

# A WINDOW OF OPPORTUNITY FOR PUBLIC HEALTH

## Key points

- COVID-19 has thrust public health into the spotlight. Proposals to reform the public health system come with risks, but also opportunities, for how population health is prioritised and resourced in the future, as part of the nation's recovery from the pandemic, and in preparation for future threats to public health.
- While the future destination of Public Health England (PHE)'s other responsibilities, in particular its health improvement functions, have yet to be set out in detail, it is vital that no expertise is lost, and that national and local leadership for these responsibilities is maintained with sufficient investment both to make up significant shortfalls over recent years and to ensure an effective function in the future.
- Years of cuts to public health budgets have undermined the sustainability of public health services. In the wake of the pandemic, it is all the more important now for the government to commit to robust and long-term investment in public health services, in recognition of the essential role they play in supporting the resilience to emergencies such as the pandemic.
- While the role of national leadership is critical during times of national emergency, there is a risk that embedding this into a future public health system will result in local government and local partners including trusts becoming further disempowered to act for the good of their local communities. Local leaders, who are closest to and understand most about their communities, who can tailor services and communications to meet their needs must be empowered to work flexibly according to what they know works. This should involve a partnership between NHS organisations, local government and the voluntary sector.
- As system working evolves, integrated care systems (ICSs) are more clearly becoming a forum for local partners to work towards shared goals in population health – indeed this is a core aim of the proposed new statutory partnerships involving local government, the NHS and wider public sector partners at the system level. As health improvement responsibilities are redistributed and potentially devolved to a more local level, it is vital that this takes place with system working in mind, and it will be all the more important for local authorities to have a seat at the table in discussions taking place about local resources and population outcomes.
- As part of the reconfiguration of public health responsibilities there is an opportunity to reconsider the commissioning arrangements for some public health services, which, since legislative reforms in 2012 have become fragmented and vulnerable to funding cuts, leaving those delivering the services (often community providers) struggling to meet demand for the resources available. Alongside a strengthened role for ICSs in public health and a robust voice for local government within systems, we believe clinical public health services would be better commissioned alongside other NHS services.

## Introduction

The COVID-19 pandemic has brought to the fore many questions about how well public health services are resourced and organised in England. During the first wave of the virus, amid high-profile challenges around testing, PPE guidance and supply, questions arose about the country's preparedness for a pandemic. The impact of cuts to public health funding over the years and the role of PHE were brought into the spotlight with far-reaching consequences.

In August 2020, Matt Hancock announced the dissolution of PHE and the creation of a new National Institute for Health Protection (NIHP) – charged with protecting the nation's health from external threats such as pandemics, infectious diseases and biological threats – which will assimilate NHS Test and Trace, the Joint Biosecurity Centre and PHE's infectious disease unit.

This leaves unanswered questions about the future of PHE's other vital functions including its role in addressing the broader determinants of health, and the implications of these reforms for the wider health sector. Trust leaders have raised concerns about the long term impact the pandemic will have on health inequalities and how this will be addressed, and flagged risks to preventative services including screening programmes, the national cancer registry, and public mental health functions, all of which depend on the synergy between national coordination and local expertise.

We are concerned about the timing of this reconfiguration, however there is a clear opportunity to make positive changes through this new structure. This briefing sets out what we see as being the key issues to tackle as part of the restructure of public health functions over the coming months.

# Considerations for a new public health system

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Currently, public health is the responsibility of a mix of national and local organisations, in which national direction and support on policy priorities is as essential as local delivery of interventions. The dissolution of PHE creates a need for public health and health improvement functions to become the responsibility of an alternative national body or local function. We anticipate the publication of an options paper exploring these proposals further, however there are several considerations for a new public health system, regardless of where responsibilities sit.

## Recognising the importance of local expertise and collaboration

The response to COVID-19 has been centrally coordinated, but interventions to support people with COVID-19, either socially, medically or financially, have been delivered locally. The national social distancing restrictions, coronavirus testing, and the vaccination programme have been enabled by local delivery, but there have at times been tensions between the centralised coordinating role, and the desire of local leaders to have enough flexibility to meet the needs of their communities.

It is in this context of active learning from the pandemic as it evolves, that the NIHP will emerge. The timing of the creation of this new body may represent a government response to an increased focus on health protection in the current climate and a reaction to historical lack of sufficient resource and focus on this area of public health. However, it is critical to the success of the future public health arrangements that these reforms are not just reactive and expedient but are founded both on the needs of the population, in response to lessons learned from the pandemic, rather than short term priorities.

Successful public health interventions rely on a synergy between national enabling policy direction, local leadership and coordination, and place-based delivery of services and interventions that support the health of diverse communities. This is the case not just during health crises such as the pandemic, but across the range of public health priorities overseen by PHE and executed at a local level, in partnership with local government, health and social services, and the voluntary sector.

While there are benefits to a sharp focus from government on managing disease outbreaks, including a nationally consistent directive and framework for a coherent and consistent local response, the 'local' element of this dynamic has not been consistently supported, and local leaders have not always felt empowered to lead the local response to the virus and support their communities. The effectiveness of the national coordinating role has not always been underpinned with the necessary supportive local flexibility. Where the government has attempted to operate large-scale programmes, it has often been hampered by a lack of detailed local data and operational challenges, for example, local authorities trying to coordinate local support and contact tracing efforts have struggled to get the data they need from NHS Test and Trace. In its inquiry into the development of NHS Test and Trace,

the National Audit Office noted that 'local government stakeholders expressed concern that they had not been sufficiently engaged on the design and implementation of test and trace services'; and that government had not considered alternative options to the national system such as a hybrid of national and local capacity for contact tracing.<sup>1</sup>

The success of the vaccination programme has offered a future path out of lockdown, and the first signs of the programme beginning to take effect can be seen in declining COVID-19 mortality among the highest priority groups. It underlines what the health system can achieve with a clear national directive, and local flexibility to deliver. But it also highlights the need for local organisations such as provider trusts and primary care to be given more flexibility to meet the needs of the communities they serve. The delivery of the programme, with its independent prioritisation process, nationally coordinated supply chain and delivery schedule, has taken longer to be fully tailored to local communities and their diverse circumstances.

For example, health professionals working in deprived parts of the country raised early concerns that the Joint Committee for Vaccination and Immunisation priority groups did not take account of health inequalities which might lead people under the age of 70 in deprived areas to be faced with the same risk of serious complications of COVID-19 as more affluent 80 year olds – healthy life expectancy in these areas is 19 years lower than in the least deprived parts of the country, meaning people experience the health problems that could make them more vulnerable to the virus younger than elsewhere.<sup>2</sup> Now, new modelling has highlighted the need to consider wider determinants of health when assessing COVID-19 risk among different demographics and the guidance on who should shield has been updated, meaning more of those who are at a higher risk of complications of the virus will be vaccinated sooner, and will have their risk status communicated to them.

COVID-19 mortality was higher in more deprived local authorities, and the factors influencing this include existing health inequalities, overcrowded housing, and the fact that lower paid occupations are higher risk for exposure to the virus including caring professions and other frontline key worker roles.<sup>3</sup> Local leaders also have a role to play in helping build trust in the vaccine, and promote take up of the vaccine when it is offered – this is especially important given confidence in the vaccine among Black, Asian and minority ethnic communities is lower, while risk of severe COVID-19 illness in this group remains high due to inequalities.

These issues all raise critical questions for the future of public health, population and prevention functions: whether responsibility for public health functions should sit within the NHS or local government, and subsequently, what the correct balance between centralised control and local agility and autonomy. NIHP will need to work hand in glove with local partners, and maintain strong links to local government public health teams, in order to

1 <https://www.nao.org.uk/wp-content/uploads/2020/12/The-governments-approach-to-test-and-trace-in-England-interim-report.pdf>

2 <https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-uk>

3 <https://www.health.org.uk/sites/default/files/2020-12/Build-back-fairer--Exec-summary.pdf>

take advantage of the value these experts bring in engaging with communities, convening wider public services, including housing, justice, parks and leisure, as well as public health services, social care, and education. While health protection is comprised of a specific set of functions and will benefit from focused leadership to drive the health protection agenda, these must not become divorced from the wider context in which people live their lives, and all the wider factors which influence health, and subsequently vulnerability to the direct and indirect impact of health threats.

## The need for sufficient funding and investment

Recent figures from the Local Government Association estimate that councils could face a funding gap of £5.3bn by 2023/24 which could increase to £9.8bn due to uncertainty around the impact of COVID-19. The public health grant, which is paid to local authorities to deliver public health services, is now 22% lower in real terms compared to 2015/16.<sup>4</sup>

The role of local government in supporting the population's health and wellbeing is not confined to public health and adult social care, and encompasses a range of services related to people's health and wellbeing including housing, education, leisure, green spaces, local transport and employment. These services are critical to the successful maintenance of the health of communities however financial pressures have led to reductions in spending across the board for many councils as they attempt to balance their books. For example, spending on planning and development, housing, culture and related services has been cut by more than 40% on average, spending on social services by 20%.<sup>5</sup>

The creation of a national body for health protection, or a redeployment of other public health functions, will not resolve issues with the public health system alone. COVID-19 has laid bare the impact of the lack of investment in public health over the years, with well-publicised inequalities in the impact of the virus on Black, Asian and minority ethnic communities, amongst others. A lack of resource and overly complex funding mechanisms have led to a fragmented public health infrastructure, and local authorities, having been largely stripped of their public health resources, were not empowered to play their pivotal role in meeting diverse communities' needs during the pandemic. This, coupled with an apparent lack of preparedness for a pandemic including the lack of suitability of the national stockpile of personal protective equipment – exposes a need to review the policy trend of deprioritising public health funding across the breadth of its functions.<sup>6</sup>

The NHS may play a greater role in public health going forward, and if this is to be the case it must be supported by investment so that trusts are not asked to carry out vital prevention work without the resources they need to provide the services people need.

4 <https://www.kingsfund.org.uk/projects/positions/public-health>

5 <https://www.ifs.org.uk/uploads/publications/comms/R121.pdf>

6 <https://www.nao.org.uk/report/supplying-the-nhs-and-adult-social-care-sector-with-personal-protective-equipment-ppe>

## A continued focus on health inequalities and health improvement

The advent of NIHP heralds a new focus on disease control and health protection, but this must not be at the expense of a sharp focus on prevention and tackling health inequalities – after all it is those who faced the worst health inequalities going into the pandemic who have borne the brunt of its impacts, and so any artificial distinction which is created by the separation of health protection and health improvement risks neglecting the fact that those responsible for tackling external health threats need to understand and respond to the factors which influence how those threats impact upon communities. The inequalities seen in outcomes from COVID-19, including case numbers, impact on employment and income, and mortality, do not occur in siloes but have emerged as a consequence of many years of pervasive structural inequalities, including racism and poverty, that render communities vulnerable to the worst effects of the virus.

For example, the mortality rate in the most deprived areas was almost double that in the least deprived areas between March and July 2020 and followed trends seen in other conditions, suggesting COVID-19 risk is influenced by similar drivers to those of other conditions – inequalities we knew about before the pandemic.<sup>7</sup> Men who worked in elementary occupations or caring, leisure and other service occupations had the highest rates of death involving COVID-19, with 66.3 and 64.1 deaths per 100,000 males, respectively.<sup>8</sup>

Not only are disadvantaged communities feeling a greater impact from the virus, but COVID-19 has also had a disproportionate impact of COVID-19 on people from Black, Asian and minority ethnic communities. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity were twice as likely to die from COVID-19 as people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity were between 10 and 50% more likely to die from COVID-19 when compared to people of White British ethnicity. Again, these statistics only serve to emphasise the impact of inequalities that were already deeply engrained in society. The causes behind these patterns are complex and interlinked because inequality snowballs out of structural racism to create inequality in housing, education, employment opportunity and ultimately, health outcomes. Deeply-rooted race discrimination has, over time, created systemic barriers to the conditions needed to live a healthy life, and the pandemic has now shone light on the tragic consequences of these inequalities.

More deprived communities also feel a stronger social impact of COVID-19. People in working poverty have been more likely to experience reduced hours/earnings, be furloughed or made redundant. 65% of people in working poverty have seen negative employment change compared to 20% of those who were not.<sup>9</sup>

7 <https://www.health.org.uk/sites/default/files/upload/publications/2020/Build-back-fairer-the-COVID-19-Marmot-review.pdf>

8 <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020>

9 <https://li.com/reports/poverty-during-the-covid-19-crisis>

Crowded, multigenerational housing or more insecure income makes self-isolation more difficult or financially unfeasible, leading to a higher risk of exposure to the virus. More disadvantaged children were disproportionately harmed by closure of schools due to loss of access to learning time, access to online learning and resources, access to private tutoring and inequalities in the exam grading systems. Teachers in deprived areas were more likely to say their students were more than three months behind compared to teachers in the least deprived areas.<sup>10</sup> This demonstrates how health inequalities form a cycle – the impact of COVID-19 can harm the life chances of young people and worsen the poverty which can lead to poor health, leaving these communities even more vulnerable to the virus.

The creation of a specific body for health protection leaves many unanswered questions about the future of PHE's other vital functions, and the implications of these reforms for the health sector. Among these, health leaders have raised concerns about risks for screening programmes, the national cancer registry, and public mental health functions, all of which depend on the national coordinating role of PHE to thrive. Several options have been set out for the future of health improvement, from embedding these functions into an existing national body such as the Department of Health and Social Care (DHSC) or NHS England and Improvement, creating a separate national organisation responsible for health improvement, devolving it fully to local government, or giving the NHS a greater role in public health, either through integrated care systems (ICSs) or some other mechanism.<sup>11</sup>

There is value in a national role driving a focus on health inequalities and health improvement, particularly at a time when the COVID-19 pandemic has affected communities unequally and shone light on the impact of the pervasive inequalities in society. An ongoing focus on addressing these inequalities is essential, both in the response to the pandemic but also in the wider economic and social recovery from the pandemic. This will take national leadership, with a focus on health inequalities at the centre of decisions made about health and other public services in the wake of the pandemic, and we would welcome clarity on where national oversight for prevention and population health will sit, as well as the delivery of services themselves. The lessons learned from the pandemic must not be forgotten or overlooked.

<sup>10</sup> <https://www.health.org.uk/sites/default/files/upload/publications/2020/Build-back-fairer-the-COVID-19-Marmot-review.pdf>

<sup>11</sup> <https://www.gov.uk/government/publications/the-future-of-public-health-the-nihp-and-other-public-health-functions/the-future-of-public-health-the-national-institute-for-health-protection-and-other-public-health-functions>

## The role of trusts in a new public health system

Trusts have a key role to play in driving public health and preventative approaches. For example, they look after the wellbeing of staff and patients, deliver some public health services such as smoking cessation, weight management and alcohol screening and are taking an increasingly active role in the health of the population that they serve as anchor institutions, contributing to local employment opportunities and establish healthy workplaces, and work collaboratively with partners in the health and care system to tackle wider determinants of health. Trusts playing an active role in prevention are clear that it takes board-level sponsorship and integration into the 'core business' of the trust to work effectively. Our report, *Providers deliver: New roles in prevention*<sup>12</sup> highlights the work trusts are doing to embed prevention and population health into their COVID-19 response and recovery, and their interventions are locally designed and tailored to local communities.

But there are still barriers to address. The way NHS services are commissioned does not always enable trusts to extend their reach beyond core services into wider preventative services. While there is an expectation that trusts will contribute to reducing health inequalities in the population, with increasing pressures there is little resource left to spare for work beyond those they are explicitly commissioned to provide. Changes to the payment system coupled with a more clearly defined role for the NHS in tackling health inequalities and improving population health will go some way towards strengthening trusts' ability to embed population health and preventative approaches into the design of their services.

### The case for a new approach to commissioning clinical public health services

Public health functions were transferred from the NHS to local authorities under the Health and Social Care Act 2012. This led to the formation of PHE in April 2013, and the creation of the statutory position of director of public health within local health and wellbeing boards. These reforms were part of a drive to develop a more joined up approach to tackle the wider determinants of health (like housing and education). In some areas, these arrangements have led to a more joined up approach. However, the transfer of public health functions to local authorities has also coincided with years of budget cuts and given rise to fragmentation between the NHS and the public health and prevention agenda.

The dissolution of PHE amid the pandemic and the title of the NIHP suggests that 'health protection' issues such as disease control will be led centrally (as currently). This raises important questions for a number of the functions PHE currently discharges in partnership with regional and local colleagues in the NHS and in local authorities to tackle the wider determinants of health and to promote a preventative approach to service delivery across the health and care system.

The existing arrangements for public health service commissioning have introduced fragmentation between clinical public health services, such as sexual health services and drug and alcohol services, which currently suffer from a lack of coordination between

parts of the system funded by the NHS, and those commissioned by local authorities. The transfer of public health funding and responsibilities to local government, while addressing the issue of public health not sitting close enough to the wider determinants of health, may in some areas have led to it being too far removed from the NHS.

Where these links between public health services and NHS services have been weakened, trusts describe challenges around the fragmentation and complexity of commissioning arrangements, funding, and communication between services. This leads to issues such as patients needing to visit multiple services for different elements of their sexual health or mental health needs, and care is less joined up, with an artificial divide created between services that are considered 'public health' and those which are considered 'healthcare'.

The challenges around public health funding, as well as funding for the wider determinants of health, and the impact of these challenges, are well documented. With many local authorities forced to reduce spending and cut services across these areas just to fund their statutory duties in respect of adult social care and social services, much has already been lost in the way of local authorities' financial capability to support a holistic and tailored approach to population health. This has inevitably compounded existing problems and has created a situation in which local authorities struggle to sustainably fund the services they are responsible for delivering. Budgets are often small, and trusts holding contracts for these services often struggle to meet demand and deliver a sustainable service for the money they are being paid to provide it.

Regular re-tendering of contracts in a bid to increase efficiency and value for money has created instability in services and made it difficult for trusts holding these contracts to plan for the future or invest in and transform services. A dispute about who was responsible for funding the 2019/20 Agenda for Change pay uplift for NHS staff working for local authority commissioned services (largely in community trusts), while eventually resolved, underscored the impact of the current divisions between public health and the NHS.

In 2019, DHSC carried out an exercise to explore whether some public health services – sexual health, health visiting and school nursing – should be brought back into the NHS, as part of a long-term plan commitment to review whether the NHS should play a stronger role in commissioning these services. We argued at that time that the risk of disrupting these services during a period of instability and financial pressure in the NHS would outweigh the reward of doing so, despite the potential benefit of reducing fragmentation and enabling investment in services due to the NHS's comparatively better financial position.

These benefits and risks remain relevant but in light of forthcoming changes to the health and care architecture, including the dissolution of PHE, the creation of NIHP, and plans in the NHS white paper to put integrated care systems on a statutory footing in 2021, there is now a need to reconsider how clinical public health services are commissioned and funded under this new structure, given the separation of health protection and health improvement and an increased focus on the role of the NHS in public health in the context of the COVID-19 pandemic. Among the proposals set out for the future public health system is the bringing of local authorities into the remit of the providers selection regime to simplify and strengthen

joint working between the NHS and local government, and a consultation on these proposals also gives scope for public health to be brought into NHS commissioning, raising multiple questions about how future public health services are funded and commissioned.

There are benefits to the arrangements put in place in 2012, including the greater recognition of public health as a multidisciplinary, population-based approach to prevention and a greater ability to engage the full range of levers that local authorities can access to promote place-based planning and delivery of services. It will be important not to lose these benefits. We continue to emphasise that investment is needed wherever the funding and commissioning responsibilities sit, and that the NHS being responsible for these services will not alone be sufficient to resolve issues created by a lack of funding.

Bringing public health services back into the NHS, and the NHS budget, may afford services greater protection against the cuts in local government finances, which in many areas has led to disinvestment in services and erosion of budgets. Trusts which hold contracts for these services have seen their finances suffer in recent years, particularly community trusts. However, it will be important to avoid a situation in which the commissioning and funding of these services is brought back into the NHS's remit without any additional funding – papering over the cracks in this way will not achieve the longer-term aim of putting public health services on a more sustainable footing.

Public health and the services provided by the NHS are inextricably linked. Any new system for public health, wherever services sit and whichever body funds them, must take account of this fact and ensure that nothing is lost in the transfer of responsibilities, including ensuring services are tailored to people's needs, and connected with the wider determinants of health. There will also be a need to avoid over-medicalising prevention and public health, which in reality is an amalgamation of influences, of which healthcare is just one. However, a change to the way these services are commissioned may incentivise greater strategic focus on prevention at all levels of trusts' activity, bolstering trusts' contribution to prevention and public health and facilitating better joint efforts to tackle health inequalities, as well as enabling a stronger link between these services and the other services trusts provide.

## The role of integrated care systems in public health

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From the long term plan to the prevention green paper, various policy initiatives have restated the ambition for the NHS to play a stronger role in prevention and public health. COVID-19 has brought to the fore the impact of health inequalities, and there is increasing pressure on the NHS to make a meaningful contribution to the population health agenda. As the public health system evolves, there is an opportunity to articulate the contribution of the NHS to prevention and public health and the role of health and care organisations, including trusts play as anchor institutions creating economic and social value for local communities. Integrated care systems have been defined as the desired mechanism for NHS and other bodies to work together to improve the population's health, with system partners working together to make shared decisions about how resources are used to improve people's health. Most recently, the white paper proposes a new statutory partnership of NHS, local government and wider partners to focus on tackling health inequalities and improving population health – alongside a duty to collaborate and promote the 'triple aim' of better care for all patients, better health for everyone, and sustainable use of NHS resources.

The 2021/22 NHS England and NHS Improvement operational priorities letter sets out a focus on addressing the health inequalities that COVID-19 has exposed, describing how "systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks."<sup>13</sup>

The ICS agenda may then be a useful lens through which to look at the NHS's contribution to population health as part of a wider system response to challenges at the region, place and neighbourhood level. Local health and care organisations embedding public health and prevention into their plans, including beginning to develop population health management systems, demonstrates the potential of system working. However, as they stand, systems act as a convenor for existing system partners to collaborate, rather than as a formal unit of delivery or commissioner of services. We may expect to see a more formal role for ICSs in prevention and public health as ICS policy develops, and this will need to be considered carefully alongside planned changes to the national public health architecture, to ensure that accountabilities for public health outcomes and interventions are clear and well aligned.

The NHS white paper sets out how ICSs will be placed on a statutory footing, comprised of an ICS NHS Body and a separate ICS health and care partnership. While the proposals envisage the ICS NHS body will be responsible for planning and securing health services, including commissioning, the ICS health and care partnership will bring together health, social care, public health and potentially representatives from wider public services such as social care and housing providers. This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the NHS ICS body and local authorities will have to have regard to that plan when making decisions. This raises a number of questions about how these bodies will work together and enable close working between health and other partners, but signals a direction of travel towards a much stronger role for NHS organisations in population health.

<sup>13</sup> <https://www.england.nhs.uk/coronavirus/publication/important-operational-priorities-for-winter-and-2021-22>

Partnerships at a local level are critical in enabling people to live healthily, with decisions made by local government and other organisations having a bearing on whether an environment promotes or detracts from good health, with consequences for the NHS. This is the case across all policies. Sufficient stock of good quality housing, including social housing, reduces the risk of homelessness and helps to prevent respiratory illness from poor housing conditions. Transport infrastructure, with affordable public transport, enables people to participate in society and work, improving mental health, reducing social isolation, and encouraging physical activity. Local investment in business and enterprise reduces unemployment, boosts the local economy and encourages participation and engagement. NHS trusts, local authorities and other public services are anchor institutions, with influence in local communities and economies, a strong role in the local labour market, and thus can play a key role in influencing these drivers of good health provided the right enablers are in place.

An important element of the successful development of ICSs as a local forum for delivering public health is maintaining close relationships with local government and other non-NHS partners. System working offers an important opportunity for local government in its capacity for providing public health services, social care and wider services which contribute to health and wellbeing to work more closely with the NHS. Sustainability and transformation partnerships and (STPs) and ICSs across England have reached different stages of maturity of the relationships they have built between the NHS and its local partners. However, STPs and ICSs vary in composition, population size and geography. A local approach to implementing joint working is essential if integrated care is to be achieved in a way which meets the needs of diverse populations and deliver on its core aim of improving the health of the population. With local authorities responsible for other services which contribute to population health, it offers a chance for local systems to tackle health inequalities, address the wider determinants of health as part of a whole systems approach to prevention, and provide joined up services.

## Conclusion

Changes to the organisation of public health at a national level offer a window of opportunity to rethink the way population health, health inequalities and public health services are coordinated and delivered. The impact of the pandemic on public health, and health inequalities, goes far beyond the impact of the virus itself or the need to manage disease outbreaks. While we are concerned about the timing of the reforms, and the risks associated with separating health protection and health improvement when the two are so strongly connected, there is a clear opportunity to make positive changes through an increased focus on health inequalities and population health going forward.

The COVID-19 pandemic has highlighted a challenging road ahead for public health; the impact of the virus has been felt unequally across society, and the impact of health inequalities and economic disparity has come to the fore as a key focus for policy makers in the recovery from the pandemic. Addressing these inequalities must be a focus for any organisation which takes on responsibility for population health as part of the reforms, whether that is a new national body, an existing national body, or devolved local responsibility at the level of delivery. This will need to be accompanied by sufficient funding and investment to maintain and build expertise and capacity where it is needed to deliver public health services and restore lines of accountability.

The creation of NIHP represents a welcome new focus on preparing better for future disease outbreaks, and managing the impact of COVID-19, but this must not come at the expense of much-needed investment in wider public health functions. There are currently many unanswered questions about what a restructured public health system means for providers working to support the health of their local communities, through systems and in partnership with other local organisations.

**Your feedback is very  
welcome – for any  
comments or questions,  
please contact  
[leanora.volpe@nhsproviders.org](mailto:leanora.volpe@nhsproviders.org)**

For more information:  
[www.nhsproviders.org/a-window-of-opportunity-for-public-health](http://www.nhsproviders.org/a-window-of-opportunity-for-public-health)

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