Public Health England

Protecting and improving the nation's health

Public Health England submission to the Health Devolution Commission

March 2020

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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This submission has been prepared with the support of Metro Dynamics. Metro Dynamics is a consultancy that works with those leading, growing or investing in towns and cities to support the development of more inclusive and prosperous local economies.

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1. Health and wealth are ‘two sides of the same coin’

“The best way of ensuring a long life in good health is to have the best start in life, a decent education, a warm and loving home, and an income sufficient to meet our needs. Or to put it more simply – a job, home and a friend are the things that matter most to our health.” Duncan Selbie’s Friday message, 1 February 2019[i]

“Evidence from around the world shows that health is a good measure of social and economic progress. When a society is flourishing health tends to flourish. When a society has large social and economic inequalities there are large inequalities in health.” Michael Marmot, Health Equity in England: The Marmot Review 10 Years On, February 2020[ii]

Health and wealth are ‘two sides of the same coin’ – places cannot have one without the other. Public health and economic development are strongly linked, social and economic factors are key health determinants, just as good population health is a key determinant of economic prosperity – the relationship is cyclical. In The Marmot Review, the social determinants of health were identified as early years and health status; education and health; work, health and wellbeing; income and health; and communities and health[iii]. Research has shown that the estimated impact of social and economic environment determinants on health status is 50%[iv].

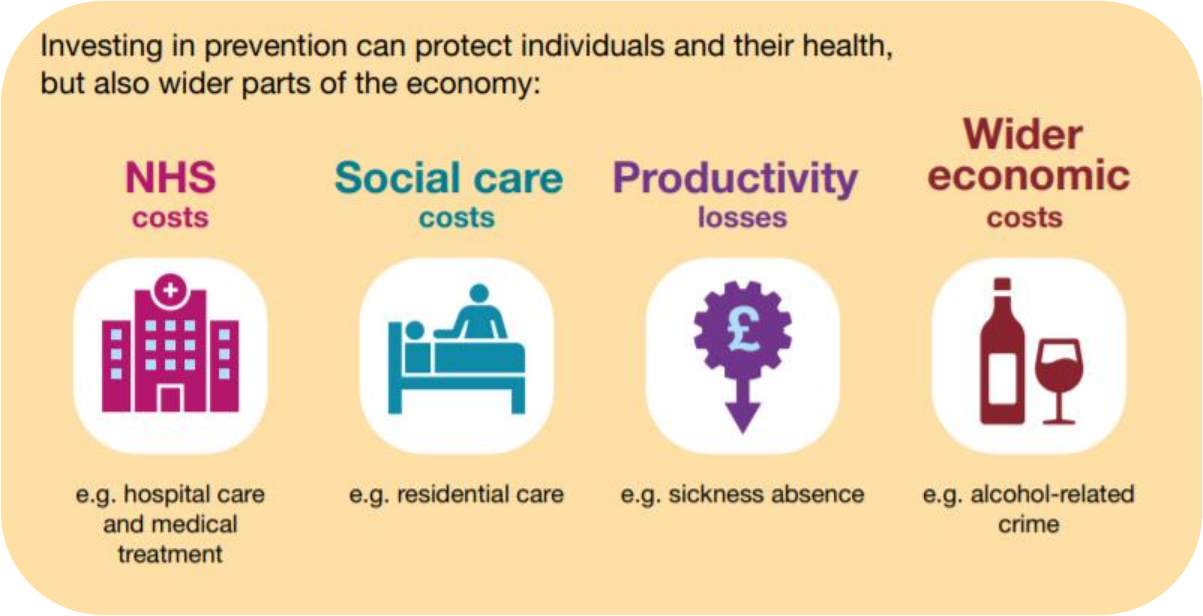
Poor health outcomes and high levels of health inequality in turn weaken economic growth and prosperity. Fewer people are fit enough to work and there are higher fiscal costs[v]. Lost taxes and higher welfare payments are estimated to cost £20-32bn per year[vi]. Nationally, productivity losses account for £31-33bn per year[vii]. These losses play out regionally with recent estimates showing that 30% of the £4 per person per hour gap in productivity between the Northern Powerhouse and rest of England is due to ill health. Reducing this gap would generate an additional £13.2bn in GVA[viii].

The link between health and wealth is also evident from challenges around deteriorating health, widening health inequalities and the inability of the poorest in society to contribute to and benefit from economic growth. Since 2010, life expectancy in England has stalled with marked regional differences – there have been large decreases in life expectancy in the most deprived 10% of neighbourhoods in the North East and the largest increases in least deprived 10% of neighbourhoods in London[ix].

Healthy life expectancy is a more significant indicator of inequalities in health between places and people. People in more deprived areas spend more of their shorter lives in ill-health than those in less deprived areas[x] with people becoming prematurely ill with avoidable illnesses, often linked to poor health outcomes in childhood[xi].

To overcome these inequalities and benefit individuals and the economy (as set out in Figure 1), a shift to a prevention paradigm is needed. Improving health and wellbeing is about creating prosperous and productive local economies that all residents can contribute to and benefit from, recognising that there cannot be inclusive growth without a healthy workforce[xii]. Devolution to mayoral combined authorities (MCAs) presents an opportunity to develop and embed this approach.

Figure 1 – Making the case for prevention[xiii]



2. Public health approaches to the wider determinants and population health

MCAs have the potential to implement preventative policies at scale, as they operate on a large geographical footprint, corresponding to a functional local economic area. They can integrate public health into their economic and public service reform strategies, linking health improvement with improved productivity and more effective demand management for critically stretched statutory services. Public Health England (PHE) is embedded in MCAs across the country through staff secondments and joint work on projects and ventures. This work complements and adds value to the public health work that is undertaken by local authorities, which is the level at which most of the specific public health interventions are designed and implemented.

There are a number of high-profile examples of PHE working with MCAs on projects taking a multi-agency public health approach to wider determinants, such as violence reduction and early years, and to improving population health. A few case studies are outlined here.

Greater Manchester Combined Authority (GMCA)

GMCA is a leader in the prevention agenda. It was the first combined authority to have a place agreement with PHE. This allowed GMCA to pool the public health grant in order to manage the system as a whole to prioritise prevention.

Greater Manchester is also the only MCA outside of London to have health and social care devolved. In 2016, GMCA took charge of the £6bn spent on health and social care in ten boroughs, with an additional £450m of funding to transform services. This is overseen by the Greater Manchester Health and Social Care Partnership (GMHSCP), which includes the combined authority, NHS organisations and councils, NHS England, the voluntary, community and social enterprise sector (VCSE), Healthwatch, Greater Manchester Police and Greater Manchester Fire and Rescue Services. PHE is working with GMHSCP on improving air quality.

The Working Well programme[xiv], which has been running since 2014, links employment and health. It offers services to support people experiencing or at risk of long-term unemployment. The pilot supported 5,000 residents and was later expanded to 50,000 people, starting with an initial expansion to 15,000 more people.

In 2018, the £52m Working Well (Work and Health Programme) was launched, aiming to support 23,000 residents between 2018 and 2024. InWorkGM delivers the programme – this is a partnership between Ingeus, The Growth Company, as well as Pathways CIC and Pluss, which are specialist health, wellbeing and disability support organisations. It delivers 200 different health interventions through a key worker based delivery model.

Liverpool City Region (LCR)

PHE have provided leadership and analytical capacity to LCR, initially for 18 months and extended for a further 12 months, to develop the city region Wealth and Wellbeing Programme. The extension was at the request of the Mayor.

This work has involved a range of outputs, including:

- Engaging with politicians including the Mayor
- Developing an explicit commitment to a systems leadership approach
- Partnering with two universities to quantify the link between productivity and poor health, and form a qualitative understanding of the experience of people out of work for health reasons
- Holding a series of workshops with voluntary organisations that support community engagement
- Conducting an evidence review of what works and producing a work and health profile for the city region and individual boroughs
- Including good work and wellbeing as one of four themes of the Local Industrial Strategy – a direct and acknowledged response to the work of the Wealth and Wellbeing Programme
- Holding a summit workshop in February 2020
- Developing a workplan for 2020 with three main strands: employment support programmes; wellbeing economics; and workplace and work reform

West Midlands Combined Authority (WMCA)

PHE is working with the WMCA on programmes tackling the wider determinants of health, including:

- The Violence Reduction Unit – applies a public health approach to understanding and addressing the causes of violence
- The West Midlands Homelessness Taskforce – involves working with statutory partners to tackle the root causes of homelessness
- Addressing fuel poverty – by incorporating actions around health inequalities and housing quality, and working with the private sector on social value principles and corporate responsibility
- Healthy Weight – supports people, particularly those from disadvantaged backgrounds, to benefit from eating well, moving more and making healthier choices
- Thriving on the Move – supports physical activity and addresses inequalities in participation
- Transport Strategy – including a focus on health impacts and active travel
- Thrive at Work – provides an evidence-based workplace wellbeing accreditation framework and toolkit to support employers to improve employee health and wellbeing

There has also been collaboration on population health. The Population Intelligence Hub, which is part of the Inclusive Growth Unit, is a virtual intelligence hub established by PHE and the WMCA. It conducts primary research, supports the development of data systems and integrates a wide variety of existing intelligence, resulting in actionable insight to improve outcomes and reduce health inequalities. It demonstrates impact of the WMCA Wellbeing Board, and supports evaluation of the impact of strategies and programmes on health inequality. This will help to inform approaches to population health management, embedding policy in economic strategy and place-based working.

3. Barriers to potential benefits of health devolution being realised

Despite a strong and growing commitment to improving health outcomes there are nevertheless formidable obstacles. Differences in system knowledge, culture and language across organisations, a lack of geographical alignment across services, institutions and systems, and insufficient prevention funding and powers are barriers to the potential benefits of health devolution being realised.

System knowledge

There is insufficient knowledge within policy and political circles of how the public health system operates. This is illustrated by a tendency to perceive health and anything health related as solely the responsibility of the NHS. There is also a lack of understanding about how public health and economic growth intersect, and the need for a preventative, rather than reactive health system.

Organisations use different language to one another, in terms of how they define opportunities and challenges, identify high risk cohorts and measure outcomes and progress. This can cause frictions in terms of aligning systems, objectives and priorities. Often health, employment, skills and business systems work in isolation of each other with a poor understanding of one another or their areas of mutual interest.

Lack of geographical alignment across services, institutions and systems

In some parts of England, there is a mismatch between the geographical footprint of different services, institutions and systems. For instance, within a place, there may be lower and higher tier local authorities, sustainable transformation partnerships, Department of Work and Pensions districts, Local Enterprise Partnerships, combined authorities, and Police & Crime and Fire & Rescue areas. These institutions may cover slightly different geographical footprints, resulting in challenges around governance and prioritisation, even though in practice they should all be focussing on trying to shift the same set of social outcomes, for the same people.

National silos, and insufficient prevention funding and powers

A key constraint is that funding and powers are not aligned at MCA level in a way that allows sufficient system co-ordination and upfront investment in prevention. At present, most MCAs have powers over transport, housing, strategic planning, and skills and training. Greater Manchester has devolved powers over health and social care, but none of the other MCAs have so far sought or been given similar powers, although most do have components of health and wellbeing[xv]. A lack of prevention powers means that there are also insufficient levels of funding to enable MCAs to invest in preventative interventions.

4. Role of devolution in advancing the health and wealth agenda

It is important to be clear about the challenges that health improvement is trying to address and the opportunities it presents:

- Creating a paradigm shift towards recognising the imperative of good health to the creation of wealth
- Promoting prevention and early intervention across the life cycle at scale using powers, resources and funding
- Embedding health and wellbeing into all areas of economic policy to impact the wider determinants of health

Health improvement devolution would empower MCAs to take a strategic enabling role in advancing the health and wealth agenda and co-ordinating and accelerating prevention. This includes:

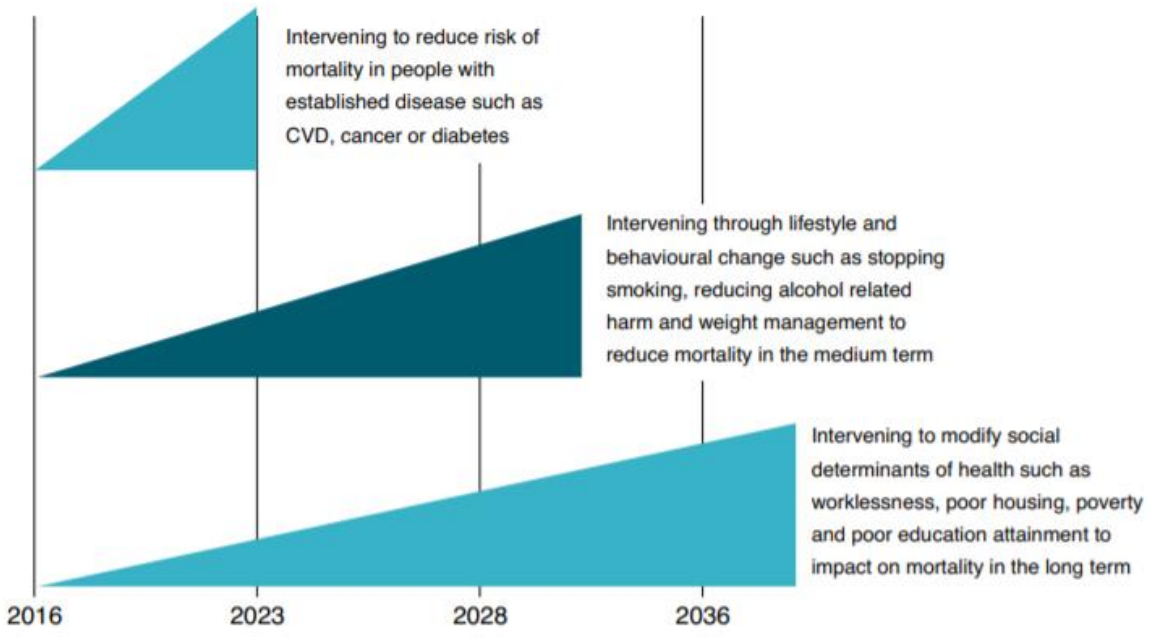
- Bridging siloes across sectors, organisations and policy areas
- Developing place-based responses to health challenges
- Using innovative funding and investment models

Bridging siloes across sectors, organisations and policy areas

A holistic, whole system approach to health is needed to support the shift towards a prevention based approach to health improvement. Devolution enables collaboration across public, private and voluntary/not-for-profit sectors and organisations to develop regional policies for health and wellbeing improvement, and integrated public services. This has the potential to accelerate prevention at scale by drawing together local plans and reducing duplication, so that the whole is more than the sum of its parts.

MCAs can act as brokers in this process, bringing together a large number of partners across different policy areas, including health and social care, economic development, skills, transport, housing and planning. By setting strategic objectives and outcome measures that all local organisations can sign up to, MCAs can ensure that prevention, health and inclusive growth are embedded in all policies and interventions. As shown in Figure 2, interventions in the social determinants of health have the longest-term impacts on mortality.

Figure 2. Long-term benefits of prevention[xvi]



Health devolution cannot be considered in isolation of other devolved powers, as success and progress in these different policy areas is interdependent. This way, MCAs can strategically join up policy in devolved areas to drive this agenda.

Developing place-based responses to health challenges

Devolution should enable MCAs to develop place-based strategies to reduce health inequalities, prevent ill health and support thriving people, economies and communities. This would allow for interventions and programmes that focus on local health and wellbeing priorities, are responsive to locally specific health challenges and target the people and places where need is greatest. Using the levers available to them, such as powers, duties, funding and multi-agency governance, MCAs should have the freedom to shape the nature and size of their ambition around health improvement, wellbeing and economic growth.

Using innovative funding and investment models

By overcoming fragmented and siloed funding, devolution should enable MCAs to use innovative funding and investment models to invest in preventative interventions at a place level. It is important for places to have the flexibility to allocate spending based on need and where there is greatest impact. This could be through pooled budgets or front-loaded prevention funds, which would enable money to be easily moved around the system.

5. Recommendations

There are five main recommendations for taking forward health devolution:

Recommendation 1 – Establish a clear role for MCAs in system leadership on health improvement

MCAs have a critical role to play in providing system leadership on health improvement. This is about developing a shared strategy with partners, using the mayoral platform to communicate directly to the public, and marshalling resources to scale up the impact of local prevention initiatives. This could be supported by a new duty to improve public health by aligning resources and priorities to focus on achieving better health outcomes, with the aim of levelling up healthy life expectancy. MCAs could then act as the designated authority for receiving specific additional Government funding linked to this duty to support prevention, for example through establishing a radical prevention fund. Fundamentally, this is a strategic enabling role, which would complement the delivery role of local government. Far from this being about taking powers from local authorities, this duty could enable MCAs to accelerate transformation and scale up projects developed by local authorities.

Recommendation 2 – Invest in prevention and account for it

To realise the benefits of health improvement devolution and move the dial on health improvement, there needs to be a substantial shift in funding towards preventative investment. There needs to be appropriate resource to support this change, whilst not adversely impacting existing services. This should involve developing pooled, multi-year, multi-pot budgets, reprofiling expenditure to allow MCAs to spend more up front,and setting targets for increased spending on prevention.

Recommendation 3 – Put prevention and life cycle measures at the heart of local economic strategies

Increasingly, a public health approach is used across policy areas to address different socio-economic challenges, including violence reduction and early years. Public health and prevention need to be integrated across wider economic strategy and inclusive growth. To facilitate this change, key life cycle metrics, such as school readiness at the age of five, should be integrated into frameworks for measuring social and economic progress.

Recommendation 4 – Establish greater funding parity between investment in social infrastructure and in physical infrastructure

Historically, investment in physical infrastructure has been prioritised over investment in social infrastructure, but both are important for growth and prosperity. As set out in the RSA Inclusive Growth Commission[xvii], a new model for inclusive growth should integrate social and economic

policy by investing in both social infrastructure, including public health, and physical infrastructure. Social infrastructure refers to the systems (such as childcare, early intervention, skills, housing, health and social care) that enable society to work effectively. A recent report from the Centre for Progressive Policy argues that integrating investment in social infrastructure into economic policy is critical to addressing the underlying structural causes of deprivation[xviii].

Recommendation 5 – Each devolved area should develop its own prevention and health improvement plan

A prevention and health improvement plan would enable devolved areas to develop a strong evidence base around their place-specific challenges and opportunities around health and wellbeing. Drawing on the insights from this analysis, MCAs would be able to clearly identify key objectives and priorities, and design programmes and interventions to improve health outcomes and reduce health inequalities. These objectives and priorities can then be integrated across all MCA strategies.

Annex 1 – The review process underpinning this submission

Literature/policy review

A desk-based review of existing literature and policy was carried out. This included:

- All Parliamentary Group for Longevity (2020) The Health of a Nation: A Strategy for Healthier Longer Lives. London: All Parliamentary Group for Longevity.
- Bambra, Munford, Brown et al. (2018) Health for Wealth: Building a Healthier Northern Powerhouse for UK Productivity. Newcastle: Northern Health Sciences Alliance.
- Centre for Progressive Policy (2020) Productivity knocks. Levelling up with social infrastructure investment. London: CPP.
- Department for Health and Social Care (2019) Advancing our health: prevention in the 2020s. London: Cabinet Office, Department for Health and Social Care.
- Metro Dynamics and Public Health England (2017) Health and Wealth: The Inclusive Growth Opportunity for Mayoral Combined Authorities. London: Metro Dynamics.
- Michael Marmot, Jessica Allen, Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, Ilaria Geddes (2010) Fair Society, Healthy Lives: The Marmot Review. London: Institute of Health Equity.
- Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity.
- Public Health England (2020) PHE Strategy 2020-2025. London: PHE.
- RSA (2017) Inclusive Growth Commission: Making our Economy Work for Everyone. London: RSA

Consultation

Input and evidence has been provided by senior PHE officials, PHE officers embedded within Mayoral Combined Authorities and PHE officers working in regional centres.

Annex 2 – References

[i] https://publichealthmatters.blog.gov.uk/2019/02/01/duncan-selbies-friday-message-01-february-2019/

[ii] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity.

[iii] Michael Marmot, Jessica Allen, Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, Ilaria Geddes (2010) Fair Society, Healthy Lives: The Marmot Review. London: Institute of Health Equity.

[iv] Canadian Institute of Advanced Research (2002) *In:* Department for Health and Social Care (2019) Advancing our health: prevention in the 2020s. London: Cabinet Office and Department for Health and Social Care.

[v] All Parliamentary Group for Longevity (2020) The Health of a Nation: A Strategy for Healthier Longer Lives. London: All Parliamentary Group for Longevity.

[vi] Michael Marmot, Jessica Allen, Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, Ilaria Geddes (2010) Fair Society, Healthy Lives: The Marmot *Review*. London: Institute of Health Equity.

[vii] *Ibid.*

[viii] Bambra, Munford, Brown et al (2018) Health for Wealth: Building a Healthier Northern Powerhouse for UK Productivity. Newcastle: Northern Health Sciences Alliance.

[ix] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity.

[x] *Ibid.*

[xi] Parliamentary Group for Longevity (2020) The Health of a Nation: A Strategy for Healthier Longer Lives. London: All Parliamentary Group for Longevity.

[xii] Metro Dynamics and Public Health England (2017) Health and Wealth: The Inclusive Growth Opportunity for Mayoral Combined Authorities. London: Metro Dynamics.

[xiii] Public Health England (2020) PHE Strategy 2020-2025. London: PHE.

[xiv] https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/

[xv] Metro Dynamics and Public Health England (2017) Health and Wealth: The Inclusive Growth Opportunity for Mayoral Combined Authorities. London: Metro Dynamics.

[xvi] North East Health and Social Care Commission (2016) *In:* Metro Dynamics and Public Health England (2017) Health and Wealth: The Inclusive Growth Opportunity for Mayoral Combined Authorities. London: Metro Dynamics.

[xvii] RSA (2017) Inclusive Growth Commission: Making our Economy Work for Everyone. London: RSA.

[xviii] Centre for Progressive Policy (2020) Productivity knocks. Levelling up with social infrastructure investment. London: CPP.