Taking the PARTY *out of* POLITICS

HOW IT'S SUPPOSED TO WORK
- WHY IT ISN'T WORKING -
AND HOW TO FIX IT.

Hello and Welcome to *Taking the Party out of Politics*!

This is a podcast about understanding how politics is supposed to work, …
… why it isn't working as well as it could be working, …
… and what we might be able to do about it.

Because:
by understanding a little bit more clearly *how* things are supposed to work,
and *why* they are a bit messed up,
we *might* be able to get things to work a *bit better*. Perhaps even a *lot better*.

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This is a little journey we are taking together, about the systems and functioning of Politics: systems which we should all understand, because those systems affect all of our lives, all of the time.
And this podcast is about how we might be able to make those systems work a bit better.

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In Season 1, we took a look at how government is supposed to work, from the perspective of us – the voters.
In Season 2, we took a look at how government is supposed to work, from the perspective of someone trying to get elected, and then trying to do a good job.
Looking ahead, in Season 3, we will be looking at what we might be able to do, to make things work a bit better. Importantly, when we get to Season 3, we will be sharing our ideas, but also sharing some of the best of YOUR ideas, about how to make things work a bit better.

Welcome to the third episode of our mini-series, looking at people, organisations, and issues which fall outside the established (party) political systems. We are looking at how some of those people and organisations are seeking to influence what happens in this country, and in the world more generally – in other words, seeking to affect our lives for the better (but – not necessarily – bothered about party politics). And, we will be looking at some of the issues which currently aren't being addressed successfully by our political party dominated system of politics.

Today, we're going to look at Public Health.

Briefly:

- What is Public Health all about?
- How does it affect us? and
- How does something like Public Health manage to be (on the one hand) controlled by elected politicians, with budgets which are allocated by elected politicians, and yet (on the other hand) to be – to at least a large extent – independent of politicians?

To help to guide us through this, we are joined today by Andy Fox

Yep, yeah hi. I'm Andy Fox. I'm Assistant Director of Public Health in Lincolnshire.

What does the Assistant Director of Public Health do?

So, a lot of different things, of course.

I think the core task of public health is to try and improve the health of the entire population and which means you can look at the how the health system works, the hospitals, etc., GPs, and try and improve the delivery there.

Or you can look at what we call the wider determinants, the things that actually make some people get sicker than others, and you can look to try and investigate why that is and do something about it. To do some prevention, in essence.

And that can translate into any kind of thing, from going into meetings around how the hospitals functioning to discussing education and schools and coming up with interventions to actually help kids do better to working with almost any aspect of the public sector, and indeed sometimes voluntary sector in the private sector to just try and steer the ship towards improving people's health rather than seeing people in ill health. So, a lot of different things.

No two days are the same.

So that's everything from the individual – how our individual health is – through to what companies are doing, pollution, the planet, the environment, the air.

Very much so, absolutely and indeed in public health you can be quite focused on what we call “health care public health”, which is about health care delivery, and we can get quite involved in things like infection prevention and control. So, with the COVID pandemic, we're very focused on keeping individuals well, and making sure that we give the right advice to keep people from getting infected with COVID, and what to do if they do, right through too broadly, how whole populations are getting on.

As I say, some populations will be more healthy than other populations. Why is that? Well, it you know, maybe it's to do with employment. Maybe it's to do with housing quality and going and chatting to the people who have the power and those levers to pull in terms of doing something about that.

And when you talk about populations, your population is Lincolnshire.

My population is Lincolnshire. Every single person in Lincolnshire.

How does one become a Deputy Director of Public Health?

It's a medical specialty that doctors trained to do public health, but you can actually train to be a consultant in public health, which is my professional job without being a medical doctor, which in the UK, which is my background, it is a background other than medicine as it's known. And famously, that's because we don't treat people, we treat populations. So, I say to people it's like I'm a doctor, except I don't fix people; I fix cities and counties.

So, as Deputy Director of Public Health for Lincolnshire, you are responsible for the health of the population of Lincolnshire – of every single person in Lincolnshire, but you talk about populations within the overall population of Lincolnshire. Is that because there are different areas which have different levels of health; different life expectancies – often cheek by jowl with each other?

Very much so. Absolutely. And the famous work on this was the Marmot report done in 2010. Sir Michael Marmot highlighted the "health inequalities", the technical term of Glasgow where there are two wards next to each other, a six-minute bus ride apart, which have an over a 20-year difference in the life expectancy. Those disparities, those inequalities can be seen throughout the UK, and throughout the world. Certainly, also in Lincolnshire.

Yes, because the idea that all of this happens in Glasgow make might make it sound like it doesn't happen on my doorstep. But it does.

It very much does. Somebody born into the areas that are high in what we call "social economic deprivation" – very simply, those who don't have that much resource – are on average (and this is all about averages) are going to live far less long lives and those born into the more affluent areas.

It's a shocking thing to think about. But it is true. A lot of public health is about trying to address these what we would say are avoidable and unjust inequalities in health.

Is this true across the whole country?

This is true across the whole country. Depends where you look at, but for example in Lincolnshire there are areas of the county that are in the top 20% deprived areas of the entire country.

And sure, we don't have some of the most deprived areas that you'd see in a city, like parts of London Liverpool the northeast, but we do have a high disparity. We have some areas where they are in that bottom 20%, and we have some of the most affluent areas in the in the country as well. And if you measure the populations how they do in those two different areas – the top 10% say of Lincolnshire and the bottom 10% expressed in terms of that social economic spectrum – you find huge differences. Huge differences in almost every conceivable measure of health.

So, do you work for the NHS, or for the local authority, or … ?

I work for the local authority, and that's Lincolnshire County Council (which) is my employer. About 10 years ago, I would have actually worked for the NHS doing what I do, but in 2012 there was an act of Parliament which moved public health out of the NHS infrastructure into the local authority infrastructure and that makes there's a lot of sense in that because local authorities look after things like roads, transport, housing, children, services, adult social care. These are things that impact what I call the "wider determinants of health": those things that have more to do with your body that are to do with how society functions, and how it influences our health.

So, you don't work for the NHS and nobody else works for you, but I would imagine that you work very closely in partnership with many aspects of the NHS.

Absolutely. We work very closely with the NHS. Every area has a Director of Public Health – who is my boss – and as we move towards different NHS structures, that role the Director of Public Health, and the team which I help to lead, is a fundamental part of the wider health and care system. I won't get into

technicalities of it, but there's a lot of work going on to redefine and redesign health and care systems at the local level in the UK at the moment, and that public health role is that key bridge role between the local government apparatus, if you like, and the NHS.

How do you describe and define the objectives and targets for Public Health?

Broadly, I have this phrase which I like to use which is "maximising population health gain".

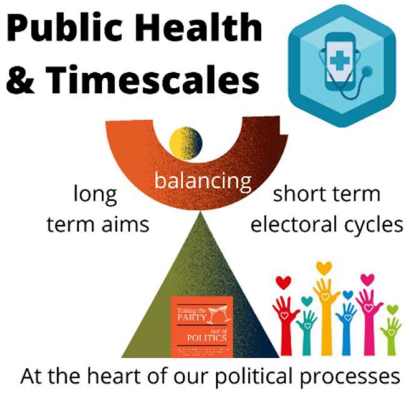
Basically, whatever resource we have as a system, then we want to use that in the most efficient, intelligent, effective way to get the most health gains for the population.

How do you measure that 'gain'?

A lot of it is driven by, as you say, by legislation or by government, but we also compare ourselves with other areas of the UK, as benchmarks. Take the example of tobacco: there's a national ambition to reduce the prevalence of smoking to 6%, by 2030, and so we're going to try and deliver that in Lincolnshire. There's a lot of challenge there. That's one of those things that we don't necessarily have the levers to pull, to ensure that will happen, but we can use our resources in the best possible way to give the best chance of that happening in Lincolnshire.

At an international level, we had Millennium Development Goals aiming for the wider global population health agenda. Then we had sustainable development goals, which superseded those, which were sort of 20- or 30-year timeframes on a local level.

We can have targets which look forward generationally to improving outcomes, in 10-, or 20-, or 30-years' time, but a lot of the time actually we are working to a much shorter time frame. We are having to demonstrate measurable change improvement, within a one-year time frame, or a two-year time frame. That's much harder, when we're dealing with the kind of population health metrics and issues that we often have to deal with.



What sort of thing is measurable over 12 months, in terms of public health?

Well, you can measure anything in terms of how people are using health services. You can measure cancer rates over a given period of time. You can measure attendances at accident and emergency for any injury that you like. You can measure things like the Stop Smoking Service performance. You can measure child educational outcomes health outcomes. There's a lot you can measure, and see how we're doing compared to last year, or the year before.

A lot of the time we'll be asked to deliver improvements in the next year or two, and sometimes that's possible. And sometimes, it's not.

And of course, the context is very important. The fact that rates attending at cancer clinics has gone down over the last two years – with a pandemic on our hands – is nothing to do with the performance of the cancer specialist units within hospitals.

Precisely so. This is where we get into some of the really interesting stuff, around what actually does make averages (across whole populations of health) go up and go down. Actually, if you look at it, there

are things that really influence why a population will have certain health outcomes. They're a lot more complex than simply the performance of a commissioned and delivered health service.

They will get into people's lifestyles, their habits, and even the environmental barriers and the economic landscape. There are almost no limits of the things you can find. You can start with the proximal: people's lifestyles, how they use health services, what they eat, what they drink; and you can go right back to the really distal stuff: around politics and economics. In each of those elements you can find plenty of things that affect how people's health outcomes are manifested.

So, to ask a similar question, but with a slightly perspective, is it reasonable to measure your success, or your performance, in terms of whether a particular target set in a particular year is metal?

The definition of reasonable is really interesting there isn't it. Is it reasonable?

It's sometimes not helpful.

I always say if you can do one thing, what would you do, to try to maximize population health gain?

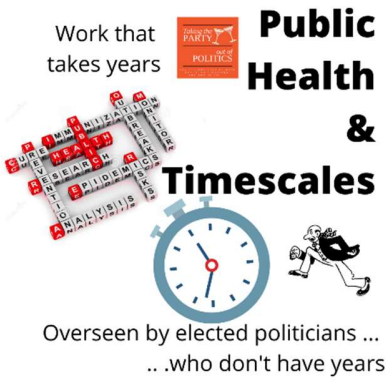
There's no easy answer to that, but I would always go back to working with children and young people. Maybe even working with mums and dads of new babies, trying to institute some sort of way to support people, to enable them to parent well, parent effectively, love their kids, and help them grow up to develop, and get that best start in life, which is something that we all would say we want for our kids. If you do that, then that is the way to really change. To change the lifestyles of children and young people. You can do things that will help them change their outcomes throughout their entire life course.

And then you can see an impact upon that at every stage of their life course.

That's one way, for example, of trying to address the inequalities in disability free life expectancy. It's not just life expectancy. Those from the poorer, more deprived groups will tend to live the last 20 years of their life in significant ill health, and with disabilities, whereas those from the more affluent groups are far less likely to.

If you want to do something about that, if you want to really change that, you go right back to the very foundations of life in terms of working with children, young people, working with the lifestyles of families. But you're not going to see a measurable change in those metrics in a year, or in two years. If you take that approach, you're talking fifty, sixty, seventy years. There are very few systems you work to that will be happy to wait fifty, sixty, seventy years to see a return on their investment.

So, how do your timescales sit alongside those of elected public officials, who are looking at getting re-elected over a four- or five-year timescale? Even those elected public officials make a decision within the first few months of being elected, a moment ago you were talking about 10, 20, 30 year timescales. Now you're talking about possibly 60 or more years.



A lifetime, literally a lifetime.

It's a really interesting question, because obviously if an elected politician wants to point to a real success, when they next get re-elected, they will be looking for measurable improvement. Best case scenario four years.

And if you do take an approach where you're looking ahead at a very sort of early intervention, preventative approach – which is often the best thing to do – it's rare that you're looking at a four-year improvement. Which makes it challenging. It means that often you're having to demonstrate the importance of your approach using second order metrics. Counting widgets, essentially, rather than looking at the outcomes. We've engaged with this many people. We've done this many interventions with people. We've supported this many people. Yes, we haven't seen the change in this behaviour, or that behaviour, or this outcome, but we wouldn't expect to, yet. But we can still point to success.

However, that has less of an impact. It looks far less exciting than saying: "Smoking dropped by 20%, so lung cancer has dropped by 20%", if (what we are actually saying is that) older adults, or people who are frail in older age, are not getting admitted to hospital for falls so much because people are moving much more, and people are staying healthy. Dementia is reducing because people are staying physically active and engaged in their community longer. If you are taking a preventative approach for those things, you may have to start looking at a shorter-term rather than a longer-term outcome.

We do talk in public health, about primary, secondary and tertiary prevention. Primary prevention being stopping anybody from actually getting a condition. Secondary prevention being identifying people who do have a precursor condition, or risks for a condition, and then stopping that from getting worse. Tertiary prevention being basically what hospitals do: treating the condition.

Taking the context of those timescales, the people who are assessing your objectives are elected politicians. They may not be setting the detail of them, but they do hold the purse strings.

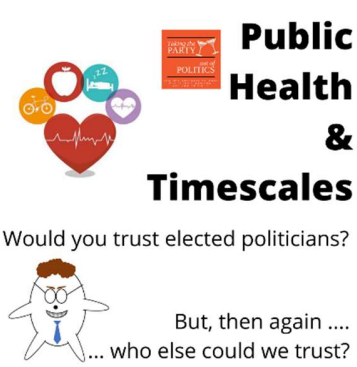
They're at least approving them. They're voting them through.

But, as we have already discussed, their timescales for demonstrating impact, for demonstrating success, are not the same as your timescales. They are of a different order.

If their parameters for being judged to be successful, or not, are different to yours, then *should* they be the people who approve your plans? But, if not our elected officials, then who else?

It's a really good question. The best approach I guess, is to have that working relationship with elected members, where there is a high degree of trust, and they're able to say to you: "What metrics can we use? What success measures can we use?" And we'll work to develop those.

But, of course, then who's going to hold us to account? And, who's going to challenge us in terms of being able to deliver change quickly? So, it always ends up being a bit of a quid pro quo. A bit of a mutual challenge.



Part of our job, of course, is working in a political environment, and part of the skills that we need to have as professionals are helping politicians to understand the life course impact of some of the policies that we're doing, and trying to steer things in that direction.

But there's always that tension there. It is never going to be straightforward. Working with the electoral cycles that we do, to have a population health approach embedded in what the public, and indeed private, sector is doing.

Is it reasonable to try to measure your success in terms of whether these targets are met, or not? Is there an effort made to look back and say: "Well, in 1960 they did this. What has been the effect of that? Are those sorts of measurements attempted?

Very much so. Actually, the whole of the medical sector, industry, health care, whatever you like to call it, is built on the principle of evidence-based medicine. We work very closely with academics who review and research policy procedure in medical interventions, etc., to make sure that they are effective and appropriate for our population, whichever population you're looking at.

That process is constant, of reviewing evidence, adding to the evidence base. There's a big academic component in what we do, and it's for that reason that we do it. It's not just to get papers published in journals etc., for our own benefit. It's to make sure that we are all working to build that basis of what works, and constantly reviewing what works, and challenging what works, to make sure that we are always trying to maximize population health gain, in all that we do.

What about at government level. Is there a constructive, engaged challenge there?

There is a wider government infrastructure, which is actually changing at the moment. In the UK, in terms of public health, we have a new department, actually called the Office for Health Improvement and Disparities, which sits under the Chief Medical Officer, which has just been created.

And there is, of course, the Department of Health and Social Care, NHS England infrastructure, and that's recently been changed. There's a regional director of public health role, which is now being created. For the last few years, that's been in the pipeline.

So, there are various arms of national government, and regional government which can offer that challenge. In fact, on the health care delivery side, with the NHS, there is regular, robust and clear challenge from NHS England and Improvement (the overarching body on delivery of local health care, through the clinical commissioning groups and the new integrated care systems).

OK, another question, if I may. From my ignorant perspective as a non-expert, here's one thing, cutting across different health and care systems, something which many people might have heard of, and that is the linkage between hospitals and care, where it's being described as bed blocking: because local authorities who fund or who support the funding of social care are not incentivized to

help the NHS work better. It is much more expensive to keep people in hospital when they no longer need to be in hospital.

But – very often – those people need some sort of level of care. But the authorities who are responsible for providing that social care – and therefore making it more possible to release the more expensive, more intensive, health care – well, it hasn't been made their responsibility to do what is cheapest for the country as a whole, only to keep a lid on their own, limited budgets.

Is that an accurate reflection of the situation?

So, there's just elements of that that are actually spot on, but I would say that local authorities are very much incentivized to actually help. It's actually key part of our role. I have literally just been in a meeting, prior to this chat, with somebody talking about that exact issue in Lincolnshire, and it is a part of that bridge role, (with) the public health team being that link between local authority and adult social care, being one of those elements. In the wider NHS, it is one of the holy grails of not just public health but health care practice in the UK, to make sure that we can get people out of hospital who don't need to be in the hospital. Because, just to be clear, being in hospital is not a great place to be if you are well. If you're well enough to be discharged, you don't want to be there. You want to be in your own home, in your own bed.

There are all sorts of ways we can get people recuperating and recovering, when they're clinically well enough to not need that hospital care, but perhaps still aren't, you know, really up on their feet.

We can get them into their own bed as a priority, really. That's not just the role of public health, but we do support that, and kind of try and steer the whole system into better ways of working, that ensure there are no perverse incentives for anybody to be kind of keeping a system going that isn't working efficiently.

The term that's been used historically is *delayed transfers of care*, as in transferring care from the NHS to adult social care, and getting people the support that they need. We'd also talk about *reablement*, getting people back up, and well, and able to look after themselves. I think *home first* is the principle that we're now talking about a lot in this this world. (Home) is the best place for people to be, for their wider health, emotional well-being. Mental health is at home.

Take your pick from any number of those terms. It's a major focus of our work, and something that is a constant effort to try and improve.

Alright, thank you. And so, for people listening to this who perhaps didn't realize that this was something they might be interested in, is there any sort of final message about the value of what your team is doing? Anything which people might not be aware of?

So, I'm biased, of course, or not biased, but I have a perspective on this, which is that public health is one of the most important things that you could do. I mean, who else gets trained and supported and then empowered by the government - and we still have this role in in this country.

And it's a privilege to try and improve health and improve life for the whole population and to actually have the job of thinking long term about how best to do that; and then, given – not a great budget but a budget – to go and actually make that happen. It's a massive privilege.

We've touched on the wider determinants of health. I chat to so many doctors who use the analogy of getting interested in public health (through) this old picture of somebody coming along to a river. There's somebody struggling – drowning – in the river, so they pull them out. Then, two minutes later, there's somebody else floating down the river who's struggling, and drowning, and they pull them out. After they've pulled 20 people out of the river, they're getting exhausted.

So, they walk further up the river and they find there's a bridge with a massive hole in it that people keep falling (through).

If you can go upstream, and fix the bridge: well, that's prevention.

If you can stop people getting sick, and then you can make a massive difference across the population. Sometimes it can be very simple things that make a huge difference across a population. It just needs the right voice to say, have we considered this? And, you can make a massive difference.

A small reduction in risk of, say, cancer, or something for a large number of people, can massively change average health outcomes across the entire population. It's that the power of that population approach – the big picture approach – that really only public health is trained and empowered to do, in terms of the public sector, local government and health system in the UK.

Makes sense. I love the analogy. Long may you and your team continue to fix the holes in our bridges.

Thank you.

We'll keep trying.

And, thank you for listening.

If you would like to have a look at transcripts of the podcast, including links to all of our sources and references, please go to www.talktogether.info, and follow the links to the Podcast from there. And, of course, if you would like to contact us – not least if you would like to share any ideas which you have about how we could make things better, or if there are any areas of how Politics is supposed to work, but why it isn't working – then please email us at any time on info@talktogether.info.

If you have enjoyed this podcast, then I hope that you will take the time to tell your friends. And perhaps you could also take a moment to give us a rating wherever you found us – that not only helps other people to find us; it also just really makes us feel appreciated. ☺

That would be great. Thank you.