Coventry & Warwickshire Regulatory Services & Public Health Joint Workshop:
"Joint action to address the wider determinants of health"

Thursday 12th December 2013
Old Court, Shire Hall, Warwick

Title of keynote speech "Local authorities and the social determinants of health" by David Kidney, Chief Executive, UK Public Health Register

Check against delivery

INTRODUCTION

"The doctor is in and will see you now"

So begins a new session for a conscientious GP in a modern Warwickshire surgery.

By the end, the GP has noticed that a statistically significant number of patients have respiratory problems, they smoke and they live in rented homes where they have little control over repairs and maintenance.

The GP has prescribed treatment to ease their breathing – an inhaler perhaps – but knows that they will be back.

As we look at that situation from the other end of the telescope, we know something else.

We know that outside the GP's surgery, there are many other residents in Coventry and Warwickshire who smoke and whose homes are damp, mouldy and cold.

We know also that if someone could tackle these wider issues – stop smoking and decent homes – at population scale, we could reduce the number of GP visits by individual patients in respiratory distress.

The someone who could tackle these wider issues is in this room.

The wider issues that need to be addressed at a population level are the social determinants of health – what some people describe as the "causes of the causes".

PUBLIC HEALTH – A PREVENTIVE SERVICE

We have seen dramatic rises in life expectancy during our lives. Pension schemes have gone bust because actuaries underestimated the health gains of our generation.

More people are living longer lives and I say hooray to that.

But more and more people, living longer and longer lives, with increasingly complex health and social care needs are heaping pressure on already over-worked health and social care services.

And the numbers, and the pressures, will only continue to grow.

So going upstream, addressing needs at both individual and population levels is not a nice idea. It is a necessity.

Public health's time has come.

Or rather, I should say public health's time has returned.

Look back to the industrial revolution, when rapid industrialisation was matched by rapid urbanisation.

Vast populations were thrown together in overcrowded, disease-ridden settlements. Malnutrition was rife. Infectious diseases like cholera swept through communities killing hundreds, or thousands, in successive outbreaks.

Then, the public health heroes were the pioneers of sanitation and clean drinking water, epidemiology and infection control – and regulation of working conditions.

Over time, we developed free education for children, slum clearance and clean air regulation.

They were massive challenges weren't they?

And our predecessors rose to them and conquered them.

HEALTH INEQUALITIES ARE SO UNFAIR

So is it a case of "job done"? Are there no comparable challenges for today's public health community? Of course there are.

Sir Michael Marmot wrote a report for the UK Government in 2010: the Marmot Review "Fair Society, Healthy Lives". He looked back over about 70 years of UK health outcomes and what he uncovered is shocking.

For all the gains we have made in setting up the NHS and a "welfare state", for all the specific attention given to public health's prevention agenda, health inequalities in the UK have stayed the same or got wider, they have not narrowed as we might have expected.

Inequalities are evident in many health outcomes, including mortality, morbidity, self-reported health, mental health and death and injury from accidents and violence

In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods.

Worse still, the average difference in disability-free life expectancy is 17 years.

So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability.

We see these differences between local authority areas:

Average life expectancy for men in Warwickshire – over 79 (79.1) years
Average for men in Blackpool – under 74 (73.8) years

Average for women in Warwickshire - 83 years. For Blackpool – 80 years

We see differences within local authority areas:

Life expectancy is over 11 (11.7) years lower for men and nearly 8 (7.9) years lower for women in the most deprived areas of Coventry than in the least deprived areas.

Life expectancy is over 8 years lower for men and 7.5 years lower for women in the most deprived areas of Warwickshire than in the least deprived areas.

Reducing health inequalities is therefore a top priority for reasons of humanity, fairness and social justice as well as the economic imperative of controlling health and social care costs.

SOCIAL DETERMINANTS OF HEALTH HAVE TO BE TACKELD

The World Health Organisation says social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels

Sir Michael Marmot describes a social gradient in health – the lower a person's social position, the worse his or her health. Action on health inequalities, he argues, requires action across all the social determinants of health.

But he does not say that we must focus all our effort solely on the most disadvantaged – he says such an approach will not reduce health inequalities sufficiently. Instead, Sir Michael proposes that our public health actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. He calls this proportionate universalism.

This approach will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

There is plenty more to learn and adopt from the Marmot Review, including the life stages approach to planning interventions and its six policy objectives covering best start in life, protection from childhood illnesses, decent jobs for all, a healthy standard of living and "people power" so that we all have control over our lives.

Sir Michael is very keen on effective participatory decision-making at local levels, empowering individuals and local communities.

From the league table of preventable killers we can see that many lives can be saved and a great deal of disability averted if we can just focus on and re-double our efforts to:

- Stop smoking
- Control and reduce high blood pressure
- End over-consumption of alcohol
- Eat less, or at any rate eat less unhealthy food; and
- Be more physically active

We want individuals to take responsibility for the behaviour change they need to make to achieve these goals.
But we can help individuals as well as entire populations through:

- Providing education and information
- Helping ensure there are enough homes and all are of decent standard
- Fighting to retain existing jobs and promoting Coventry and Warwickshire as attractive locations for new jobs
- Maximising residents' income, be it through promoting a living wage, ensuring benefit take-up or supporting small businesses, entrepreneurs and self-employment.

Regulatory services probably have more direct interactions with these target business groups than any other council service.

COUNCILS AND COUNCILLORS IN THE LEAD

In England last April the public health lead returned to local authorities, having been transferred from them to the NHS in 1974.

Why have local authorities been entrusted with the public health lead once more?

It is in recognition of the importance of the social determinants of health.

Recognition of the need for population-based interventions.

And recognition of the necessity to go upstream to tackle causes of ill-health before individuals experience symptoms and have to go to doctors – prevention is better than cure.

And who is best placed to lead on this upstream, population-scale work?

Local authorities of course:

Their activities already touch the lives of their entire population

Their services are capable of reaching all groups

They are trusted by their residents and businesses and voluntary organisations

Their elected members represent local people, share the same experiences and they have the skill and experience of speaking to and giving a lead for their communities

It is a matter of democratic legitimacy.

There are two reasons to my mind why elected representatives in particular should be in the driving seat:

1. Resources are limited and it is essential to make choices and prioritise activity and spending – Councillors have the legitimacy, the breadth of vision and the authority to make these life-affecting decisions

2. Communication is the crux when it comes to making health everyone's business, changing behaviour, winning support – and overcoming the "Nanny State" counter-blasts – Councillors have the skill and the trust that effective communication requires.

This is not to say that local authorities are the perfect choice, there are obstacles:

Local authorities have lost their public health knowledge and expertise since 1974 - there is much to re-learn from their Directors of Public Health and their teams recently welcomed in from the now defunct primary care trusts.

There will be tensions between the short-termism pressure imposed by the electoral cycle and the long-term nature of the commitments that will make a real difference to people's health.

There is also a danger of public health failing to bring council services out of existing silos – including as between different local authorities in two-tier areas like Warwickshire. Public health interventions really must be "joined up" across all local authorities' services

I have left to last the obstacle that is no doubt most on your minds - local authorities are strapped for cash – the biggest reduction in resources due to austerity following the global financial crash.

However, no-one is saying that you have to deliver improved health outcomes on your own – it is a leadership role, there are other resources locally and nationally which will help you.

LOCALISM – IT'S YOUR PLACE

Locally, the Health and Wellbeing Board brings together local government, the NHS and the voice of patients and service users, Healthwatch.

As you know, the task of your local Board is to develop your local strategy for improving the health of your residents and reducing health inequalities within your communities.

This is localism writ large. No-one from outside is telling you what to do or how to do it. The decisions are for you to make.

It is also joined up government writ large. Key participants, local authorities, Clinical Commissioning Groups and NHS England, for example, have to plan and commission services to improve the health of the populations they serve and reduce inequalities.

There is a national framework for this work - the two outcomes in the Public Health Outcomes Framework:

1. Increased healthy life expectancy
2. Reduced differences in life expectancy and healthy life expectancy

At the local level, this means you must assess the evidence (this is done through the Joint Strategic Needs Assessment), set a strategy for local action (this is the purpose of the Joint Health and Wellbeing Strategy) and deliver and commission services in line with that strategy.

The effectiveness of the interventions that are prioritised in the strategy should be evaluated and then the cycle of evidence – strategy - delivery is repeated.

I would make two pleas to you:

1. In targeting health and wellbeing, don't overlook or underestimate the significance of mental wellbeing: isolation, depression, powerlessness and mental illness

2. Good though local authorities will be at reaching into every community, very often voluntary organisations are better still – in their own spheres of influence - so please do plan strategically to make full use of what they have to offer.

Many of the interventions needed are best directed by local authorities – in areas such as education, environmental health, access to green spaces, housing, leisure, planning, social care, sport, trading standards and transport. It's a long list.

Local authorities will themselves be expected to shape their own services so as to support the local strategy.

But local authorities will also engage with other organisations active in their locality – businesses, housing providers, not-for-profit groups, police and fire and rescue services, for example – to secure as great a focus of resources as possible on meeting the priorities of the local health and wellbeing strategy.

THE PUBLIC HEALTH ROLE OF REGULATORY SERVICES

Public health is an area where there are clear links with regulatory activity, in areas as diverse as air quality, food safety, housing quality and tobacco control.

In particular, regulatory services provide a mobile front-line workforce engaging local businesses and the public, who themselves have a key role in local public health.

In my experience, local regulatory services are not always strong on collecting and using evidence as a key driver of practice and commissioning. This has to change if they are to contribute effectively to meeting the council's public health challenges.

There must be a strong focus on outcomes and developing clear rationales for projects that demonstrate impact on Public Health Outcomes.

This is a strength of the public health staff moving into the local authority, so I foresee the two teams working together on increasingly substantial public health interventions.

And regulatory services, like all other council services, and like the services provided or commissioned by partner organisations, will have to make a reality of Make Every Contact Count so as to deliver maximum impact on residents' health and wellbeing.

Council contacts with employers, including those through regulatory services like health and safety at work and food safety, can become particularly fruitful:

Workplaces offer access to a wide cross-section of the County's working population enabling key health and wellbeing messages to reach big audiences.

Dame Carol Black has been particularly influential in establishing the benefits to employers of taking part; benefits such as improved productivity and reduced costs.

Some employers have signed the Government's Responsibility Deal on health and wellbeing in their workplaces – for example, ASDA, BT and The Co-operative Group.

There are many examples of successful collaboration with business to deliver improved public health outcomes, including Kirklees Council's 'Better Health at Work' programme.

Better Health at Work
The council works with companies to help them understand their health and safety responsibilities, and works with GPs to help patients return to work.

Advisers provide free, confidential advice to businesses and individuals to improve health and safety in the workplace. They help firms to encourage employees to have healthy lifestyles, to carry out health MOTs, and to improve productivity by reducing the costs associated with sickness and absence, such as additional recruitment and overtime payments.

By doing so they engage with companies that otherwise wouldn't come into contact with public health.

LOCALISM YES, BUT YOU ARE NOT ALONE

Localism means that you decide the strategy that best suits your place and people.

But you are not unsupported on your epic public health journey.

During the early years of your new public health service the Department of Health is providing you with a ring-fenced grant and the Department also provides a framework for focusing your efforts, namely the Public Health Outcomes Framework

The Local Government Association is there to support you and all other local authorities as you get to grips with your new responsibilities.

NICE now provides support for local government via a dedicated section of its website, containing public health evidence, guidance, briefings and pathways.

OTHER GROUPS

There are other sources of support and guidance, too. For example: CLeaR is a new approach to improving local tobacco control, specially designed for councils in England as they take on their new responsibilities for public health

Another example is the Kings Fund. It provides a wealth of evidence and analysis, such as its October publication “The future for health and wellbeing boards: side show or system leader?”

It concludes:

“Our findings suggest that developing a strong and purposeful partnership between CCGs and the local authority offers the best prospects for the boards to make a real difference to their local population.”

PUBLIC HEALTH ENGLAND

Public Health England is your new best friend and arguably your most important supporter and helper. It is already offering you relationship support, building on what hopefully you felt were good relationships with, for example, the Health Protection Agency and the Public Health Observatories.

Over time, Public Health England will prove itself to be:

A vital source of evidence, intelligence and guidance

The public health system’s leader

A provider of practical publications – recent examples include two “Healthy people, healthy places” briefings on obesity jointly with LGA:

1. Obesity and the environment: increasing physical activity and active travel
2. Obesity and the environment: regulating the growth of fast food outlets (based on a toolkit published by the London Assembly and CIEH)

PUBLIC HEALTH CHALLENGES – THEY JUST KEEP COMING

While old enemies such as tuberculosis and measles still exist, there are new challenges, too.

Smoking, obesity, poor nutrition, lack of physical exercise, alcohol, drugs, sexually transmitted infections and climate change.

The World Health Organisation estimates that globally climate change is already contributing to 150,000 deaths a year.

Front-line healthcare workers report a rise in asthma levels as well as injury, trauma, sickness and death attributable to more extreme weather events.

I saw Public Health Warwickshire's Cold Weather Plan prominently displayed on the council's website. This is commendable, especially in the light of the shock news of the rise in deaths attributable to excess cold last Winter.

However, increasingly, we will be preparing for heat-related weather events as well.

In past ages, public health services have been invaluable in devising and delivering the health protection, health improvement and equitable access to healthcare that has saved society from formidable health threats.

More than that, it has, and it continues to, point the way towards a fairer, healthier more civilised society.

Working in public health is an honourable and life-improving profession.

It is meaningful and satisfying work.

Work that is appreciated and makes a difference to so many of your residents' lives and the quality of their lives.

Dr. Linnane, I see in your 2013 Public Health Annual Report that you pledge to work with all public sector bodies to ensure improving health and wellbeing is seen as core to all you do.

I congratulate you for your commitment. I'm sure it is shared by your colleagues in public health across Coventry and Warwickshire. I support you all in the crucial work you are doing to improve public health outcomes in your communities.

The UK Public Health Register shares your ambition, your determination that we shall improve people's health and reduce health inequalities in our lifetime.

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