The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow each year.

The BMA welcomes this opportunity to submit written evidence to the Health Select Committee’s inquiry on Public Health post-2013 – structures, organisation, funding and delivery and commends the committee for choosing to review this area.

Executive Summary
- The Health and Social Care Act 2012 implemented significant changes in how public health services are delivered in England. These reforms have created a public health system which is fragmented, complex, confusing and lacking in clear lines of responsibility and accountability.
- Public Health England should be re-established as a NHS body.
- Public health teams must include medical public health staff.
- Medical public health specialists in LAs and PHE should be offered contractual conditions analogous to NHS terms; this is essential to continue to attract doctors to this specialty and into LA teams.
- Some local authorities are diverting the public health grant to cover cuts to other parts of local authority budgets rather than targeting public health priorities.
- The Government must prioritise and protect investment in ill-health prevention and public health services by continuing to ring-fence the public health grant and reverse cuts that have already taken place. Cuts to public health funding will not only result in a reduction in public health services, but will increase the burden on the NHS and have adverse effects on public health outcomes in future years.

Introduction

The delivery of public health functions
1. The Health and Social Care Act 2012 came into force fully on 1 April 2013, introducing a number of new structures and arrangements for the NHS in England. The Act is a complex and far-reaching piece of legislation, which introduced significant changes in responsibility for public health services in England. At a national level, Public Health England (PHE) was established as an executive agency of the Department of Health (DH). At a local level, responsibility for delivery of public health functions has been transferred from NHS primary care trusts (PCTs) to local authorities (LAs).

Public Health England
2. The BMA has repeatedly raised concerns about the establishment of PHE as an executive agency of the DH. We do not believe PHE is sufficiently independent from Government and as such, its policy positions appear to be influenced by government politics. These concerns have been reinforced by the Secretary of State’s recent repeated refusal and delay in publishing a review by PHE of the international evidence on measures which could reduce consumption of sugar.¹ We agree with the Chair of the Health Select Committee that this decision ran contrary to Public Health England’s Framework Agreement with the Department of Health, which explicitly states both PHE’s ‘operational autonomy’ and that PHE ‘is not required to clear the contents of its professional and operational announcements with DH or any other agency in advance’.²
3. It is essential that PHE is free to publicly challenge government decisions relating to public health. To this end, we believe PHE should be re-established as a NHS body. Public health specialists working for PHE are professionals responsible for treating a population: they must be entirely free to advocate for the physical and mental health of those populations. Allowing this freedom to be stifled by governmental influence and contractual terms and conditions, which may restrict the ability of public health specialists to speak out on issues of public health, places the health of the UK at risk.

4. Since 2014, PHE has been delivering a programme of internal restructuring to implement budget cuts of £65m (approximately 20%) in 2015-16. We have strong concerns that these large scale changes will impact on the organisation’s ability to deliver core functions and to retain expert staff.

Transfer of PCT functions to local authorities
5. The Health and Social Care Act created confusion locally by transferring responsibility for the control of public health functions from PCTs to LAs, resulting in wide variation in the extent to which public health is funded and prioritised. The BMA has consistently warned that this transfer of public health functions and the separation of funding streams, with the public health grant now branded ‘non-NHS’, would lead to confusion and a perception that public health services are separate from the wider NHS.

6. The NHS must continue to include public health functions, and the artificial distinction between public health and the wider NHS is not helpful. We think this terminology, which distinguishes between NHS and ‘non-NHS’ public health services is confusing for patients and the wider NHS who understandably believe that services provided by local authorities, such as sexual health services, dementia care and health checks, remain part of the NHS.

7. We are concerned that separating public health functions from the wider NHS has had negative implications for public health finance, for professionals’ access to crucial health data, for the public’s understanding and for productive working relationships. We do not believe that maintaining the separation between NHS and public health is sustainable in the longer term or in the best interests of the public’s health.

8. We are also aware that some LAs have become less keen to contract with multiple small providers, such as GPs. Where general practice is chosen, for example for contraception provision and smoking cessation services, difficulties are often encountered. Contracting arrangements have become increasingly complex and LAs lack basic understanding of patient and GP needs. This must be addressed in order to commission appropriate services.

Commissioning arrangements
9. Specialist public health advice must be embedded in all aspects of commissioning. We have repeatedly expressed concerns that the transfer of public health services from PCTs into LAs brought with it the risk that public health consultants would no longer be actively involved enough in commissioning decisions. Public health doctors specialise in evidence-based commissioning and their skills are crucial in ensuring local health services deliver according to population need. Without such professional advice, key healthcare services may not be prioritised. We are concerned for example that parity of esteem for mental and physical health may never be achieved if specialist advice is not available or given due influence. While it is recognised that Clinical Commissioning Groups (CCGs) are obliged to seek PH advice from LAs in commissioning decisions, we believe it would be preferable if public health specialists were recognised as integral to CCG boards. The BMA believes each LA public health department
should have dedicated public health consultant staff to provide essential support to local CCGs and each CCG must include a public health medicine specialist on its board.

**System fragmentation**

10. New commissioning arrangements have transferred responsibility for commissioning across a range of bodies, including NHS England’s central, regional and local structures, CCGs, PHE and LAs. These changes, alongside the establishment of PHE and the transfer of former PCT public health functions into the control of LAs, has led to further fragmentation of the public health service.

11. In order to maintain the integrity of the public health service, it is essential that the fragmentation of public health services brought about by the Health and Social Care Act is reversed. A national network of highly skilled and capable professionals must form the cornerstone of public health services. Organisational boundaries must not be allowed to restrict this essential work.

12. An example of this fragmentation has been the separation of GUM services into sexual health and HIV. Local authorities are required to provide testing for all STIs including HIV; they are also required to provide treatment for all STIs with the exception of HIV. This has resulted in a disrupted patient pathway (many patients are co-infected and vulnerable), loss of staff morale and recruitment difficulties.

**The effectiveness of local authorities in delivering the envisaged improvements to public health**

13. It is essential that if LAs are going to be effective in delivering envisaged improvements to public health, the public health grant from the Department of Health to local authorities continues to be ring-fenced and funds are spent for their intended purpose, which is to promote public health. Data obtained by the BMA under the Freedom of Information Act in June 2014 revealed that most LAs had used funds from the ring fenced grant to pay for services that were already being provided by local authorities out of general council funds. Data showed that the most common services that were previously funded by general council funds but were now paid for by the public health grant included: substance misuse, child health services, sport/leisure activities and promotion, sexual violence, domestic violence and teenage pregnancy services. In some local authorities, this has allowed innovative new approaches to develop; in other LAs, population health measures have been protected from drastic cuts in other parts of local authority budgets. However, the BMA is concerned that some LAs are using these transfers to plug gaps in budgets and diverting the public health grant to cover cuts to other parts of local authority budgets. This is an ongoing cause for concern.

14. We would like to see PHE being given the necessary levers to hold LAs properly to account for the expenditure of the public health grant.

**The public health workforce**

15. The transfer of public health staff from PCTs to LAs and PHE has led to a significant change in the dynamics of the public health workforce.

16. We are concerned that LAs undervalue public health specialists. There is currently no requirement on LAs to ensure they employ medically-qualified public health consultants, the absence of whom could have a devastating impact on the future of public health medicine and public health outcomes. Data obtained under the Freedom of Information Act by the BMA already reveals a downward shift in the number of medical public health specialists employed by LAs. Data from 114 LAs revealed that the number of medical public health specialists has fallen
from 187 posts in 2013 to 155 in 2015. The same Freedom of Information request revealed that the number of non-medical public health specialists in LAs increased from 237 posts in 2013 to 254 in 2015.\(^4\) In order to properly fulfil LAs’ statutory responsibility for the delivery of public health services, it is essential that public health teams have the right skill mix. This must include medical consultant public health staff.

17. It is also vital that medical public health specialists in LAs and PHE are offered contractual conditions analogous to NHS terms; this is essential to continue to attract doctors to this specialty and into LA teams. If pay and conditions differ significantly between public health roles and NHS roles, recruitment into the specialty will become difficult. Shortages in this highly trained workforce will weaken the national infrastructure and affect the UK’s resilience to deal with public health emergencies and the public health challenges that arise from the burden of communicable and non-communicable diseases.

18. Similarly, if LA terms are worse than those available at PHE, a two-tier public health service may start to develop with recruitment into LA teams becoming even more difficult. We have repeatedly expressed concerns about changes brought about by the Health and Social Care Act which have meant that public health staff previously employed by the NHS are now working for a number of new employers, including PHE and LAs. Although staff transferred on protected NHS terms, a voluntary move to a new post within the public health system would lead to the loss of their NHS contractual terms and conditions. The BMA is aware that many employers are harmonising terms across all staff, which is reducing entitlements for some staff groups including doctors. We would also support the introduction of an additional condition attached to the public health grant that would require LAs employing health professionals to have regard to the need for movement between NHS bodies, PHE and LA public health when setting pay and conditions.

19. It is vital that employers are able to recognise previous employment history within the public health system for the purposes of certain statutory employment rights; this will help ensure staff are free to move around the new public health system to where their skills are needed and best suited. We believe this change, which is supported by the whole public health system including the Local Government Association and PHE, could be achieved through a Modification Order (MO) which would allow LAs to recognise previous service of public health staff in the NHS and Public Health England, and bring public health staff into line with treatment of staff from other public services. A failure to make this change risks not only discouraging staff from moving into new roles and moving between roles in PHE, LAs, the NHS and academia but may also disincentivise doctors and other staff from specialising in public health at all. We have formally raised this proposal with the Cabinet Office on several occasions since March 2015, and understand that colleagues in PHE and the LGA have done similarly, but to date we have received no response.

20. Finally, the BMA’s 2014 survey of public health specialists (medical and non-medical) found that although some felt the return of public health functions to LAs was a positive step, the majority felt the reforms had not benefited public health and that it was now more difficult for them to influence the health of their local population\(^5\).

Public health spending
21. As discussed above, funding for local public health services in England is allocated by the DH to LAs through the public health grant. The grant is currently ring-fenced (though this is under review by the DH) and may be used by LAs only in order to discharge their public health responsibilities; spending must be approved by each LA director of public health. The BMA
believes it is essential that the ring-fence is maintained and the grant grows in line with NHS funding. Directors of public health (DsPH) must also be empowered to ensure this crucial funding is spent on areas of greatest need locally.

22. The BMA has also called for public health monies to be held centrally by PHE and deployed directly to DsPH. The BMA would also like to see clearer statutory duties on LA use of public health funding as well as improved local accountability whereby Health and Wellbeing boards receive regular reports from DsPH who would be required to declare that public health funding had been properly spent in accordance with a full assessment of need, with the aim of delivering a comprehensive health service. However, Health and Wellbeing boards would need to be strengthened significantly and provided with transparent governance arrangements and adequate resources before they could take on these crucial additional responsibilities. DsPH need to be expected to optimise the grant’s use, rather than merely approving that it has been spent in accordance with accountancy criteria.

23. The public health grant allocation is based on historical spend by PCTs, and this has led to some LAs being significantly under-funded since the 2013 transfer of public health responsibilities due to past low spending by PCTs. We have long believed that ill-health prevention activity is hugely underfunded and have called for an increase in the public health grant to bring the level of the lowest-funded local authority up to that of the highest. It has been estimated that this would require an increase of £1bn, which is approximately one per cent of the health service budget.

24. The BMA was deeply disappointed therefore by the announcement made by the Chancellor of the Exchequer on 4 June 2015 that a package of savings would be made across government in 2015/16, including a saving of £200million from the public health grant. The Department of Health has since announced proposals to take a standard rate of 6.2% from every local authority’s allocation, which will be implemented through a reduction in the fourth quarterly instalment of the grant. Most recently, the comprehensive spending review has implemented a further 4% cut annually in real terms over four years.

25. These swingeing cuts to the public health grant are both at odds with the Government’s expressed commitment to protect and invest in public health services and the emphasis on prevention in the NHS Five Year Forward View (FYFV). The FYFV states that the future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a radical upgrade in ill health prevention and public health. Without significant funding to tackle obesity, alcohol abuse and smoking, it will be impossible to implement the public health measures set out in the FYFV.

26. Cuts to the public health grant will inevitably lead to service reductions and will, in the longer term, result in greater costs for the NHS and the taxpayer. It will have a significant impact on the ability of local authorities to provide vital public health services such as health visitors, school nurses, NHS health checks and alcohol addiction services. There is a strong risk that with continued budget raids, all parts of the public health system will struggle to fulfil even their statutory responsibilities. Coupled with the reduction in PHE’s budget for 2015-16 by £65m, it seems clear that government is not serious about investing in public health.

BMA vision for the future public health system

27. In January 2015, the BMA published its vision for the future public health and healthcare delivery. The BMA believes the following changes need to be made to improve the public health system:
• A review of public health funding streams, outcomes frameworks and delivery mechanisms is required to ensure activity is better co-ordinated and limited funding is spent to best effect.
• There should be clearer statutory duties on local authority use of public health funding and improved mechanisms for local accountability regarding spending decisions, for example, by mirroring the duties of CCGs as set out in the Health and Social Care Act 2012. The accountable officer for spending of PH public health funding should be the director of public health and a report of public health spending should be submitted to the HWB (health and well-being board).
• A new model should be considered that draws together public health services and improves accountability for outcomes. This could be based on establishing HWBs as the central commissioner of comprehensive and integrated local health and social care services.
• Once better protection of the public health grant is in place, and in line with the recommendation in Sir Michael Marmot’s review *Fair society, healthy lives*, commissioned by the secretary of state in 2008, funding for ill health prevention should be increased in the short term by 10 per cent per year, with a view to increasing the proportion to 0.5 per cent of GDP in the long term. Spending should be focused proportionately across the social gradient and should be allocated on a per capita basis and adjusted for need.
• PHE should be re-established as a NHS body in order to ensure it is free to publicly challenge Government decisions relating to public health.

14 December 2015

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2 *Letter from Chair of the Health Select Committee to Duncan Selbie, Chief Executive, Public Health England, 9 October 2015*
3 BMA Public Health Medicine Committee, June 2014: *Public Health Grant: Results of Freedom of Information Act- Request of local authorities*
5 BMA – Health Policy and Economic Research Unit (March 2014) *Findings from the Public Health Survey*
6 *Department of Health: Local authority public health grant allocations 2015/16, Government response to public consultation on in-year savings and Equality and health inequalities analysis, November 2015*
7 *NHS England, Five Year Forward View, October 2014*
8 BMA– (January 2015) *Public health and healthcare delivery task and finish group, Final Report*