

Saving a lost decade



How a new deal for public health can help build a healthier nation

Richard Sloggett

Foreword by Rt Hon Damian Green MP

and Lord Filkin CBE



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During his time in Government Richard worked on the development of the NHS Long Term Plan, the Secretary of State's vision for prevention and Prevention Green Paper.

Richard has been named one of the 100 most influential people in healthcare policy by the Health Service Journal and is an award-winning health policy professional with over ten years' experience in the sector.

He is regularly cited in the national media on health and social care issues and has recently written articles for The Times, the Spectator and the Health Service Journal. He has also been quoted in the Financial Times and the Economist on NHS service issues.

Policy Exchange's Build Back Better programme

The COVID-19 pandemic has provoked fundamental questions about our health and social care system. Is the current NHS accountability structure the right one for responding to global pandemics? What is the most effective way of protecting and funding those requiring social care? How can we lock in the technological gains from the pandemic? And how should we build hospitals that better serve the needs of the UK population in the 21st century?

Policy Exchange's Build Back Better Programme aims to provide the answers to these questions. Over the coming months we will be announcing a series of events, research projects and engagements with the health and social care community. In all of our work we will seek to inform the policy debate by considering how to grasp this 'critical moment' in reassessing how the system can be placed on a sustainable footing for the decades ahead.

For this work Policy Exchange would like to thank Tina Woods, Director of the APPG for Longevity for her co-operation on this important topic.

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Foreword

Rt Hon Damian Green MP and Lord Filkin CBE

The Prime Minister in his Manifesto declared that his government would work “for everyone to have five extra years of healthy independent life by 2035 and to narrow the gap between the richest and poorest”. This is a noble commitment which if realised will improve the lives of many people and increase the resilience of our economy and our national health. The COVID pandemic now makes this goal even more important. This Policy Exchange paper explores how a new approach to public health can help realise the ambition.

In February this year, just before COVID broke, the All-Party Parliamentary Group for Longevity, which we lead published “*The Health of the Nation – a Strategy*” which set out what our expert groups had advised was needed to achieve this great goal¹. Covid-19 has highlighted the lack of resilience of our national health. Before the pandemic we knew that having the highest obesity rates in Europe was problematic, but the virus has starkly exposed how a lack of action on prevention and population health improvement has compromised our nation’s health, especially in our most vulnerable communities. Obese people have a 50% higher risk of dying and people who smoke, are inactive, have diabetes or coronary heart disease are all at greater risk.

So, COVID demands that we improve our health resilience and the Government’s manifesto goal of five more years of healthy life expectancy is exactly the right focus to mobilise the necessary actions. Our strategy paper set out what was needed to improve our national health – resolute action by localities, NHS, business, and Central Government as well as innovations in data, technology and science. The key recommendation in our report was the need for appropriate national leadership. This is why this report is so timely and important. To improve our national health requires a clear ambition and the manifesto goal of five extra years of healthy life by 2035 and reduced health inequalities provides this. It requires the collective intelligence and mobilisation of business, localities, the NHS and civil society – harnessing the agility, urgency and shared sense of purpose that has so far galvanised communities around the common good throughout the crisis. The decision to re-structure public health services in England is an opportunity to design the leadership systems to mobilise across central government, to support local leadership, to shift the NHS and care system to do much more to keep people healthy, preventing and detecting risks and symptoms earlier to reduce obesity, smoking, inactivity, diabetes and CHD.

We strongly agree that improving the health of the nation should

1. The APPG have already acted to address two of our nine recommendations – forming a new *Business for Health* Coalition to promote greater contribution by business to health and to reduce activities that harm it. This will be launched in November. Second, the APPG has formed an expert group to define what is needed to establish an Open Health system.

become a national mission, underpinned by a new deal for public health with greater Ministerial accountability and leadership. The Government's commitment to increasing the number of healthy life years of UK citizens by five by 2035 needs the strategy, system and funding to do so and so enable the 'levelling up' agenda. The small extra cost of this are trivial compared to the economic, fiscal and social costs of another pandemic on an unhealthy nation and, as the report says, the Public Health Grant should be increased and linked through to NHS funding.

We urge Government to act on these recommendations and offer our support in doing so.

Executive summary

The state of our nation's health

The UK is one of the sickest countries in Europe. High rates of obesity, increasing health inequality and stalling life expectancy have all translated into a higher death rate recorded from the pandemic. The latest data show over 65,000 excess deaths in the UK during COVID 19². New analysis from Policy Exchange has revealed that the Government is in danger of a lost decade of health, with ambitions to meet a manifesto target of increasing healthy life expectancy by five years by 2035 well off track.

For far too long our healthcare policy has been focused on an institution, the NHS, rather than the health and wellbeing of those who use it, work in it and cherish it.

The COVID 19 pandemic has exposed the flaws of this approach.

The 2012 health and social care reforms scattered responsibility for improving the nation's health across a wide range of national and local organisations. The obscure policy structures have been enablers for a shallow debate on public health focused on the 'nanny state' coupled with years of underinvestment and a lack of accountability.

The 2015 Spending Review, which saw NHS spending 'ringfenced' whilst other areas of public health, staff, capital and workforce were cut back was a major political misjudgment. More money for the NHS is needed against rising demographic and societal needs; but when it is not complemented with adequate investments in public health, social care, capital and workforce it leads to stagnation and decline. The lack of resilience in our public health system and neglect of social care have been brutally exposed by this virus.

The recommendations in this paper are not in of themselves radical. The pandemic and indeed recent structural overhauls of our health system has shown that the best policy response is often not to create huge structural changes to deliver what is needed but rather to increase investment and focus on structures that exist. This paper believes that with a combination of leadership, investment and clarity of objective that a better public health system can be built that delivers improvements for our citizens.

Looking to the future

COVID 19 has demonstrated that health does equal wealth. A healthier nation will be a more productive and economically successful place. With the Government – elected to office only last December – keen to extend opportunity to communities left behind through 'levelling up', improving

2. <https://www.ft.com/content/a2901ce8-5eb7-4633-b89c-cbdf5b386938>

health and wellbeing should be a central part of the equation. We should no longer quote the differences in life expectancy between Blackpool and Beaconsfield, we should have a proper plan to close them.

The decision to remove health protection functions from Public Health England to a new National Institute for Health Protection presents an opportunity to reimagine and design a better public health system.

Improving the health of the nation should become a national mission, underpinned by a 'new deal' for public health.

This new deal should see greater Ministerial accountability and leadership. Ministers have committed to increasing the number of healthy life years of UK citizens by five by 2035³. They now need to put a strategy, system and funding in place to deliver on it.

The majority of Public Health England responsibilities should be moved into the Department of Health and Social Care into a new unit the National Institute for Health Improvement.

A new strategy should be set, responding to the Prevention Green Paper setting out how the laudable goal of five healthy life years by 2035 will be delivered and how improving health will support and enable the wider 'levelling up' agenda.

New funding should be unlocked for the Public Health Grant. The grant should be assessed by the Treasury against the services delivered within it; and a new formula pegging the grant to rises in NHS spending, GDP or inflation considered to ensure continued progress. This approach to public health funding will demonstrate the Government's commitment to public health and provide certainty to local public health teams of future resources and investments. The overall size of the grant remains small when compared to the NHS and overall Government spending and represents good value for money.

The new deal should translate regionally and locally through closer working with the NHS to deliver better health outcomes and a critical role for 'place' in changing NHS regional plans.

More money for public health should see greater collaboration with and accountability of local public health directors. New lines of engagement between national policymakers in the Institute and public health leaders should be created to ensure progress on outcome improvement is accelerated, good practice shared and variation tackled.

For too long public health has been the forgotten part of our healthcare system. Through new national accountability, leadership, funding, NHS collaboration and better data we can build back a better public health system that improves the health of our nation.

3. <https://www.gov.uk/government/publications/industrial-strategy-the-grand-challenges/industrial-strategy-the-grand-challenges>

Summary of recommendations

Recommendation 1: Ambition – The Government should make improving the health of the nation a new national mission and publish a public health strategy/White Paper setting out how to deliver five healthier life years by 2035 including targets and milestones to deliver on this long term goal

Recommendation 2: National structures – The majority of PHE’s health improvement functions should move into the DHSC with closer Ministerial accountability. A new National Institute for Health Improvement should be established linking health improvement to wider ambitions for Government ‘levelling up’. Screening and disease registries should move to relevant NHS organisations

Recommendation 3: Funding – The Government should maintain the Public Health Grant as the primary mechanism for funding public health through local authorities, but review the amount of money against services and population health need. HM Treasury should regularly review the public health impacts of fiscal events and consider a future uplift formula for public health funding linked to inflation, GDP or the NHS

Recommendation 4: Local government – Local authorities should continue as lead public health commissioners, taking steps to find the right structures to work collaboratively with changing NHS systems. Regional public health leaders should be maintained within NHS regional offices

Recommendation 5: NHS – NHS ICSs in their assurance plans should set out how they are ensuring the voice of place in their regional plans and set ambitious targets on health improvement and prevention in priority policy areas

Recommendation 6: System working and performance – The new National Institute for Health Improvement should have stronger working relationships with local authority public health leaders to ensure an acceleration of improvement in public health as a result of increased funding. New population health data captured through NHS and public health outcomes frameworks, underpinned by the new NHS data strategy and a future health index should be used to improve performance and outcomes

Greater accountability for public health through a new deal

The proposals in this report and ‘new deal’ will improve the accountability and delivery of public health services.

Government accountability

- Creating a new Institute for Health Improvement housed in the Department of Health and Social Care, reporting to Ministers and the Chief Medical Officer
- Setting new Ministerial targets for improvements in healthy life expectancy and publishing a national prevention strategy
- The Institute for Health Improvement to work across Government to embed public health more widely in Government policy

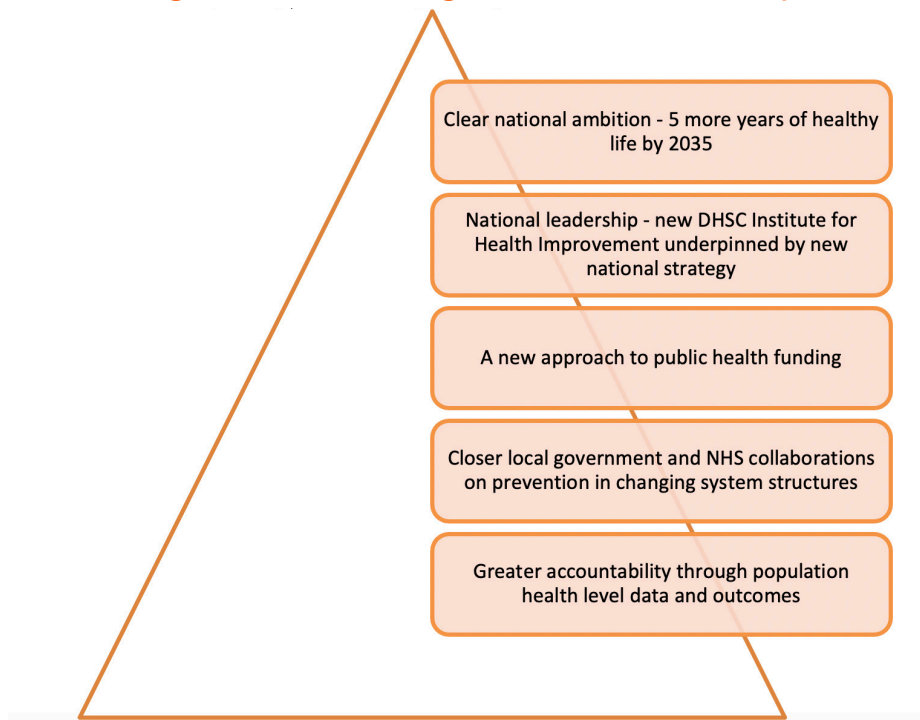
NHS accountability

- Passing some prevention responsibilities from Public Health England to the NHS including screening and disease registries
- Setting new prevention metrics and targets for NHS systems to work in consort with public health systems

Local authority accountability

- Increasing funding for public health teams to support improved population health
- Greater engagement between local public health directors and national government on delivering the ambitions for improving health life expectancy

The Building Blocks for a Strengthened Public Health System



Introduction

At a speech at Policy Exchange, in August 2020 the Secretary of State for Health and Social Care championed the importance of prevention to the current and future healthcare agenda:

“As the Prime Minister made abundantly clear with the launch of our Obesity Strategy last month, we are passionately committed to health improvement – the prevention agenda.

And of course the 2 are linked, protection and prevention: we’ve seen how conditions like obesity can increase the risk for those who have coronavirus.

Levelling up health inequalities and preventing ill health is a vital and a broad agenda.

It must be embedded right across government, across the NHS, in primary care, pharmacies, and in the work of every local authority.

So we will use this moment to consult widely on how we embed health improvement more deeply across the board, and I’ll be saying more on this over the coming weeks⁴.”

In the context of the manifesto commitment to extend healthy life years by five by 2035, this research paper explores the options for Government as it considers how to re-distribute and re-assign responsibilities for health improvement following the decision to abolish Public Health England. A Government Steering Group has been established to explore options and this paper is designed to inform the thinking of this group.

The publication of this paper lands at a time of immense uncertainty with a second wave of coronavirus. This paper seeks to take a view that tries to look beyond the pandemic whilst assessing how lessons can be learned and applied from the COVID 19 response to build a strong and more resilient public health system.

This first public health report from Policy Exchange specifically looks at the structures of our public health system and improvements that can be made following the news of changes to PHE. It does not go into details on the specific policy interventions that are needed to improve public health and prevention. This is a consideration for future research.

4. Rt Hon Matt Hancock MP. Policy Exchange speech. August 2020

Public health responsibilities

Following the 2012 health and social care reforms, a number of changes were made to public health. Two of the main structural changes were:

- Abolishing the Health Protection Agency, and creating a new Executive Agency for public health, Public Health England
- Moving public health commissioning responsibilities from the NHS to local government

A Department of Health and Social Care circular set out the wide range of new commissioning responsibilities for local authorities (see overleaf).

The circular also noted:

- That the list of commissioning responsibilities was not exhaustive
- That local authorities were responsible for ‘commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections (STIs) testing and treatment services’, with the paper noting that the transfer of these services offers great opportunities to integrate sexual health services to wider services
- Directors of Public Health should advise ‘on whether screening or immunisation programmes in their area are meeting the needs of the population, and whether there is equitable access,’ and to have a role in championing screening and immunisation locally
- That Directors of Public Health should also provide population health advice to the NHS⁵

On screening and immunisation programmes the reforms saw a close operating model between public health and the NHS:

“The NHS Commissioning Board will be accountable for delivery of the national screening and immunisation programmes in accordance with an agreement between the Secretary of State for Health and the Board which will set out the terms in which the Board will exercise a Secretary of State function. Public Health England will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening⁶.”

5. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216712/dh_131901.pdf

6. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216712/dh_131901.pdf

DHSC Circular – Local authority, public health commissioning responsibilities, December 2011⁷

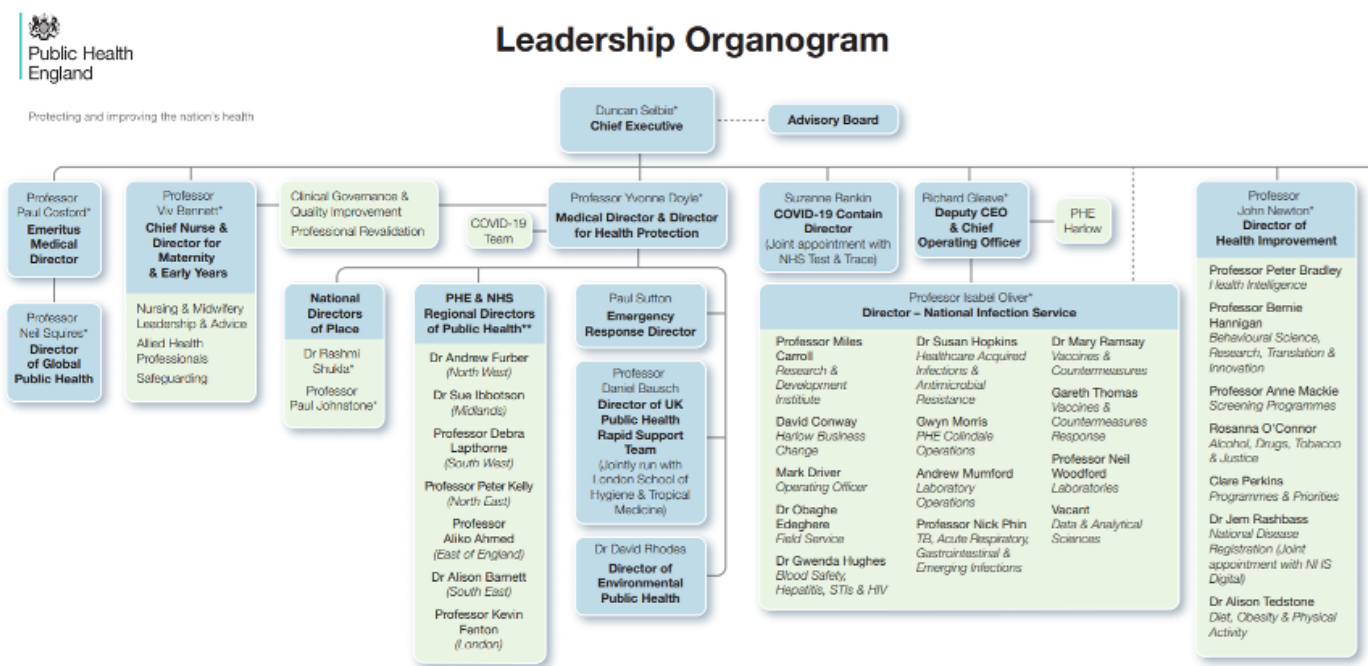
- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

7. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216712/dh_131901.pdf

The most recent Ministerial letter to PHE, from Jo Churchill MP to Duncan Selbie establishes the responsibilities it is expected to discharge at a national level:

- support and advice on the Government’s prevention and levelling up priorities, specifically including work on childhood obesity, mental health, smoking, health inequalities and the needs of the most vulnerable groups in society, and NHS-led national screening programmes;
- developing and implementing wider public health programmes, including for sexual health and antimicrobial resistance;
- contributing to the development and implementation of a number of cross-government programmes, such as on rough sleeping and illicit drugs, including support for Dame Carol Black’s review of drug treatment;
- delivering evidence reviews commissioned by DHSC
- work to create the future UK infrastructure for public health scientific capabilities and capacity through the Science Hub Programme⁸

Structurally the most recent organogram from PHE sets out seven main domains of health improvement for which the organisation is responsible⁹:



Public Health England’s work on health improvement is also central to several important Government priorities:

- Obesity – Playing a leading role in the new obesity strategy particularly with regards to salt reduction, reformulation and advertising and promotional restrictions

8. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882570/PHE_Remit_Letter_from_Jo_Churchill_to_Duncan_Selbie.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882570/PHE_Remmit_Letter_from_Jo_Churchill_to_Duncan_Selbie.pdf)

9. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903185/Our_Leadership_organogram_22_7_2020.pdf

- NHS Health Check – PHE is a major contributor to the review of the NHS Health Check, being led by Professor John Deanfield
- Illegal drug misuse – Responding to Dame Carole Black’s report
- Sexual health strategy – Working with DHSC on a new sexual health strategy
- Mental health – Working on the cross Government suicide prevention plan
- Gambling – Promoting a public health approach to gambling
- Tobacco control plans – Including a review of electronic cigarettes
- Water fluoridation – Increasing coverage of water fluoridation across the country

Recent Government action on public health and the impact of COVID 19

Recent Government action and commitment to public health has been variable, inconsistent, and subject to a number of false starts.

The May Government's approach to public health was characterised by a series of difficult debates around obesity policy.

Upon entering Number 10 the then Prime Minister watered down the first chapter of the childhood obesity strategy to a mere thirteen pages. The strategy did include the introduction of sugar tax, but avoided wider and much called for measures to tackle childhood obesity¹⁰.

After the 2017 election and in the face of criticism of the first chapter and early evidence that the tax was working, leading businesses to reformulate, May published a second chapter which went much further. The chapter included proposals for expanding the sugar tax, banning energy drinks for under 16s along with advertising and promotional restrictions¹¹.

The second chapter of the plan led to the publication of a series of consultations on the proposals.

Matt Hancock's arrival as Secretary of State at the Department of Health and Social Care saw renewed focus on the prevention agenda¹². Prevention was one of three early priorities identified alongside workforce and technology. This culminated in the publication of a 'Prevention Vision' in November 2018. The Vision re-stated the Government commitment to increasing the number of healthy life years of UK citizens by five by 2035 by:

- Keeping people healthy, happy and treating their health problems quickly
- Empowering people to manage their own physical and mental health needs closer to home with the support of professionals in the community
- Delivering care in the right place, in settings that suit them and their need

The vision would be delivered through:

- Prioritising investment in primary and community healthcare
- Making sure every child has the best start in life
- Supporting local councils to take the lead in improving health

10. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/718903/childhood-obesity-a-plan-for-action-chapter-2.pdf

11. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/718903/childhood-obesity-a-plan-for-action-chapter-2.pdf

12. <https://www.gov.uk/government/speeches/matt-hancock-my-priorities-for-the-health-and-social-care-system>

locally through innovation, communication and community outreach

- Coordinating transport, housing, education, the workplace and the environment – in the grand enterprise to improve our nation’s health
- Involving employers, businesses, charities, the voluntary sector and local groups in creating safe, connected and healthy neighbourhoods and workplaces¹³

The vision document translated into a Prevention Green Paper published in July 2019. The paper sought to both utilise the power of new technologies, known as ‘predictive prevention’ to tailor interventions for individuals as well as new population level measures on matters such as obesity, clean air, and water fluoridation. The paper landed during the end of the Conservative leadership contest, with future Prime Minister Boris Johnson expressing scepticism at elements of the plans¹⁴.

With the early part of his Premiership dominated by Brexit, public health was not an area of priority in the initial months of the Johnson administration. Focus in healthcare policy was placed on the NHS, with new hospitals and reduced GP waiting times prominent. The 2019 election saw the Government push its NHS commitments strongly for more doctors, nurses and hospitals against a worsening backdrop of performance data. Whilst the NHS was a major battleground, public health was not discussed. The Conservative 2019 manifesto included an outline pledge to a public health strategy and re-iterated the commitment to improve healthy life expectancy by five years by 2035¹⁵.

Upon returning to Downing Street with a majority, the Government began the task of building delivery models for each of the manifesto commitments. This work was curtailed by the arrival of COVID 19 in March 2020.

COVID 19 has demonstrated the importance of a well funded, prepared and fully engaged public health system. It has also highlighted the impact a pandemic can have on a society with high health inequalities and high rates of obesity.

Whilst there has been some Government action on the latter, there is a strong case to be made that it has been too slow. On health inequalities action since 2012 has been poor, as cost pressures have driven policymaking and funding decisions.

The Government’s welcome commitment to ‘levelling up’ has not yet translated into or connected with a plan to tackle health inequity in these areas.

The importance of an approach to tackle this was highlighted by Public Health England’s evidence review of the impact of the pandemic on BAME communities which found “the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males)¹⁶.” A study

13. <https://publichealthmatters.blog.gov.uk/2018/11/05/matt-hancock-my-vision-for-prevention/>

14. <https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document>

15. <https://www.conservatives.com/our-plan>

16. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

from North Carolina has connected high rates of obesity to greater risk of hospitalisation and deaths¹⁷.

Whilst the national system has struggled with the COVID 19 response across testing, contact tracing and rolling out new technologies it has shone a welcome light on the important and expert work of local public health directors and teams in delivering for their local communities. There is variation in quality across areas, but the pandemic has illustrated the need for any new emerging public health system to have a strong grounding in place and localism.

The pandemic has fundamentally shaken Government’s approach to public health. Boris Johnson has undergone a reversal of his approach to obesity policy; publishing the first part of an obesity strategy in July 2020, following his own serious COVID 19 illness. The strategy introduces a number of the measures from the May government and sets out plans for further interventions in the months ahead regarding incentives and support for people to make healthier choices.

The decision to abolish Public Health England to create a national agency focused on health protection has created uncertainty about the future of health improvement and wider public health policy. This is a critical moment and opportunity for public health. The National Institute for Health Protection will help to tackle the consequences and impact of pandemics, but the best way of mitigating them in the future will require a different approach to the prioritisation, funding and support for health prevention.

The case for action: stalling healthy life expectancy

Before the pandemic Government action on improving healthy life expectancy (HLE) was not progressing at the rate needed to deliver on the manifesto commitment. HLE is the average number of years that an individual is expected to live in a state of self-assessed good or very good health, based on current mortality rates and prevalence of good or very good health.

The following table sets out improvements in HLE amongst males and females from 2000-02 to 2016-18.

Healthy Life Expectancy UK 2000-02 to 2016-18

	Health Life Expectancy UK (yrs)	
	Male	Female
2000-2002	60.7	62.4
2009-2011	62.7	63.8
2016-2018	63.1	63.6
2000-02 to 2016-2018 change	2.4	1.2
2009-11 to 2016-2018 change	0.4	-0.2
2035 target	68.1	68.6

17. <https://www.sciencedaily.com/releases/2020/08/200826083015.htm>

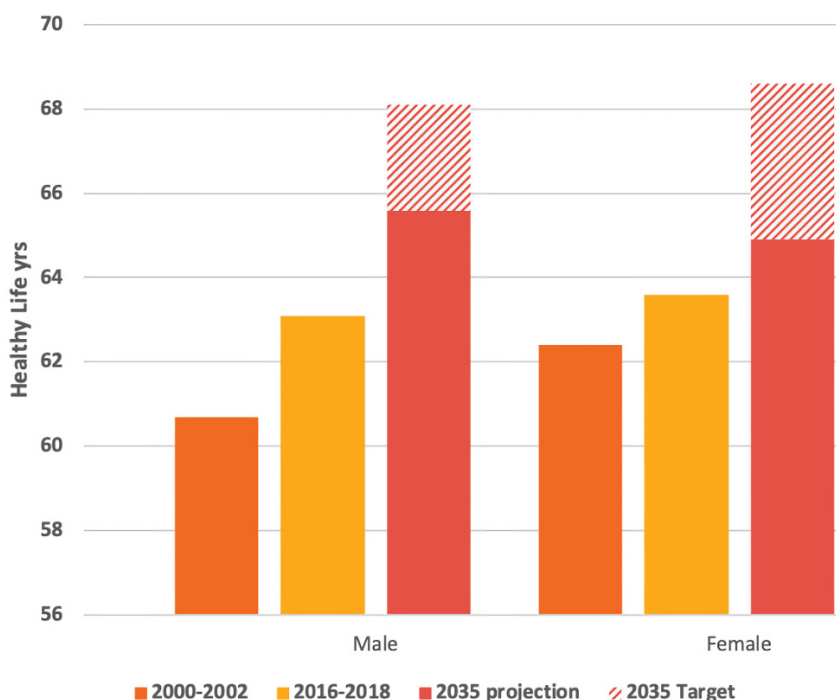
In the sixteen years to 2016-18 the HLE of UK males increased by 2.4 years, for females the number was just 1.2. Male HLE grew from a lower base, with the gap in HLE closing from 1.7 years in 2000-02 to 0.5 years in 2016-18. Progress slowed or reversed after 2009-11, where for males HLE grew by just 0.4 and for females healthy life expectancy declined by 0.2 years.

Future projections for HLE

The target for 2035 on these figures is set at 68.1 years of HLE for men and 68.6 years for females. There are a number of factors that will impact HLE in the years ahead and constructing accurate future models is highly challenging. The following analysis takes a simple linear projection of performance from recent years and extends it into the future. Such an approach is speculative, but is informative in assessing the scale of the challenge the Government faces in meeting its set objective against its recent record. It highlights the need for new approaches, whether from a policy, structural or investment perspective to meet the target.

On projections from 2000-2002 the Government would miss its 2035 target. Indeed it would take 33 years or until after 2050 to meet its target for males. For females it would not reach the target for 67 years, or 2085, fifty years after the set date. By 2035 on this model, male HLE would be 65.6 and female HLE would be 64.9¹⁸.

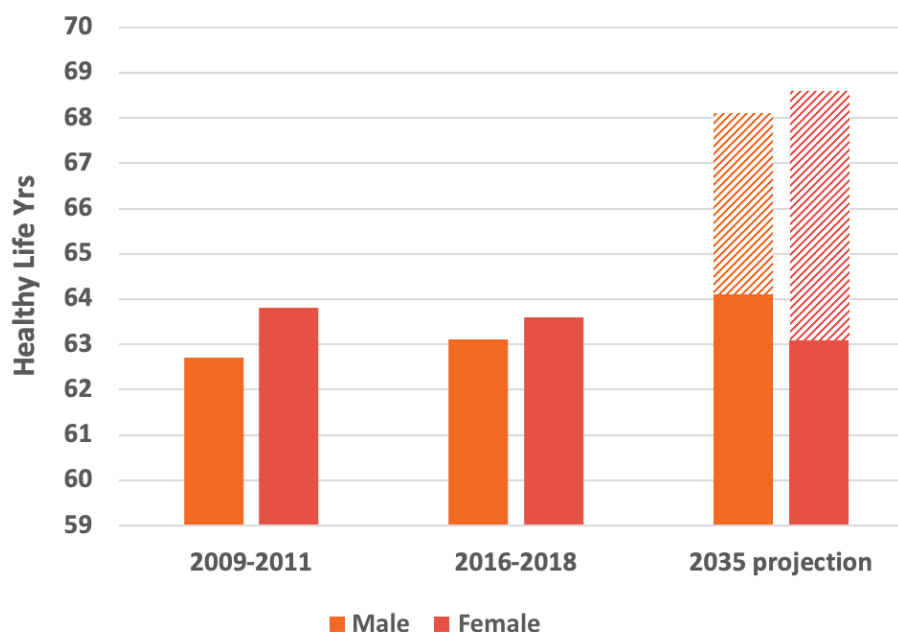
Health Life Expectancy - United Kingdom projected improvement to 2035 (projection based on 2002-2018 progress)



18. These models are pure projections based on past performance and do not account for the differences in male/female baseline HLE on 2000-02. It is highly likely but not proven that as the baseline for male HLE was lower that more rapid improvement was easier in comparison with female HLE which had a higher starting point. If this is the case then this would make changes from a higher baseline of HLE which we are now at, even more challenging than they were in 2000-02 (albeit not counting for technological innovations and changes).

If the Government proceeded at the rate of change from 2009-10 the situation would be even worse. On these projections the Government would never achieve its target for females given the decline in HLE observed. For males the 0.4 HLE increase observed in seven years, would need 88 similar years and into the next century for the target to be met. By 2035 on this model male HLE would be 64.1 and female HLE 63.1.

Healthy Life Expectancy - United Kingdom projected to 2035 (projection from 2011-18 progress)



These data demonstrate the urgent need for action to improve public health and strategies to improve HLE to deliver on the manifesto commitment.

COVID 19 will have significant repercussions for this policy ambition and has highlighted the need for a new approach. McCartney et al have begun to set out what the pandemic may mean for health inequalities:

“The effect of a fully mitigated pandemic is predicted to reduce life expectancy by 0.33 years, in a single year. The effect of a completely unmitigated pandemic is predicted to reduce life expectancy by 5.96 years, in a single year. But, over a decade, the impact of inequality (and the health consequences of it) on life expectancy is six times greater than even a completely unmitigated pandemic (based on the worse case scenario modelled by Ferguson/Imperial). So, COVID-19 is potentially a significant mortality ‘shock’, but nowhere near as big as the inequality ‘long emergency’¹⁹”.

The changes to public health structures present a chance for Government to start a new approach to public health. The next section explores options for improving these structures, stopping short of delving into specific policy areas and solutions (such as action on obesity, tobacco etc). These will be considered as part of future research.

19. <https://www.medrxiv.org/content/10.1101/2020.05.04.20090761v1>

Building back a better public health system

The decision to merge Public Health England with NHS Test and Trace and the Joint BioSecurity Centre in response to COVID 19 and future health threats, creates a number of unanswered questions on what happens to the health improvement functions within PHE and the Government's wider prevention agenda in healthcare. This is only one element of a public health policy approach, but does present a chance to build a better system that can begin to accelerate progress towards the stated ambition of healthier life span.

Effectively tackling health improvement and reducing health inequalities will require a system with:

- National and local political leadership and accountability
- Committed and sustainable system funding levels
- Strong working relationships with the NHS and associated partners, but ground in place and community
- Monitoring and continuous improvement of services and outcomes

The following explores a model for delivering this across these four areas.

National leadership and structures

When assessing how best to ensure national level leadership and action on public health, there are a number of options available to Ministers for how to assign PHE's range of health improvement functions²⁰. The below grid sets these out in detail, alongside the advantages and disadvantages of each approach. This leads to a 'viability rating' of each option:

1. Not viable
2. Viable, but not advisable
3. Viable, with some barriers/issues to implementation
4. Viable, few barriers/issues to implementation

20. The option of retaining health improvement functions within the new NIHP has not been included as Ministers have ruled it out on the grounds that the NIHP needs to be a 'focused' agency

Possible options for PHE health improvement functions

Option	Advantages	Disadvantages	Viability
Turn remainder of PHE (without NIHP functions) into new Executive Agency	<p>Clear continuity of approach from PHE</p> <p>Greater independence from Government</p>	<p>Similar model would likely experience similar challenges for share of voice and impact as PHE across Government</p> <p>With health protection removed this new agency is weaker than what was present before</p>	4
Transfer PHE functions to DHSC	<p>PHE is already an Exec Agency of DHSC so continuity would be high</p> <p>Closer proximity to Ministers and opportunities for greater national advice and leadership, including cross Whitehall working that is critical to improved public health</p>	<p>A need to maintain independence of scientific advice to Ministers could be constrained by being brought into DHSC</p> <p>DHSC is not an operational organisation and some functions would need to be assigned elsewhere</p> <p>Question over how a DHSC Institute can engage effectively across other Government Departments</p> <p>Potential loss of staff and expertise in shift to Whitehall</p>	3
Transfer PHE functions to NHS E/I	<p>Could lead to a much needed and greater NHS focus on prevention</p>	<p>History demonstrates the NHS does not take prevention as seriously as other competing priorities (eg acute admissions)</p> <p>Independent and professional scientific advice may be difficult to maintain within NHS management structures</p> <p>Difficulties in quality assurance of certain NHS services (eg screening), though this could be mitigated with careful case by case service management</p>	2
Transfer PHE responsibilities to NHS ICSS	<p>Closer alignment between public health and new NHS systems</p>	<p>Not all responsibilities would be appropriate at this level and there would be concerns over lack of national leadership on public health and duplication of efforts across the ICS network that would need to be addressed</p> <p>Unclear how this model would work alongside local public health directors</p>	1
Transfer PHE responsibilities to multiple organisations	<p>Embed public health within the approach of a number of ALBs, including within the NHS</p>	<p>Lack of national leadership and accountability</p> <p>Co-ordination of agencies challenging to deliver on the agenda</p> <p>Public health staff may not want to move into non public health focused organisations</p>	1
Transfer PHE functions to local government	<p>Would ensure continued leadership role for local government in public health</p>	<p>Very unclear how this would work in practice, without creating a new national body</p> <p>A pool of councils working together as centres of excellence may work on certain aligned agendas, but will not be able to cover all PHE existing functions</p>	1

The above grid suggests that there are two options that are viable for exploration:

- A new public health agency, similar to PHE but without the health protection functions
- The movement of the health improvement functions from PHE to DHSC

In order to assess which is the best option it is necessary to understand what the new organisation or group would be tasked with delivering. The main political public health priorities are:

- An ambition to increase the number of healthy life years by five by 2035
- A Conservative manifesto pledge for “a long-term strategy for empowering people with lifestyle-related conditions such as obesity to live healthier lives, as well as tackling childhood obesity, heart disease and diabetes²¹”
- The Secretary of State has re-stated his commitment to prevention as one of his Ministerial priorities²²
- The Prime Minister has launched a new obesity strategy, with further interventions expected in the coming months²³

These are ambitious targets and commitments that can be aligned with the Government’s ‘levelling up’ ambition of re-distributing opportunity and growth across the regions of the UK.

The move to abolish PHE should therefore be seized as a moment for Government to take greater accountability of the public’s health and set a national mission for health improvement.

It should do this by publishing an ambitious response to the Prevention Green Paper that sets out a set of measures that will deliver on the national goal of five healthier life years by 2035²⁴. This response should include milestone targets in the next fifteen years to deliver on this long term goal.

This ‘Public Health Strategy’ or White Paper should be led by the Department of Health and Social Care. The strategy should have an explicit objective of connecting the Government’s ambitions for ‘levelling up’ and tackling health outcomes and inequalities more closely. In order to deliver this a cross government group should be established from relevant Government departments to input policy ideas and suggestions.

In developing the strategy the DHSC should assimilate a set of PHE responsibilities including health prevention and improvement policy (including obesity, mental health, sexual health, drug, alcohol and tobacco), public health data and analytics, joint commitments with the NHS on prevention such as the new health check, and cross government working areas, such as clean air policy.

It is important these functions are not broken up and placed around the health and care system. Having an integrated set of functions for public

21. <https://www.conservatives.com/our-plan>

22. <https://www.gov.uk/government/speeches/what-record-nhs-investment-means-for-each-of-my-priorities>

23. <https://www.gov.uk/government/news/new-obesity-strategy-unveiled-as-country-urged-to-lose-weight-to-beat-coronavirus-covid-19-and-protect-the-nhs>

24. The target of 2035 may well need to be revisited in light of the impact of COVID 19. But a headline ambition for improved healthspan by a certain date should remain.

health data, policy and outreach to Whitehall Departments and the NHS in one place is critical for delivering health improvement. As with the NHS Long Term Plan the public health strategy should be built with a wide range of input from stakeholder groups, particularly local public health directors, so the strategy is informed by experience across the country.

The new DHSC function would become a National Institute for Health Improvement. It should employ specialists in priority public health areas that are major contributors to health inequalities, making it more outcomes driven and aligned with the wider ambitions of the political and policy agenda. The Institute would be empowered to build cross Whitehall relationships on public health matters. Not only through a cross government working group on building the strategy itself but through secondments and joint appointments with relevant departments (eg DEFRA and DfT on clean air). In doing this public health would become more embedded in the wider Whitehall policy development process.

There are good examples of more independent institutes in the healthcare system, particularly the National Institute for Health and Care Excellence (NICE). NICE's independence is a strength in ensuring issues regarding for example access to new medicines and devices are based on evidence and cost effectiveness. However, the nature of public health and the interventions it entails requires more direct political leadership and public engagement and therefore needs a more politically focused approach.

To balance the need for independent evidence development, the independent scientific advice element of PHE's role would be maintained through oversight by the Chief Medical Officer. In making a shift from PHE into the new Institute there will also be the potential to utilise networks of academics and outside independent advice on specific topics to provide specialist input into particular areas. This could be co-ordinated with UK Research and Innovation (UKRI) and provide additional resource and expertise to the new entity and support it functioning effectively at the start.

Functions that are not appropriate or viable for the new Institute should go to the NHS. Screening policy should return to the NHS perhaps housed within a Centre of Excellence and disease registries, already a joint PHE/NHS venture should go to NHSD or NHSX, following the end of the review into the NHS digital landscape that is underway.

Recommendation 1: The Government should make improving the health of the nation a new national mission and publish a public health strategy/ White Paper setting out how to deliver five healthier life years by 2035 including targets and milestones to deliver on this long term goal

Recommendation 2: The majority of PHE’s health improvement functions should move into the DHSC with closer Ministerial accountability. A new National Institute for Health Improvement should be established linking health improvement to wider ambitions for Government ‘levelling up’. Screening and disease registries should move to relevant NHS organisations

Public health funding

When assessing public health funding it is important to look at three different aspects:

- Public Health Grant
- Local government finance
- Other related government budgets that impact on public health

Between 2016/17 and 2019/20, the ring-fenced Public Health Grant to local authorities in England was reduced by 7.5% (12.7% in real terms), from £3.387 billion to £3.134 billion²⁵. Whilst £145 million was announced in 2020/21, there has been a clear impact on local services²⁶. Over three quarters of public health directors anticipated service cuts due to the grant reductions and over time feel that this will have an impact on health inequalities²⁷.

The reductions to the Public Health Grant were part of a wider set of cuts to local government. An Institute for Fiscal Studies report from November 2019 noted:

“Cuts to funding from central government have led to a 17% fall in councils’ spending on local public services since 2009–10 – equal to 23% or nearly £300 per person²⁸.”

Whilst NHS spending was ringfenced in the 2015 Spending Review, there were reductions to non NHS healthcare spending (public health, social care, workforce) as well as non healthcare but related areas for public health (eg environment, communities, transport).

These pressures on the three parts of public health funding have put great pressures on local services.

Health think tanks note that the Public Health Grant is a cost effective intervention to improve health outcomes: “analysis by the University of York suggests that the expenditure through the public health ring-fenced grant is three to four times as cost-effective in improving health outcomes than if the same money had been spent in the NHS baseline²⁹.”

The value and impact of the Public Health Grant means that it is a relatively affordable way for Government of delivering health benefit. This value from public health spending needs to be seen in the context of NHS spending increasing by £33.9bn in cash terms over the next five years. As part of the NHS Long Term Plan a greater proportion of funding is moving to primary, community and mental health services as the NHS looks to focus greater resources on prevention but this alone will not be sufficient to deliver a more preventative healthcare system³⁰.

The principle of value from investment in public health should

25. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767140/DHSC_allocations_circular_template_final_1.pdf

26. <https://www.health.org.uk/news-and-comment/news/response-to-public-health-grant>

27. https://www.adph.org.uk/wp-content/uploads/2016/02/ADPH_Impact-of-cuts-survey-results1.pdf

28. <https://www.ifs.org.uk/publications/14563#:~:text=Cuts%20to%20funding%20from%20central,the%20first%20half%20the%202010s>

29. <https://www.kingsfund.org.uk/publications/local-government-public-health-reforms>

30. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>

underpin future healthcare spending review discussions between Treasury and DHSC. This should see the grant retained, supported and expanded.

The first year the Public Health Grant was published in 2012-13 had no baseline assessment of spend versus service. As David Buck notes subsequent changes to the grant have thus been run off an initial grant package that was not accurately assessed³¹.

The government has announced its intention to deliver a one year spending review for a majority of departments. Whether public health budgets will be included or excluded within a small number of exceptions is unclear. However as part of the next multi-year funding assessment, HMT should undertake an assessment of the Public Health Grant and the services delivered through it to get an accurate baseline of the funding needed.

Looking ahead the Government should provide clarity to public health leaders on how funding for services will be supported and maintained. This is necessary to provide confidence in investments which may yield improvements over multiple years rather than in-year (which is central to public health improvement and is at the heart of the commitment to five healthier life years by 2035).

An approach for this could be ensuring that public health spending is both protected and rising at a rate that supports the objective of increasing healthy life span.

One model for this could be linking spending through the Public Health Grant to:

- GDP, ensuring that economic improvements are closely tied to increases in spending on health and wellbeing
- The NHS, where new NHS funding is matched by similar investments in public health to support a more prevention based system
- Inflation, so that the value of spending through the grant is protected against rising prices

This would see the grant rising at whichever of the above was the largest in any year. As an example if the 2012/22 grant was to increase at the average of the NHS Long Term Plan this would mean an additional £108m for public health in that year.

The impact of COVID 19 on the economy across the country means that caution is needed on long standing plans to move to local business rates as the model for funding public health. Areas which wish to approach public health funding through the Business Rates Retention (BRR) model should be enabled to do so, albeit with measures in place to ensure spending levels in public health are maintained. A one size fits all approach should be avoided.

Beyond the Grant, the Treasury should ensure that major fiscal events such as Budgets and Spending Reviews for local and national government support efforts to improve the nation's public health. The Treasury

31. <https://www.kingsfund.org.uk/publications/local-government-public-health-reforms>

should commission a public health impact assessment of any Government spending plans and identify and address any issues that would be detrimental to narrowing health inequalities in the future, working with the newly established Institute (see previous section) to address them.

In summary the Government's approach to public health funding should use the following approach:

- The Public Health Grant should be maintained as the primary mechanism for funding public health through local authorities
- HM Treasury should undertake a review of the Public Health Grant against services delivered to ensure an accurate baseline of funding
- An assessment should be undertaken of pegging the grant to GDP, inflation or NHS spending growth, thereby ensuring consistent future investments in the public health system
- The Treasury should publish a public health impact assessment alongside major fiscal events, including Budgets and Spending Reviews

Recommendation 3: The Government should maintain the Public Health Grant as the primary mechanism for funding local authorities, but review the amount of money against services and population health need. HM Treasury should also regularly review the public health impacts of fiscal events and consider a new uplift formula for public health funding linked to inflation, GDP and the NHS.

NHS partnership and collaboration

The COVID 19 pandemic has demonstrated the importance of local public health teams based in local authorities to rapid contact tracing and managing local disease outbreaks.

The performance of local government in public health in recent years along with the upheaval any restructure would cause, means it would be unwise to transfer public health services back into the NHS. The history of the NHS in managing public health is mixed, with prevention often under-prioritised and sidelined when set against more short term and hospital based priorities. In his Policy Exchange speech, the Secretary of State set out clearly that he wanted the NHS to take prevention more seriously³². This reflected the NHS Long Term Plan where a high portion of new investment is to go to primary, community and mental health services over the coming five years³³. This was backed up in the plan by NHS led prevention policies, such as smoking cessation support for new mothers and new action on obesity.

Alongside this, the objectives of improving healthspan and tackling health inequalities need to address the drivers of these issues. As set out in the Lancet Public Health journal, these are:

- Place based inequalities – such as socio-economic factors
- Inequalities of protected characteristics – such as ethnicity and sex

32. <https://www.gov.uk/government/speeches/the-future-of-public-health>

33. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>

- Inclusion health for marginalised groups – such as rough sleepers, migrants, sex workers³⁴

Whilst these issues do require a role for the NHS, they cannot be tackled from an NHS led perspective. In addition there is a danger in moving to regional NHS structures, that the role of place that has proven so important historically to public health is lost or diluted³⁵.

With a myriad of regional and local structures across health and local government and a number of areas already working in close collaboration across public health and the NHS, developing a one size fits all model is to be avoided. Instead both public health and NHS leaders need to come together to align their agendas for those they serve. As part of their future plans, ICSs should set out clearly:

- The processes and structures for working with local authorities to ensure the voice of place in regional NHS plans
- Targets and ambitions for population health outcomes where prevention has a central role to play
- How they plan to improve public and citizen engagement

Local authorities for their part will need to consider the best routes for engaging with ICSs and at a more place based level, primary care networks. Models for this ICS engagement could be directly; through their health and wellbeing boards, or as consortia or networks of public health leaders. Such decisions will be based and grounded on geography and relationships.

This closer working relationship should also be reflected at regional level where public health leads have become embedded in the seven NHS regional offices as joint public health and NHS appointments. These roles should be maintained in the new structures, with reporting lines into the new DHSC Institute for Health Improvement.

Recommendation 4: Local authorities should continue as lead commissioners for public health, taking steps to find the right structures to work collaboratively with changing NHS systems. Regional public health leaders should be maintained within NHS regional offices

Recommendation 5: NHS ICSs in their assurance plans should set out how they are ensuring the voice of place in their regional plans and set ambitious targets on health improvement and prevention in priority policy areas

Monitoring and service improvement

The 2012 reforms sought to shift NHS and public health services towards a more outcome focused model. The primary mechanism for assessing this were new Outcome Frameworks across public health, the NHS and social care³⁶. The frameworks have not been as influential as hoped in

34. [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(19\)30227-0/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30227-0/fulltext)

35. Kawachi I, Berkman L. *Neighborhoods and Health*. New York: Oxford University Press; 2003

36. These are by no means the only frameworks created; but are the primary national frameworks to assess the performance of the three main elements (public health, NHS and social care) of the healthcare system

shifting healthcare from activity based performance management to more outcome based approaches; though there are certain areas of the country that have used the data more effectively than others in driving service improvement.

Research has demonstrated that the reallocation of responsibilities for discharging public health to local government has been beneficial, with improvement across the Public Health Outcomes Framework indicators³⁷.

Currently local public health directors are answerable to their local constituents. Public Health England has been able to provide support and tools to enable the discharging of their functions but has no direct lever of accountability and performance management.

During the transition to a new system and particularly if greater investment is to be made there is a need to assess whether the system of performance management and accountability can be strengthened.

The Local Government Association and the ADPH has established a strong framework for sector led improvement which needs to be sustained. However as Buck notes it is not clear: “what happens when things go wrong in local government public health (as it was when it was in the NHS), and there is a lack of clarity over how that is actually defined. For example, if a key indicator (perhaps life expectancy) or a suite of PHOF indicators drop consistently and significantly in an area compared to experience in similar areas (in terms of population characteristics) what does this mean, would that be seen as failure, and if so, who’s failure? What would be done, if anything?³⁸”

If the majority of Public Health England’s health improvement functions are to transfer to a new Institute in the DHSC then the DHSC needs to use the data and analytics capability it will inherit to play a more active role in assessing the performance, working with local public health directors and teams. There should be a refresh of the Public Health Outcomes Framework and a proper assessment of metrics collected and performance against them, properly benchmarked and tailored by locality. It is critical that any such moves are done in consort between local public health leadership and national policymakers. Greater transparency and increased funding need to be catalysts for a stronger relationship between the centre and local leaders. The gap has been exposed during the COVID response and is now thankfully closing quickly. Ensuring an independent voice for local public health directors needs to be maintained in the new structures and approach. Local public health leaders should be in a position to build stronger, clearer relationships with the CMO in the new structure to provide input into evidence development and national policy setting. If approached in the right way by both sides, such an approach could accelerate sector led improvement by:

- Increasing transparency around performance
- Ensuring increases in public spending through the Public Health Grant are filtering through into better outcomes
- Tackling variation between areas

37. <https://www.kingsfund.org.uk/publications/local-government-public-health-reforms>

38. <https://www.kingsfund.org.uk/publications/local-government-public-health-reforms>

- Building closer relationships between national and local public health policymakers

All of which would accelerate ambitions towards delivering five years of healthy life for UK citizens by 2035.

Alongside this new model of public health outcome reporting, should be a greater alignment of metrics between the Public Health and NHS Outcome Framework indicator sets reflecting the shared ambitions of different system partners. Some local areas are already pioneering such as approaches such as Southwark³⁹. Wigan has arguably gone furthest with its multiagency and public model of the Wigan deal looking to bring everyone together to build a better, healthier borough⁴⁰.

Work by Outcomes Based Healthcare and US company Centene has noted the importance of agreeing outcomes across different local area organisations and for technology to support the local linking of datasets in moves to improved prevention and population health management by NHS ICSs⁴¹. Liverpool has announced plans for a ‘Civic Data Co-operative’ to bring multi agency data together within the public sector to deliver health and wellbeing improvements for the population. The pandemic has accelerated the need for and progress towards this⁴². The Government, NHS and local government leaders should assess opportunities to refresh and improve the existing Public Health and NHS Outcome Frameworks; moving to population level health outcomes where possible to monitor performance and improvement. NHSX’s new data strategy should support moves to join-up and integrate healthcare and public health data more closely to enable this. Other NHS incentive frameworks such as the Quality and Outcomes Framework should similarly be assessed for their role in delivering greater preventative care. The Government’s Prevention Green Paper included a commitment to build a health index⁴³. This index could provide a long term national framework for measuring and assessing health improvement across the country.

Recommendation 6: The new National Institute for Health Improvement should have stronger working relationships with local authority public health leaders to ensure an acceleration of improvement in public health as a result of increased funding. New population health data captured through NHS and public health outcomes frameworks, underpinned by the new NHS data strategy and a future health index should be used to improve performance and outcomes

39. <http://moderngov.southwark.gov.uk/documents/s71624/Appendix%20Common%20Outcomes%20Framework.pdf>

40. <https://www.wigan.gov.uk/Council/The-Deal/The-Deal.aspx>

41. <https://outcomesbasedhealthcare.com/wp-content/uploads/2019/06/National-Frameworks-Review-Full-Report-May-2019.pdf>

42. <https://www.ukauthority.com/articles/liverpool-plans-civic-data-co-operative-for-health-and-care/>

43. <https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document>

Conclusion

This research paper has sought to set out what the basis for an improved public health system could be. It concludes:

- Ministers must play a greater leadership role in national public health policy. A new national strategy for delivering plans for ‘five healthier life years by 2035’ should be published in response to the 2019 Prevention Green Paper, linking plans for ‘levelling up’ to health improvement
- A new National Institute for Health Improvement housed in the Department of Health and Social Care, should replace PHE and the health improvement functions it houses. Screening and registries housed within PHE should transfer to relevant parts of the NHS
- The Treasury should conduct an assessment of the funding needs of the Public Health Grant and the public health impact of major fiscal events, addressing any issues of increased health inequality that emerge. A study should be undertaken looking at the best way to peg future public health investment to GDP, inflation or NHS spending
- Local authorities should continue to be the primary leaders and commissioners of public health services. New NHS regional structures should set out clearly how they are factoring in ‘place’ into their emerging plans and regional public health leads within NHS regional offices should be retained
- The new National Institute for Health Improvement should work with local public health directors to assess local public health performance and deliver further accelerated improvements. There should be a review of outcome measures collected across the public health, NHS and social care system; ensuring that such data collection is supporting joint efforts across the system to deliver on the ambition of five healthier life years for citizens by 2035. Long term, the introduction of a national health index could become the main mechanism to assess health improvement across the country



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