Opinion & Debate – Personal View

Public health prose

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So it's March, the start of spring. Let's put a spring in the step, shake off those winter blues and be more physically active. Choose whether to get off the bus early and walk, get on a "Boris bike", get "Dr Bike"¹ out to treat your own bike or get down the gym and join the lycra-clad. A former Chief Medical Officer said if physical activity were a drug it would be a "wonder drug".²

As the financial year closes we put in place our plans for the next. As general practice or public health commissioners or practitioners, we have the opportunity to make real the motto "prevention is better than cure". The next couple of articles in this series address challenges in taking forward health improvement (health promotion and prevention programmes), one of the core areas of public health practice. The first issue, addressed here, is "making the case" for prevention rather than treatment and care.

The importance of lifestyle factors to population health and the local health economy is irrefutable. For example, though physical activity reduces the risk of developing long-term conditions by 50%,³ 60% of males and 70% of females are not active at levels that benefit their health. The direct cost to the NHS from physical inactivity is estimated to be £1.06 billion per annum.⁴ Lifestyle factors are a major contributor to inequalities in health, with associated societal and financial costs. Physical inactivity is more common in lower socioeconomic groups, some BME groups and among women, and increases with age.⁵ Addressing inequalities, the issue closest to my heart, will be covered in the next of this series.

First, commissioners and partners in public health and primary care have opportunities to influence agendas and the allocation of resources in favour of prevention. We're nearly one year on from the most radical reforms in the history of the NHS. However, from where I sit, the structures and functions are settling down. This is a testament to the resilience of the workforce and of the NHS itself as an institution. The statutory Health and Wellbeing Boards (HWBs) and Clinical Commissioning Groups (CCGs) are setting their strategic directions. CCGs are getting staffing levels back up again after the government initially overlooked the fact that GPs would require

management support to commission. Public health is adapting to the councils and vice versa, although some are having a rough ride. The strong pressure to put funding into treatment services, rather than prevention, comes from a number of sources. These sources and the levers to address this problem are now discussed.

Planning timescales and political cycles are short and require quick results. This is particularly acute following structural change and when finances are tight. Preventative programmes often have a more limited evidence base, particularly of cost effectiveness, or have longer lead in times to deliver results than acute care. However, the National Institute of Health and Care Excellence (NICE), Public Health England (PHE) and other sources support us in addressing this. NICE increasingly publishes guidance on effective public health interventions, including "return on investment tools" and costing templates that identify the most cost effective interventions.^{6,7} We can also remind other decision makers that "no evidence of effect" is not the same as "evidence of no effect", and may reflect prioritisation of research undertaken. Prevention programmes should be implemented and evaluated. PHE is now producing useful data sources, although in my view there are still significant information gaps in the measurements of true local public health burden (e.g. smoking prevalence!), and of data for monitoring the impact of lifestyle interventions.⁸

In relation to funding: most councils and CCGs are under financial pressures. We are fortuitous in having the "ring fenced public health grant" until 2015–6. There is a responsibility to use this wisely and appropriately. A key challenge in this context is to implement sustainable public health programmes at scale, rather than numerous projects. This is best done alongside health protection mechanisms, such as improving access to open spaces, or addressing social determinants, such as income. This will be discussed in a future article.

Public concern can sway organisations, particularly councils, which are democratically accountable, to focus on treatment and care. London councils are in an election year. Yet councilors who see the "common sense" of prevention may be welcome allies. Also,

other council departments may well understand better the connections between education and *wellbeing*, for example, than the *medical model of health*.

Overall, as commissioners or as leaders or partners setting CCG and HWB strategy, we can work with stakeholders and communities and use political influence, evidence and data to prioritise prevention.

Primary care practitioners as providers have a key role to play in taking forward the prevention agenda and can “make the case” to patients, business partners and peers. Patients are much more likely to give up/change their behaviour if advised to do so by their GP.⁹ There is an important opportunity to identify lifestyle issues and give advice and support, or to signpost and refer. Primary care staff can be given one-day brief intervention training to develop skills in having those tricky conversations with patients. Brief intervention is highly cost effective.⁹ Tools such as the General Physical Activity Questionnaire can be helpful to assess a patient’s level of activity and perhaps refer to a GP exercise referral scheme. Some practices suggest time constraints are an issue, while others have cracked it. Engagement in Locally Enhanced Services (LES) or Quality and Outcomes Frameworks can offer financial rewards to assist. It would be good to hear GP’s examples of how you have overcome barriers and incorporated prevention into your practice.

Finally, we have a role as advocates, as some health improvement policy requires national action. In my view the case for minimum pricing for alcohol is clear. The “responsibility deals” with industry have proved controversial. Health practitioners should be an authoritative voice on health issues. As members of national organisations such as the BMA, Royal College of GPs and the Faculty of Public Health we need to speak up for change.

This prose is written in a personal capacity by Dr Fiona Wright. It does not express the views of any organization to which I belong or by which I am employed. We would love to hear from you with comments, queries and thoughts. Address for correspondence: phprose@gmail.com

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