Introduction

My name is Eugene Milne and I am Director of Public health for Newcastle upon Tyne. I am also co-editor of the Journal of Public Health, Vice-Chair of the Technology Appraisal Committee at NICE, and honorary professor at Durham University.

Prior to 2013, I had been Deputy Regional Director of Public Health for North East England. With the establishment of Public Health England, I became Director for Adult Health and Wellbeing in the national Health Improvement Directorate, where I remained for 11 months before becoming DPH in Newcastle.

I am probably still one of the few people to have chosen a move from Public Health England to a Local Authority, a decision that, two years on, looks even better to me than it did at the time. I remain steadfast in my belief that the most interesting, exciting and fertile place for public health practice right now is at this local level. Despite the financial problems with which we are beset, there continues to be a real sense of possibility. Indeed, there is a good body of opinion, manifest in the WHO Healthy Cities programme or in Bloomberg Philanthropies, that cities and city-regions have the potential to be the most dynamic foci and facilitators of change and innovation in the modern world.

Public health in local authorities

The shift of responsibility for public health to local authorities was possibly the least controversial of changes in the Health and Social Care Act. Many of us welcomed the move, as it represented a logical progression of the type of public health practice that we had been advocating, and trying to implement, for some years.

In 2007, I had led the development of a health and wellbeing strategy for the North East of England entitled ‘Better Health, Fairer Health’, which had strongly emphasised broader determinants. In its structure, the section on ‘Economy, Culture and the Environment’ was given pride of place, followed by ‘Mental Health and Wellbeing’.

Under that structure, we had prioritised work on transport and winter warmth, but, despite good collaboration across sectors, it remained very difficult to reach into the mechanisms by which decisions critical to those broader determinants of health were made.

We are still only just getting to grips with issues of that kind, and striving to understand how they may be influenced. But it is clear already that there is a shift in the perception within councils of how health and wellbeing change can be effected. I am optimistic that we are seeing developing opportunities to influence future health through decisions on urban space, transport, housing and so on.

A point that I have found myself emphasising repeatedly over the past two years has been that the transfer of responsibility for public health to councils...
should be seen properly as a much more profound shift than simply a movement of practitioners, with a limited commissioning role in provision of services. Instead, it needs to be seen as a requirement to adjust fundamentally the way in which the whole range of council decisions is taken.

In doing that, we need to see a more vigorous assertion of the primary preventive role of council functions, alongside their contribution to secondary and tertiary prevention. The need for this has been thrown into sharp relief by changes to funding since the transition.

In Newcastle, we had an initial ring-fenced allocation in 2015-16 of £21.3m. The transfer of health visiting at the level of its estimated cost in the NHS should have raised this to £26.7m. However, next year we will receive £24.7m. At the launch of his review, Prof Sir Michael Marmot was asked what should be the level of funding for prevention. He replied that he did not know, but would suggest that it be at least double that which prevailed at the time. It is very disappointing to see that figure heading in the opposite direction.

In total, about 70% of our public health expenditure falls into the three categories of a) early years (that is, health visiting, family nurse partnership and school nursing), b) sexual health and contraceptive services, and c) drug and alcohol prevention and treatment services.

We are naturally keen to avoid compromising provision for early years, in line with our aspiration to act on the recommendations of the Marmot Review. And it is particularly perverse, after five years of working to boost NHS-commissioned health visitor numbers, that their switch to council commissioning should expose them to the risk of an immediate reversal.

To a degree, public health has not been well-served by our colleagues on the side of the health service who have labelled alternative uses of public health funds as ‘raiding the public health budget’. This perception undoubtedly contributed to a view that the ring-fenced grant was seen in some councils as a honeypot into which they could dip their paws.

I would strongly challenge this from our perspective. In my time at the council we have moved nearly £1m within the grant to support parks in Newcastle, and we did that without loss of cost-effective services elsewhere. I would emphasise that this was done not only with my support but at my suggestion. It forms part of a longer term approach to try and re-purpose and invigorate public and green space across the city as part of our support for wellbeing and health. It sits squarely alongside our Core Strategy and Urban Core Plan, and forms part of the dialogue we are having with partners in the NHS and third sector about support for healthy living.

I thoroughly endorse the statement made by Duncan Selbie in his evidence to the Public Accounts Committee on the grant to local authorities in January 2015 in which he said:

“The duty to improve the health of the people rests with local government. It is not equivocal; it is in the legislation. That is what Parliament said, “to improve the health of the people”. That was given back to local government in 2013. They last had it 40 years ago. It is not to provide a public health service, and it
is not to spend a public health grant in a particular way; it is to improve the health of the people."

With councils under severe budgetary pressure, it is inevitable that we must take stock of those council activities contributing most to the improvement of people’s health and take appropriate measures to safeguard them as best we can.

Crucial to understanding the role of councils in public health is the concept of population shift articulated as the ‘Rose Hypothesis’ – that greater gains in health are achieved by small changes in the whole population rather through large changes even in high risk sub-populations.

This places an emphasis on reinforcing and developing those activities for large numbers of people among whom some will benefit though you cannot identify who exactly they will be, as opposed to activities for small numbers of identified individuals. In practice, we do both, but the need to develop an emphasis on the former substantially makes the case for the 2013 transition.

It also throws into much sharper focus the importance of the NHS Five Year Forward View position on secondary prevention. To a great extent, secondary prevention is an expression of the high-risk, named individual approach – public health, effectively, as the treatment of individuals. Although the services currently offered by council-based public health embrace many such services, the future shape of council-based prevention needs to be achieved through its wider population influence.

There is already a perceived need for a health economic dialogue (though not necessarily articulated in those terms) at a local level in determining how we should best use a limited resource to achieve the greatest gain and limit future costs – both in terms of money and health. We lack the means as yet to conduct this. And this is compounded by the disadvantage suffered by local authority services in relation to the NHS with regard to research. We suffer far more often from insufficiency of evidence than we do from evidence of insufficiency. This playing field needs to be levelled if the agenda is not to be permanently dominated by ‘wonder drugs’.

Devolution may offer a way into this problem. We are watching the progress of Greater Manchester with great interest on this score. The questions that need to be addressed are not easy and provoke strong emotional reactions. However, it is impossible to see how the system will live within its means without grasping that nettle. How are we to reconcile the need for health services and social care? Is our configuration of health services the most efficient and optimal for the health of local people? To what extent is it justifiable to spend on environments to produce health, as opposed to treatments for ill-health?

**Public Health England**

Our relationship with PHE at a local level is excellent.

The ‘Centre’ based in Newcastle has been essential to public health protection – a function that it continues to provide as the successor to the
Health Protection Agency. I think it is easy to overlook quite how significant this role continues to be, and I have concerns about the way in which health protection has had to suffer, and continues to suffer, cuts to its budget. Areas of provision such as this tend not to be noticed until they are gone, or until a response to some unforeseen major event exposes deficiencies. Historically, neglect of protection functions led to the appalling problems characterised by the Stanley Royd Hospital outbreak – which those with longer memories will recall led to the Acheson Commission and the establishment of public health as an NHS function.

We have also received terrific support from PHE in relation to our work on drugs and alcohol. Throughout our reconfiguration of these services, colleagues at PHE have been highly supportive, and we continue to work closely with them as we address issues such as so-called ‘legal highs’ which are a scourge on health in our city and are creating a significant burden for emergency services.

PHE’s information function is also good and improving – the quality of analyses and reports made available for local use has, in my opinion, improved over the past 2-3 years and some – such as their report on mortality attributable to PM2.5 air pollution – have been powerful tools. On the other hand, I do regret the loss of the Public Health Observatories and their ability to provide and support some of the more ad hoc, regional and local intelligence functions that we enjoyed prior to 2013.

It is in the area of health improvement, however, that the organisation has least found its role, as the recently published IPSOS MORI survey for PHE illustrates. Although it should be noted that this is a systemic problem with the configuration of public health to some extent, it also reflects a failure to shift properly to a disseminated, locally-led public health rather than a more top down, directive model. As a consequence, in health improvement, PHE finds itself attempting to lead where it should follow and support, and attempting to exert direction when it lacks the mechanisms or credibility to do so.

In the interspace between local and national government, I would argue that there are essentially four areas in which PHE is able to operate. These are:

- **Intelligence and provision of evidence**
- **Media and communications**
- **Policy, funding and performance management**
- **Lobbying and advocacy**

As I noted above, the intelligence side of PHE’s function is improving, though the broader system has been slow to ensure availability of data to local authorities and public health departments to support their functions. These continuing problems of data interchange and confidentiality between organisations continue to dog efforts to deliver seamless support to the public.

On provision of evidence, PHE is in a remarkably poor position, despite expectations of its function in this field. NICE is essentially better place to conduct evidence reviews, as are many academic departments. PHE can only really operate as a broker of authoritative evidence from elsewhere.
Although nominally within PHE’s functions, there is a strong Department of Health flavour to its media and communication activities, which may be perceived as reflecting the philosophical conflict over the role of public health practice which I discuss below.

Funding and performance management are no longer within the remit of an intermediate tier, and the relationship with local authorities is necessarily less directive than within NHS structures.

Policy, on the other hand is where one might have expected PHE to score – working from ‘within the tent’. But internal change is far better achieved in the context of external debate. And the point is often missed that the objective of public health campaigns to change a law is less the change in the law itself and more the debate that leads to that change. A case in point is the 2007 tobacco legislation. With hindsight we see the legal change as the tipping point, but the true tipping point is more properly seen as the shift in public opinion that allowed it to happen, and which took place in advance of the vote, partly as a consequence of the debate triggered by a White Paper that did not go sufficiently far. In fact, this may be seen as echoing the pattern in California years earlier, where smoking rates began to fall in advance of ‘Proposition 99’, as a consequence of the campaign that led to the proposition and its adoption.

The argument that policy change from within should be the principal modus operandi of public health practice is also undermined by the positioning of PHE within the current system.

Philosophy of public health

It is impossible to consider the state of public health post-2013 without recognising that the changes have also embodied a philosophical conflict over the nature of public health practice. This is broader than just those parts of the system that label themselves as ‘public health’ and relates to the whole discourse relating to wellbeing, health and society.

Perhaps this is most obvious in questions of independence and autonomy – of what licence practitioners of public health should have to address policy issues as part of public health practice, and of whether that should be something done on the public purse.

Since 2010, the government has made clear that it does not consider policy questions should be addressed by NICE. Public health practitioners within PHE are governed by the Civil Service code, and are, therefore, required not to align themselves publicly with policy positions other than those of the government. Within PHE and the Department of Health there is a clear perception – at least on the part of the DH – that the latter is the ‘head’ and PHE the ‘hands’ of public health. The recent guidance on lobbying and advocacy by bodies in receipt of public sector grants takes a further step in this direction.

Set alongside the policy preference of government for action only at the lower rungs of the Nuffield ladder of interventions, this illustrates a profound
difference in perception of what should be the position of public health practice.

Yet historically, public health has been the most political of health specialities. One has only to read histories of 19th century public health to appreciate this. Virchow said that ‘politics is nothing but medicine on a grand scale’ – this is as true now as it ever was.

Marmot is unequivocally political in advocacy of broader determinant change to improve health and reduce inequalities. Yet by far the strongest emphasis we see at present is on individual behaviour and responsibility, rather than on shifts in those underlying factors.

To an extent this is not necessarily a conscious choice. Public health is one of those areas in which everyone has an opinion – everyone believes that prevention is better than cure – and everyone thinks they know how to do it. So much of it seems obvious, and yet it isn’t. Understanding why a screening test may do more harm than good can be complicated. Understanding the difference between tobacco control and Stop Smoking Services eludes many very intelligent and able people. The justification for prioritising spending on exercise rather than new cancer drugs is robust, but not easily or quickly communicated.

Welcome though the commitments to prevention in the NHS Five Year Forward View are, there is little real reference to public health in the current NHS planning guidance. Even the supposed focus on obesity and diabetes prevention powerfully reflects an individual, treatment-focused, behavioural – and, to some extent, victim-blaming – approach to the problem. It is, yet again, an illustration of the way that primary prevention loses out to the tangible appeal of secondary prevention and treatment.

It is, moreover, extraordinarily top down in its approach. Again, the principle that was embodied in the Health and Social Care Act of taking leadership in health and wellbeing improvement to a local level – through local authorities to communities themselves – is not being supported in practice. The national procurement and imposition of a particular approach to diabetes prevention illustrates this discrepancy.

**Workforce**

A couple of pragmatic points on the implementation of the public health changes are worth making:

Firstly, there is a very wide perception that issues of terms and conditions of public health staff, and the future of training, were insufficiently addressed in the transition. These have not been adequately resolved. It is already very difficult to sustain comparability of Ts&Cs between councils, NHS and PHE, and this is often problematic. There are great advantages to sustaining a workforce capable of moving between the different areas of public health practice – not least in ensuring the resilience of the system should we be required to mobilise a significant response to a public health challenge. This coherence has been eroded and remains under threat.
Secondly, there also remains an unresolved issue over the mixed recruitment of public health specialists from medical and non-medical backgrounds. The pay differential that applied in the NHS is unsustainable within pay and seniority structures elsewhere. This may have the effect of rendering public health a non-medical profession outside of PHE and the NHS. I think this would be a significant loss to the system, and would certainly remove a breadth of experience and understanding that I believe is beneficial.

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