

PERSPECTIVES ON PUBLIC HEALTH SERIES

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The Politics of Public Health and the challenges of current proposals for elected members.

Current health service reforms and particularly the transfer of public health functions to local government represent the biggest shake up of the National Health Service since its inception. There is an expectation of Elected Member leadership overseeing joint strategic needs assessments and the commissioning performance of GP consortia. This will be despite an almost universal lack of relevant experience by many Members, whose knowledge of the health service is limited to fighting campaigns to stop hospital closures. This will be further complicated with local elections on the horizon and a new influx of Elected Members.

This lack of skills and knowledge will be further exacerbated when the new cohort of local councillors arrive to face the biggest changes and the tightest financial pressures faced by local government for decades.

However, the opportunities are great and the national political direction should not affect an area of local political leadership that should cross party political boundaries at the local authority level.

There are challenges. Lack of understanding of the proposals and the function of the new public health service will preclude many elected members from taking an interest. Indeed the whole population function of public health in disease control and illness prevention is inseparable in the minds of most individuals from the person-centred treatment of ill health provided by the medical and acute sectors. Elected Members have not traditionally worked closely with GP's despite common interests. They represent the same communities and have a tremendous chance to tackle together the inequalities, not only of health, but the wider social determinants, identified so clearly in the recent report by Professor Sir Michael Marmot.

Ring-fenced budgets for the public health function, when determined, might help when transferred to local authorities. However just what is considered to be covered by such funding is unclear and cynics wait to see what functions already deemed public health responsibilities are suddenly included as being part of general government grant, already settled!

Consideration for the workings within a two tier authority system are currently unclear. Budgets will be held by the higher tier authority but those activities that will directly impact on long-term health improvement are traditionally carried out by the lower tier authority. They also have a tradition of innovation due to their tighter budget constraints. With no statutory requirement for second tier councils to deliver health improvement, budget constraints could prevent this work being undertaken.

True community leadership at a local level will be difficult for many Elected Members as they come to terms with a need to better understand the metrics of their localities. We will all need hard evidence and robust data at our fingertips, both to establish priorities and challenge outcomes. However, the evidence base for much public health work is relatively weak and mostly based on medical interventions.

The move towards localism and an enhanced expectation of the Elected Member role, no longer responding to problems and issues, but leading the charge to challenge inequalities within their communities will give Elected Members severe challenges. Balancing a locally expressed need and expectation with conflicting evidence of actual need will be a real test of community leadership.

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The longer-term benefits of public health initiatives often make budgetary decisions difficult. Investment in initiatives today will result in improved outcomes in decades or even generations. The traditional politicians' risk aversion and unwillingness to upset the public for want of re-election often results in long-term investment decisions being avoided. NIMTOO ("not in my term of office") will have to become a mindset of the past. Strategic longer term thinking is not what most councillors are renowned for.

The health and wellbeing agendas are cross cutting. Even defining the portfolio responsibility from authority to authority is difficult. Adult Services, Children's Services, Culture and Leisure, Environmental Health are all areas that take on responsibility for the public's health. This is understandable. Look at almost any local authority's business plan and corporate priorities and health and wellbeing can fall into nearly all of the priority areas.

As the scrutiny of the NHS is likely to continue in most authorities, perhaps we should be looking at ensuring Health and Wellbeing champions are in place, perhaps as specific Councillors' portfolios. Given the responsibility for the whole inequalities agenda and awareness may well be raised.

Not only should Elected Members be responsible for ensuring Equality Assessments are part of all policy changes but the impact on health and wellbeing should be included too. New skills and knowledge will be required. Elected Members coming to terms with commissioning models and then taking the lead, with officers supporting, to commission services in traditional service delivery areas will be a challenge – e.g. leisure, arts, museums, libraries.

Above all, capacity across all sectors in terms of personnel and available skills will require strong Elected Member leadership to drive business transformation and to keep investing in the staff trained to carry out such work.

Members will have to challenge outcomes and plan much further ahead than the constraints of comprehensive spending review periods. An understanding of outcomes, not targets based on local assets, and need will have to be the norm. Methods of building cross department action plans and monitoring systems to assess progress will be paramount. Partnership working and asset strategies built on community based budgeting models will be a new area where Members will have to gain an understanding.

Big Society, argued by some to have been practised particularly in rural areas for generations, should result in a much better understanding of how the voluntary and community sector can be utilised as well as encouraging a community spirit. Elected Members will have to be proactive in promoting schemes that are successful in their areas to be commissioned and not wait to be asked to implement these!

There will be difficult times for Elected Members understanding the public health culture which is based on a high degree of professional and academic authority and a culture driven by data and information. Members will have a challenge in ensuring that these are combined to maximise benefits. Blanket targeting of 'deprived' areas will become a thing of the past due to techniques to map data to household level means precise and active targeting of resources and information. Members will have to prioritise down to a local level and will be the ones who understand their localities the best but also balance 'universal' approaches when appropriate.

If working effectively, the new Health and Wellbeing Boards will become the driving force of assessing assets and needs in our communities and ensuring limited funding is being used

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effectively to tackle those priorities. Are Elected Members skilled enough, motivated enough and, particularly, have they the resources and support to cope? Currently I think not. Will Healthwatch representatives become the democratic champions of public health and the wider health agenda leaving Elected Members as a poor second?

There is no better place to initiate change in the health of our communities than through local government. The experience, knowledge, commitment and flexibility to deliver is there already. It just needs a new drive from Elected Members. They need to grasp their new opportunities, demand the support and training they need to glimpse the potential for transforming the health of the nation and removing those generation old inequalities. Our Local authority political leaders have to champion the cause and let their Members take up the challenge.