Executive summary

- Re-establish the cross-departmental sub-committee to cover inter-sectoral public health issues, including health inequalities
- In making decisions on social spending, the public health and equity implications should always be taken into account
- Take a “whole of society” approach to public health, with an increased focus on preventing non-communicable diseases
- Improve the role of public health in local government and NHS strategic decision making
- Build health improvement as core NHS activity to help reduce demand on services and improve health.
- Public health has a key leadership role in co-ordinating joined up working between local authorities, NHS and voluntary sector
- Widen the skill base of the public health workforce to include a wider range of disciplines
- Recognise and develop the potential public health role of other sectors, such as child care, teachers, fire and police for instance. Including through accreditation and training.

Brief introduction

The submission is made by the Institute of Health Equity. The Institute (IHE) supports actions and approaches to reducing health inequalities. The IHE is led by Professor Sir Michael Marmot. This submission is provided by Professor Peter Goldblatt, Senior Advisor and Dr Jessica Allen, Deputy Director.

Factual information

1. The delivery of public health functions - why public health needed to move to local authorities (Marmot Review)

There are significant inequalities in health in England - according to latest ONS figures, the gradient in health between areas represented a difference of 19 years spent in good health between the top and bottom deciles in 2011-13 for both men and women\(^1\). Most health inequalities are related to factors outside the health care system, such as experiences and conditions in early years, education, working conditions, income, community and neighbourhoods\(^2\). For this reason, action to improve public health by reducing health inequalities needs to be taken through collaboration between public health and other actors, locally and nationally – education, early years, housing and planning departments for instance. These cross
sector collaborations are best forged and implemented in local authorities. However, there have been significant financial and leadership constraints in delivering this agenda (see Section 2).

The NHS also has a key role to play in this partnership to strengthen public health improvement and health equity across the whole population. Public health’s move away from the NHS has been one factor in reducing the NHS capacity to work to improve public health. If it were to work towards health improvement, as well as treatment, the reduction in demand on the NHS would go some considerable way to reduce the increasing pressures experienced by the NHS. See Sections 2 and 4.

Many key cross-sector partnerships require central government co-ordination and leadership to ensure that Departmental budgets are used efficiently across sectors to minimise the adverse impact of social determinants on public health. The disbanding of the relevant Cabinet sub-committee has reduced the effectiveness of Central Government in contributing to this agenda and has undermined required cross government working on public health.

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

Local authorities have a clear focus on population, placed based well-being which should act to facilitate and support efforts to improve population health. Following implementation of the Health and Social Care Act 2012, a review by the Kings Fund found that local authorities showed strong leadership in establishing the Health and Wellbeing boards, with most being chaired by a senior elected member. They found that most boards produced joint strategic needs assessments (JSNAs) and health and wellbeing strategies. The highest priorities in the health and wellbeing strategies of most boards concerned public health and health inequalities. However, The Kings Fund report found that there was wide variation in progress made and their capacity for further development. The financial climate plus confusion about the roles of new organisations in the reformed health and care system were seen as the biggest factors likely to impede progress.

The potential of local authorities to deliver the envisaged improvements has been significantly curtailed by funding reductions, with further reductions planned over the next five years (see below). These will result in longer term cost increases in terms of NHS care, social care, reduce tax revenue and productivity and increased pressure on public services more generally. For example, using hospital data, researchers at the University of York were able to calculate there were more than 158,000 preventable emergency hospitalisations arising from social inequality, and nearly 38,000 deaths from treatable conditions in the 2011/12. They found that people in the most deprived fifth of neighbourhoods in England are nearly two-and-a-half times as likely to end up in A&E, for a preventable emergency, as the least
deprived fifth. Emergency admissions would be nearly halved if everyone had the same rate of A&E admissions as the least deprived. In other words, nearly half of emergency admissions are attributable to inequality and are largely avoidable.\textsuperscript{5}

One under-exploited route for improving health and reducing inequalities is Social Value commissioning. Specifically, the 2012 Social Value Act, places a requirement on public sector procurement bodies to consider

‘How what is being proposed to be procured might improve the economic, social and environmental well-being of the relevant area, and... How, in conducting the process of procurement, it might act with a view to securing that improvement’.

This Act has not been implemented with the necessary scale and intensity to achieve these improvements so far\textsuperscript{6}. There have been good examples of where social value contracting has led to improvements in local social, environmental and economic conditions – and through these – health improvements.\textsuperscript{7}

3 The public health workforce

The public health workforce is under considerable pressure and there is a strong push to focus on delivery of essential core public health services. This has led to a marginalisation of efforts to improve population health and reduce health inequalities. One way ahead is to encourage workforces not traditionally identified with public health, to build on their existing roles and improve population health and reduce health inequalities; there is an opportunity for these workforces to achieve greater population health improvements, and some evidence and examples of where this is already happening. These organisations and work force include fire services, planners, early years workforce, schools and employers for instance. Much more can be done to develop these skills and make the public health role of these workforces explicit and recognised in training and qualifications. The health service can consider commissioning these non health sector workforces to improve population health, reduce health inequalities and reduce demand for health care.

The UCL Institute of Health equity has been commissioned by, Public Health England, to produce evidence reviews and guidance notes as practice resources for local action on health inequalities\textsuperscript{8}. These cover a wide range of areas which shape health and indicate just how widespread and cross-sectoral public health action must be. Recent reports cover the following topic areas:

- Good quality parenting programmes and the home to school transition
- Building children and young people’s resilience in school
- Reducing the number of young people not in employment, education or training (NEET)
- Adult learning services
Increasing employment opportunities and improving workplace health
Health inequalities and the living wage
Fuel poverty and cold home-related health problems
Improving access to green spaces
Understanding the economics of investments in the social determinants of health
Tackling health inequalities through action on the social determinants of health: lessons from experience
Using the Social Value Act to reduce health inequalities
Promoting good quality jobs, reducing social isolation and improving health literacy
Social Inequalities in the Leading Causes of Early Death - A Life Course Approach
The Impact of Adverse Experiences in the Home on the Health of Children and Young People, and Inequalities in Prevalence and Effects
Improving School Transitions For Health Equity
Housing and Mental Health (forthcoming)
Aging and mental health, cognitive decline and dementia (forthcoming)

The medical workforce can play a far greater role in improving population health. This potential has been explored by IHE in recent work with Royal Colleges, the BMA, the WMA and NHSE\textsuperscript{9}.

4 Public health spending

The ring-fenced public health budget that was transferred from the NHS to local authorities was around 4 per cent of NHS expenditure. Based on OECD health accounting guidance it largely covered only health protection and promotion activities (principally vaccination and immunisation, HPA laboratory and field staff, etc.). The Marmot Review recommended increasing the public health budget to 0.5 per cent of GDP by 2030 – approximately doubling expenditure to cover more upstream interventions to prevent the “causes of the causes” of ill-health.

Key to this activity at present are the mainstream activities of local authorities. The Institute of Fiscal Studies (IFS) has produced two recent reports on local authority spending on public services. This is funded by revenue from three main sources: grants from central government (predominantly from the Department for Communities and Local Government, DCLG), revenues from council tax and revenues from business rates.

Between 2009-10 and 2014-15, the IFS reported\textsuperscript{10} an overall 23 per cent cut in the spending power of local authorities - after accounting for inflation and population growth with net spending per capita on social care cut by 17 per cent in real terms. The report indicates that the central government grants component was cut by 39\%
per person in real terms. On average cuts were greatest in areas with a high level of spending need relative to revenue-raising capacity and those with faster population growth.

Looking forward to spending plans for the period between 2015-16 and 2019-20, IFS reported\textsuperscript{11} that grants to local authorities from DCLG are planned to be cut by 56% in real terms. However, partially offsetting that, the OBR forecast is that both council tax receipts and the revenues from the proportion of business rates retained by local authorities will grow by around 9% over the period. Taking these three sources of revenue together, IFS estimates that local government spending power is expected to fall by a further 7% between 2015-16 and 2019-20.

However, the DCLG's recent 'Provisional Local Government Funding Settlement' allocated grants in a way that explicitly takes into account the ability of local authorities to raise revenue locally. IFS concluded that resulting cuts to local authorities' overall spending power are therefore expected to be much more equally distributed than prior to 2015-16, although still greater on average for more grant-reliant authorities. These cuts undermine both the ability of local authorities to increase cross-sector activity to address upstream public health risks and, downstream, to resource social services contribution to reducing inequalities in preventable hospital admissions.

\textbf{The costs of doing nothing to tackle health inequalities are high.}

As set out in the Marmot Review\textsuperscript{2} there are significant costs associated with not taking action to reduce health inequalities. Each year in England the economic costs of health inequalities include:

\begin{itemize}
  \item productivity losses of £31-33B
  \item reduced tax revenue and higher welfare payments of £20-32B, and
  \item increased treatment costs to the NHS well in excess of £5B.
\end{itemize}

The burden to the health service is high – as the recent analysis of associations between deprivation and preventable use of the NHS shows\textsuperscript{4,5}. But avoiding these costs requires improving cross-sector work to prevent and provide community care of those with or at risk of chronic conditions such as dementia, diabetes, cardiovascular and respiratory diseases. A greater focus on the health consequences of non-communicable diseases is a pre-requisite for public health in the modern world.

It is not simply the financial and resource costs that are high - large numbers of years of life are lost (between 1.3 and 2.5 million years) and of life free of limiting illness or disability (2.8 million years) are lost as a result of inequalities\textsuperscript{2}. For example, in the winter of 2014-15, there were approximately 44 thousand excess winter deaths – the highest number in 15 years and around 15 thousand higher than the recent average winter figure\textsuperscript{12}. Research on winter deaths in an earlier time
period (1986-96) suggests that around a fifth of the excess deaths in winter are associated with living in a cold home\textsuperscript{13}.

**Not just the poor are affected**

The figures quoted earlier, from the Office for National Statistics and the recent research by York Health Economics, were expressed in terms of the difference between the top and bottom deciles or quintiles of area deprivation. However, they were calculated from the slope of a line fitted through all ten deciles/five quintiles. In short, inequalities affect everyone through a continuous social gradient in ill-health from richest to poorest. The large scale of the economic and health impacts described above result from this fact. This requires a “whole of society” public health response – recognising that much of the illness and disability responsible for inequalities results from lifelong exposures leading to non-communicable diseases\textsuperscript{14}.

While it remains the case that life expectancy and health expectancy at birth is increasing and is increasing across the social gradient overall\textsuperscript{15}, recent analyses by public Health England suggest that, despite an overall picture of continuing improvement in life expectancy at older ages, since 2011 life expectancy for older people has not increased or has fallen in many local authorities\textsuperscript{16}. This highlights the disparities in progress that can exist between local authorities, affecting many who live there.

Both the Public Health Outcomes Framework\textsuperscript{17} and the Marmot indicators\textsuperscript{18} provide more in-depth monitoring tools for assessing the factors that give rise to inequalities within and between local authorities. There is a need for both indicator sets to have access to a greater range of data that is disaggregated by socio-economic distributions within local authorities.

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References


