The Royal Society for Public Health (RSPH) is an independent, multidisciplinary charity dedicated to the improvement of the public’s health and wellbeing. We have a membership of over 9000 members working in public health and healthcare management.

Our vision is that everyone has the opportunity to optimise their health and wellbeing, and we seek to achieve this through our qualifications, conference and training programmes and policy and campaign work.

We are pleased to provide the Health Select Committee with a submission on the post 2013 policy and campaign work.

1) Delivery of public health functions

We believe that the transition across of public health from the NHS to Local Authorities has been positive. Local Authorities have a good understanding of their local public health needs as well as the ability to respond creatively to them. This is in part because Local Authorities afford public health the opportunity to take a “whole system” approach which in turn enables a greater degree of freedom and innovation. Placing public health within a Local Authority setting also underpins the focus on shifting prevention from a medical to a social model.

The view from public health teams is positive in terms of the move of public health teams into Local Authorities. In research undertaken with public health teams by RSPH in 2015¹, around 40% of respondents said the move had helped to reduce inequalities and improve the public’s health. Just under half (43%) were unsure about whether the move had had a positive impact on the public’s health, although very few disagreed with the premise that health outcomes were being improved for the public (17%). The results show an improvement on the previous year’s research when more than half (52%) of respondents were unconvinced that the move would help reduce inequalities and improve the public’s health in the future, and only 15% believed that the transition was improving health outcomes. The results of this snapshot survey would suggest that internally public health teams have an increased confidence that the transition to Local Government has had a beneficial impact on improving public health outcomes.

Despite this positive view, there are some challenges:

- Planning - In the same report² over half of respondents (58%) agreed that politics, and three quarters (75%) agreed that financial issues were impacting upon the ability of public health professionals to plan for and deliver health improvement initiatives locally. The results for 2015 showed a slight increase on the previous year which suggests politics and finance were having a greater impact on public health planning and delivery.

¹ In Good Health, RSPH (Feb 2015)
² In Good Health, RSPH (Feb 2015)
• Access to data – public health teams require access to high quality data and scientific evidence. The move to local authorities left many staff who had previously had access to key NHS data unable to access this. We believe this needs to be addressed to ensure public health teams can make decisions on the best available evidence.

• Health protection – there is fragmentation in screening and immunisation functions and a disconnect between commissioners (NHS England, Public Health England), providers and the population. We understand that public health teams are unable to access critical information which would help identify inequalities in screening and immunisation services.

• There is a need for JSNAs/JSHWs to be as comprehensive as possible – some research has previously shown that they are hugely variable across local authorities in terms of their consideration of key issues, such as mental health issues and how up-to-date the data is.³

• Research from RSPH and the DCRS (Data Collection and Reporting System), which examined the role of the Health Trainer Service has found concerns expressed about some commissioners focusing on targets/outputs, with little consideration of taking a holistic approach. Our research has also found that a growing number of Health Trainer Services have been decommissioned or Health Trainers are having to deal with mental health issues beyond their remit, due in part to a lack of mental health services.⁴

2) Effectiveness of Local Authorities in delivering the envisaged improvements to public health

We believe there are a number of factors which are enabling Local Authorities to deliver effective improvements to public health.

Firstly, it is vital that Local Authorities are given as much flexibility as possible to deal with local public health issues, identified through Joint Strategic Needs Assessments (JSNAs). The transition of public health to Local Authorities was motivated by the recognition that they have a greater understanding of the needs and issues faced by their communities and are therefore ideally placed to plan and implement public health services.

We believe the transfer of public health into Local Authorities has facilitated better working with other services which also make a significant contribution to the public’s health. The wider determinants of health identified by Professor Sir Michael Marmot in “Fair Society, Healthy Lives” include early years, education, housing, transport and planning all of which sit within Local Authorities. Local Authorities are also responsible for Adult Social Care and with an increased focus on integrated health and social care, public health can provide an important link between NHS and social care.

The effectiveness of Local Authorities in delivering public health requires strong political leadership to support Directors of Public Health in their role of championing health across Local Authorities. Some Local Authorities are reviewing their portfolios to ensure that leadership for public health is properly reflected – this might involve strengthening responsibility for public health in an elected member’s portfolio to ensure that there is clear leadership and sharing responsibilities across the executive.⁵ In addition, councillors could be provided with greater support to ensure they have an in-depth understanding of public health.

³ Are health and wellbeing boards taking account of diabetes (Diabetes UK, April 2014)
⁴ Minded to Change/Indicators of Change (RSPH/DCRS 2015)
⁵ Developing the local public health system, LGA/DH (2014)
Health and Wellbeing Boards, which are responsible for improving the health of their local populations, offer an opportunity for diverse parts of the local health economy to come together, but this is not being fully utilised in all areas. We believe the membership of HWBBs could be diversified to ensure membership reflects the wider determinants of health. While this is happening in some locations, it is far from universal.

We believe Local Authorities could benefit from greater powers in terms of planning and licensing in order to prevent the proliferation and clustering of businesses which may have a negative impact on the public’s health. In terms of planning we believe that Local Authorities should have the power to introduce planning controls to ensure that councils can, in line with their local development plans, reject planning applications for businesses such as payday lenders or bookmakers. In relation to fast food takeaways, planners should consider granting permission only to hot food takeaways that comply with certain nutritional criteria and to consider exclusion zones within the vicinity of schools. Councils are also not given much scope to decline applications from businesses on the grounds of the long term health impact, and we believe that in order for Local Authorities to be effective as possible in improving the public’s health, health impact should be included as a condition of licensing for all types of businesses.

Of concern is the variability between Local Authorities and the need to ensure that good practice is disseminated widely. Also where the Director of Public Health position is relegated to a second or third tier officer post, the likelihood of that postholder effectively influencing policy is limited: we believe the DPH must have direct access to the Council, for their voice to be heard.

3) Public health workforce

The workforce is at the heart of improving and protecting the public’s health. In 2014 the core public health workforce was estimated to equate to around 40,000 people including Public Health Managers, Health Visitors and academics. However, it is widely recognised that many occupations outside of the core public health workforce make a contribution to health and wellbeing. RSPH and the Centre for Workforce Intelligence mapped the “wider public health workforce” in 2015. The wider public health workforce was defined as:

“any individual who is not a specialist or practitioner in public health, but has the opportunity or ability to positively impact health and wellbeing through their paid or unpaid work.”

Our research which was commissioned by Health Education England (HEE), Public Health England (PHE) and the Department of Health (DH) uses the Office for National Statistics Labour Force Survey and estimates that there are approximately 15 million people in paid employment that have the ability to impact the health and wellbeing of others through their work.

In addition there are a further 5 million people providing unpaid care and support to family or friends due to disability, illness or poor mental health, all of whom contribute to optimising the health experience of others.

The estimated headcount of approximately 20 million people, spans 57 occupational groups and within these groups there are 185 working occupations. The wider public health workforce is divided into three groups depending upon their level of engagement and extent to which they are supporting the public’s health. These are:

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6 Centre for Workforce Intelligence (2014)
7 Understanding the wider public health workforce, CFWI/RSPH (July 2015)
- **Active**: those occupations which are making an explicit contribution to public health on a daily basis, work collaboratively in promoting public health outcomes or have a direct/indirect impact on wellbeing.
- **Interested**: have the influence and opportunity to proactively promote health and wellbeing on a larger scale, if given the support and training to do so.
- **Unengaged**: is defined as those occupational groups who have the potential to influence health and wellbeing but are not currently doing so.

Within this active workforce there are “early adopters” who have made the most progress in supporting the public’s health. Early adopters include: fire service, pharmacy, housing, Allied Health Professionals and Health Trainers. It is clear from our research that each of these occupational groups is already doing work to support the public’s health. RSPH would be happy to provide further details on potential case studies for the Health Select Committee.

RSPH chairs “People In UK Public Health” which represents the 4 nations of the UK and advises the Government on the future shape of the public health workforce. The membership of the group reflects some of those occupations identified as being part of the wider public health workforce, including the fire service, housing and pharmacy.

Our research suggests that there is a public appetite for the wider public health workforce to support individuals in a range of health improvement activities. Research\(^8\) suggests that 84.1% of residents in social housing would confidently speak to their housing officer about their own health and wellbeing; and 9 out of 10 people would trust the lifestyle health advice given by pharmacists or Allied Health Professionals.\(^9\)

In order to realise the full potential of the wider public health workforce there are a number of challenges which need to be addressed.

The review of the National Public Health Skills and Knowledge Framework is an ideal opportunity for more non-traditional public health roles to be captured, and for skills and knowledge required to include responsibilities which may have hitherto sat with public health specialists.

There also needs to be broad agreement on which type of public health services could be commissioned from the wider public health workforce. This could be achieved by piloting interventions to demonstrate the effectiveness of different occupations providing services. Services which the wider workforce could be commissioned to provide include: healthy conversations, NHS health checks, social prescribing and point of care testing.

4) **Public health spending**

It is an economic imperative to invest in prevention as it is cost-effective and will reduce short- and long-term demands on both health and social care services and increase economic productivity.\(^10\) The Office of Budget Responsibility has estimated that maintaining current levels of healthcare funding will drive the debt-to-GDP ratio to 187% of GDP. This will mean an extra and unaffordable £1.8 trillion by 2065.\(^11\) This predicted cost is unnecessary as we should be reducing demand for health and care services through prevention which is a much better investment in the future.

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\(^8\) SITRA/PHE (2014)

\(^9\) RSPH/Populus (2015)


especially given the forecasts which show the potentially catastrophic consequences and unsustainability of continuing poor diets, physical inactivity, smoking and harmful drinking.

The importance of public health is central to the NHS Five Year Forward View which calls for a “radical upgrade in prevention and public health”12. Simon Stevens, Chief Executive, NHS England has said that “the £8bn asked for in the 5 Year Forward View was predicated on a consistent social care offer and action on public health”. Now that the Government has committed to frontloading this investment, the requirement for effective prevention is absolutely imperative.

We are therefore extremely disappointed that despite the recognition in the 5 Year Forward View that the survival of the NHS is dependent on curbing spiralling demand with a radical upgrade in prevention and public health, there were two decisions recently which are diametrically opposed to this vision. The decision to cut local government public health spending by £200m in 2015/16 represents a false economy, which is likely to have disastrous consequences for levels of preventable illness, demand on healthcare services and, ultimately, health inequalities.

The challenge to public health funding has been compounded by the 2015 Spending Review which will add a further blow to the desired radical upgrade in health resulting in further cuts to public health funding and health education. We are concerned by the proposed new funding arrangement in the Spending Review whereby public health services are funded by Local Authority business rates. This may lead to a perverse situation in which the most deprived areas which suffer from the greatest public health problems, and therefore need the greatest support to address them will recoup the least from business rates.

There is a wider issue of a stark imbalance in how much funding is allocated to treating sickness rather than preventing ill health. In 2013/14 the Department of Health spent £106bn on health, social care and public health, although less than 5% (5.48bn) was invested in public health, of which approximately half (£2.66bn) was given to Local Authorities. While NHS spending per head equates to £1742, grants to Local Authorities for public health equated to £51 per head.13 RSPH believes that there is a current and historical mismatch between spending allocated to public health relative to the NHS budget and we believe that this funding must be rebalanced in favour of prevention which will ultimately save money in the medium to long term.

In our submission to the Spending Review consultation in “A country that lives within its means” RSPH made a number of suggestions aimed at raising revenue or leading to efficiency savings.

Revenue raising proposals would include a package of measures which could raise revenue of upwards of £2bn annually and provide additional funds for prevention. These would include:

- Implementing the proposed levy on tobacco manufacturers estimated to raise an additional £500M.14 Raising additional funds that could support interventions such as services to help people stop smoking.15 We encourage the Government to move this cross-party accepted policy forward.
- Re-instating the duty escalator for alcohol, estimated to raise £1.2bn over four years. As the OECD reported, harmful alcohol consumption also places significant costs on society. Alcohol taxation in the UK is relatively high compared to other countries but the costs to

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13 King’s Fund/Local Government Association 2014 – Making the case for public health interventions
14 Action on Smoking and Health/Landman Economics, February 2015
society far outstrip the revenues raised. Reinstating the duty escalator would not only recoup an estimated £1.2 billion over the next four years, it would help to counter the health risks generated by low alcohol prices.

- Introduction of taxes on sugar-sweetened soft drinks, confectionary and snacks estimated to raise an additional £1bn. The evidence linking sugary food and drink with overweight and obesity as well as dental decay is accumulating and examples of governments introducing taxes on sugar-sweetened soft drinks, confectionary and snacks are growing in number and providing useful indications of the effect of such taxes. The Government should consider these types of policies for both reducing the consumption of sugar across the population and raising needed revenue to support prevention and care services. An excise duty on sugar-sweetened drinks of 20p per litre has recently been proposed by Sustain, and the Academy of Medical Royal Colleges has called for “an at least 20% tax”. The UK Health Forum has also recommended that taxes should be applied to sugar sweetened soft drinks. An excise duty of 20p/litre would raise around £1 billion in revenue.

RSPH believes that these measures are supported across UK public health organisations and professional bodies as policy priorities to both raise needed funds and achieve the NHS Five Year Forward View. They would also incur little or no cost to the state and are likely to meet less public resistance for deficit reduction than other measures.

14 December 2015

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17 The Alcohol Health Alliance reports that costs to society from alcohol harm exceed £21 billion, which is more than double the tax receipts from alcohol duties (£10 billion).