Written evidence submitted by the London School of Economics and Political Science (PHP0003)

My name is Walter Holland. I am a Visiting Professor in Public Health at the London School of Economics and Political Science, having retired in 1994 as Professor of Public Health Medicine at the United Medical and Dental Schools of Guy’s and St Thomas’s. I had been President of the Faculty of Public Health (1989-1992), President of the International Epidemiological Association (1987-1990) and Honorary Director, DHSS Social Medicine and Health Services Research Unit (1968-1994) at St Thomas’ Hospital Medical School, later UMDS.

I was on several of the DHSS working parties concerned with the 1974 health reforms advising both Secretaries of State, Richard Crossman and Sir Keith Joseph. Some of my research, funded by DHSS, was concerned with the first randomised controlled trial of screening in adults in general practice (now called health checks) (1968 to 1977) and the National Study of Health and Growth in primary schoolchildren (1971 to 1994), which was a national system of surveillance to monitor the health of primary schoolchildren.

I was involved in working with public health in local authorities from 1962-1994 particularly in Kent, Lambeth and Harrow.

I am very concerned about the changes that have occurred to Public Health in its structure and governance as a result of the Health and Social Care Act.

There were good reasons for the change of Public Health in 1974 from local government to the NHS. The problems evident before 1974 have, I’m afraid, recurred. They can be summarised, in my view, as follows:

1. In order to improve health public health professionals must be able to identify and warn against proven hazards of environmental, social, occupational, nutritional and fiscal policies. Public Health has always been “political” and since the 19th century been involved in improving conditions such as housing and sanitation against the interests and wishes of landlords etc. In the past its practitioners were protected, by statute, from being sacked if they made statements, e.g. in their annual reports, that were uncomfortable to their political masters. This protection no longer exists in Local Authorities. It is also evident from statements by PHE that the latter are more interested in following the government’s “line” than an independent view and individuals in PHE are muzzled if they express contrary views.

2. PHE is considered to be the most authoritative body advising the Government on national Public Health issues. Unfortunately, since its formation, it has neglected to develop the essential links to Universities and Research bodies, crucial if its advice is to be considered as credible. It has not learnt from the experience of the Research Councils or the National Institute of Health Research how to commission independent research nor has it subjected its statements, policies or research to appropriate independent peer review. Examples are:
a. The expenditure of £350 to 450,000,000 annually on health checks, as advocated by PHE, in spite of all randomised controlled trials of this procedure showing that there is no benefit in terms of morbidity, mortality or function. This “check” is providing a form of “population screening”, as well individuals are encouraged to attend services available through pharmacies, GP surgery and other primary care services. Yet it remains unreviewed by the group most capable of assessing its effectiveness—the UK National Screening Committee.

b. The unwillingness of PHE to publish its findings on methods to combat excess sugar consumption.

c. The support by PHE of E-cigarettes before (and without) proper independent academic evaluation of their safety or possible influence to smoke normal cigarettes.

d. The advice on possible environmental hazards from fracking without proper recognition of the findings in some studies in the USA of possible hazards.

e. Suggested policies on control of diabetes which differ markedly from the suggestions and views of academic experts in the field.

The lack of credible independent research and review of public health policies and statements or links to respectable academic knowledge, expertise and practice by PHE has grave implications for the acceptance of Public Health statements or policies intended to improve our population’s health.

3. Thus the governance of PHE by its Board would seem to be insufficiently robust, an example is that one of PHE’s functions is to communicate risk information. It is striking how naïve this is, when compared, for example, to a recent commentary by Professor Sir David Spiegelhalter, of Cambridge, on HRT and breast cancer. This is an example of the lack of PHE to connect to expert academic advice.

4. It is of concern that the Head of PHE has no public health training or experience. So far he has not shown any evidence of the independence and judgment required in leading a public health organisation.

5. The separation of public health from the NHS means:

a. There is insufficient input of Public Health into the NHS Hospital or General Practice policies in which it is expert, e.g. infection control, antibiotic prescribing, radiation exposure. The separation of Public Health away from Commissioners of Health Services, based in CCG’s, cannot be good health service planning.
b. If there should be a major outbreak or emergency, coordination of public health and disease control may be difficult.

c. Separation of Public Health from the NHS means that access to health data may be impaired for public health practitioners, thus impeding methods and development of policies of health improvement and health surveillance.

6. Before 1974 it was acknowledged that the number and quality of medically qualified individuals and medical students taking up public health careers was poor in quality and quantity. This may be beginning to occur again.

7. Before 1974 I witnessed several instances of political (party) influence on the appointment of senior public health professionals in Local Authorities. This disappeared when public health became part of the NHS in which appointment only depended on professional competence. I have not seen any measure to counteract this unfortunate behaviour in the present structures. In addition there is no requirement that DsPH have completed specialty training or have any involvement with the FPH.

8. Public Health in the local authority in which I live (London Borough of Richmond-upon-Thames) does not seem able to develop policies required to improve the health of the Borough’s population nor to play any active role in, for example, becoming involved in policies or activities to improve mental health services; a major problem for many local residents.

Conclusion

I consider that the inclusion of Public Health in Local Authorities, rather than in the NHS, and the creation of PHE as a quasi-departmental body has, and will continue, to impair the essential prerequisite of public health to be an independent voice to improve people’s health and the health services we provide. The separation of Public Health from the NHS detracts from its ability to recruit high quality medical practitioners. It also detracts from its ability both to do and to cooperate with high quality research.

These statements are my own views based on about 60 years of professional experience working in universities but collaborating with Local Government and Health Authorities including DHSS, PHLS, and PHE.

I have expressed these opinions and experiences in writing but would welcome giving them to you in person to answer any questions you may have.

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