *HSJ* 2011.
43 Pollock A, Price D. How the secretary of state for health proposes to abolish the NHS in England. *BMJ* 2011;342:800–3.
44 The end of our National Health Service. *Lancet* 2011;377:353.
45 Oxman AD, Sackett DL, Chalmers I, Prescott TE. A surrealistic mega-analysis of redisorganization theories. *J R Soc Med* 2005;98:563–8.
46 Smith J, Walshe N, Hunter D. The redisorganisation of the NHS. *BMJ* 2001;323:1262–3.
47 Hunter, David J. Change of government: one more big bang: health care reform in England's National Health Service. *Int J Health Services* 2011;41:159–74.

Address for correspondence: Dr J Middleton, Sandwell Primary Care Trust, 438 High Street, West Bromwich B70 9LD.
Email: vpPolicy@fph.org.uk

© Royal College of Physicians, 2011. All rights reserved.