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Reforming the public health system in England

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The abolition of Public Health England (PHE) during the COVID-19 pandemic has raised concerns about the future of the public health system in the UK, particularly in England. The two new bodies established in haste to replace PHE prompt reflection on the executive agency's fate and the need to identify any lessons to ensure that a public health system is put in place that is fit for purpose. The UK COVID-19 Inquiry provides an opportunity to make recommendations, but it will need to act quickly to avoid recommendations being ignored. Two areas of concern are highlighted in this Viewpoint: the respective remits of the new bodies and their governance arrangements. Both issues demand urgent attention if the new structures are to succeed and avoid a similar fate to that which befell PHE. But underlying these concerns is a much larger challenge arising from the UK's broken political system. The political system in the UK suffers from several systemic weaknesses, including departmentalism, poor implementation, an inability or unwillingness of those in power to listen to the truth, and chronic short-termism at the expense of long-term planning. Overhauling the UK's dysfunctional political system is a prerequisite for successfully improving the public health system.

Current health policy is understandably preoccupied with the changes occurring in, and the rising pressures on, the UK National Health Service (NHS), which have arisen from the effects of the COVID-19 pandemic and the implementation of the Health and Care Act 2022. However, it is imperative not to overlook the public health system reforms underway in England, which have long-term implications for the health of all individuals.

PHE, established in 2012 to provide leadership for health protection, including emergency preparedness, and health improvement,¹ was suddenly and unexpectedly abolished in an announcement on August 18, 2020. The decision to replace PHE followed mounting criticisms of its performance during the early stages of the COVID-19 pandemic, especially regarding the inability to test, track, and trace the disease, and due to the general unpreparedness of PHE to cope with a pandemic.² Some commentators saw it as the "first casualty of a blame game" over the UK's high death rate and noted that the UK Government's neglect of pandemic preparedness lay in its fixation on Brexit, which was a top priority for PHE and for other departments and agencies.³

Unusually, the Government's announcement to abolish PHE occurred without any consultation with interested parties concerning what should replace PHE and how the public health system might be strengthened and better organised. Instead of considering how PHE itself might be reformed, the Government sought to abolish it outright and rushed to replace it with two new bodies: the National Institute for Health Protection (subsequently renamed UK Health Security Agency [UKHSA]) and the Office for Health Promotion (subsequently renamed the Office for Health Improvement and Disparities [OHID]). The fact that both bodies had their names changed so soon after their announcement suggests that the Government was acting in great haste. The UK Government also spent over £560 000 asking management consultants McKinsey & Company to provide a vision and purpose for the UKHSA, suggesting that policy makers did not have a clear plan in mind when they made the change.⁴

The creation of the UKHSA was announced on March 24, 2021. Like PHE, the UKHSA is an executive agency with close ministerial oversight while still permitting "independence in the delivery of policy advice". The UKHSA will act as a so-called system leader for health security with responsibility for pandemic preparedness and external threats across the UK, while bearing in mind that health is a devolved responsibility. Somewhat curiously, the UKHSA also has a wider remit representing UK public limited companies to drive economic growth and resilience, therefore acting as leader for the UK's life sciences sector and diagnostic industry.⁵ However, in a subsequent framework document between the Department of Health and Social Care (DHSC) and the UKHSA, no mention is made of this wider role.⁶ Perhaps the omission of this goal in the framework document is advantageous, because the UKHSA's remit is already a complex and challenging one and issues to do with economic growth and the life sciences sector are the responsibility of other Government departments (eg, HM Treasury and the Department for Business, Energy and Industrial Strategy).

PHE's remaining functions with regard to wider public health, including health improvement and population health, are in line with the functions of the OHID, which was established on Oct 1, 2021. The OHID is located within the DHSC, which means the OHID is even less independent than the UKHSA and is jointly accountable to the Secretary of State for Health and Social Care and the Chief Medical Officer (CMO) for England. Building on the work of PHE, OHID's priorities include tackling obesity, improving mental health, promoting physical activity, and addressing other population health issues (eg, inequalities arising from obesity, smoking, mental health, and alcohol misuse). The OHID will track delivery across government and ensure that local government, which is responsible for public health locally, is fully engaged.

To date, little is known publicly about how the two new agencies will cooperate with each other and with various

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governmental and non-governmental stakeholders. Inconsistent processes and planning amidst staff turnover make rapid response challenging to deliver when a health hazard abruptly surfaces. There is concern that the changes have been rushed through with minimal consultation and at a time when the effects of COVID-19 are still being worked through in the health system and its workforce. The changes are viewed in some quarters (eg, people engaged in delivering public health in the NHS) as an unnecessary distraction when the pressures on individuals working in public health are so marked. Furthermore, the government's motives for making these changes at such a time have been questioned, which does not inspire confidence in the legitimacy or true purpose of these new bodies.⁷⁻¹⁰

Despite the haste with which the new bodies were set up during the COVID-19 pandemic, there is merit in taking stock to identify any lessons which might be learned from the replacement of PHE and whether the new bodies offer hope to do things better. Perhaps the UK COVID-19 Inquiry that is now getting underway will provide the opportunity for doing so.^{11,12} Even then, unless the UK COVID-19 Inquiry can publish interim reports every 4 months, which is what we propose, the risk is that it could take some considerable time before the learning can take place, by which time it will almost certainly be too late. There is great urgency about learning the lessons while the UKHSA and OHID are being established and while circumstances remain reasonably fluid. Unless the learning occurs, both organisations might be found deficient.

There is already existing material and evidence upon which to draw to inform the design of the two new bodies and how they might be best placed to deliver their respective functions. Many of the insights have emerged from a research project we are completing to explore the circumstances around the rise and fall of PHE.^{13,14} However, there are other existing sources, in addition to those we have cited.^{15,16} In this Viewpoint, we focus on two major areas of concern: the respective remits of the new bodies and their governance arrangements.

Remits of UKHSA and OHID

The respective remits of UKHSA and OHID need to be clearer and more transparent if fragmentation is to be avoided. A feature of PHE, and one widely welcomed by the public health community, was its attempt to bring together and integrate the key public health functions that had previously operated in separate silos. Currently, separating communicable diseases from non-communicable diseases (NCDs) is a serious error because, as the COVID-19 pandemic has shown in stark terms, close links exist between them with regard to the groups and communities who had the highest rates of illness and death during the pandemic. A syndemic understanding of diseases and their underlying social

factors is pivotal in preventing disease in the future and avoiding fragmentation.¹⁷

An associated risk is that attention is once again focused on acute care, hospitals, beds, and treatment. Although the Integrated Care Systems (ICSs) that are being established in England have a focus on population health, finding the space—and ensuring the skills and resources are in place—to go upstream while working in partnership with other stakeholders across government will probably be difficult. Even within public health, there is a risk that attention and resources will be focused on communicable diseases, leading to a possible neglect of NCDs. To achieve a balanced response to the two disease types, strong political support and commitment are required. Details on the balance between communicable diseases and NCDs remain vague, although clarity could emerge when the DHSC, in collaboration with OHID, publishes the promised white paper later this year, which is designed to tackle the core drivers of disparities in health outcomes. However, unless a high priority is attached to prevention and public health, the NHS might become unsustainable and not survive as a tax-funded service, an outcome that was warned about 20 years ago in a report commissioned by the then Labour government from the banker, Derek Wanless.¹⁸

Regarding the UKHSA, its relationship with the devolved nations, each of which has its own public health agency, must be clarified and transparent. There also needs to be strong partnership working within England with regional public health teams, ICSs, and local government. Whereas NHS bodies are accountable to NHS England, local government is accountable to local communities and is overseen by a separate central government department, the Department for Levelling Up, Housing and Communities. Partnership working is challenging at the best of times but the existence of numerous boundaries that need to be navigated risks consuming an inordinate amount of effort, which could result in underachievement and a distraction from key objectives.

The divorce between policy making and implementation stands out as a prominent blunder of government.¹⁹ So-called operational disconnect has manifested itself in several policy areas, and public health is no exception. PHE struggled to establish strong working relationships with other bodies, including the NHS and local government.²⁰ The problem is a systemic one within Whitehall which is remote from the public and front line. As a former permanent secretary has argued, while executive agencies could be closer to their customers, these agencies still struggle to connect with them and, importantly, are often kept away from policy making, because they are accountable to ministers through civil servants located in policy divisions rather than directly. Such a separation of policy from delivery serves to keep

policy makers even further away from the reality of public health problems.²¹

Governance arrangements

The governance of the new public health bodies requires careful attention. As an executive agency, PHE was criticised for not being independent from government, which restricted its ability to speak truth to power. Because UKHSA enjoys this same independent status, it remains unclear how it intends to avoid a similar fate. The problem is a deep-seated and pervasive one within government, since it is often challenging for officials to confront authority figures.²¹ The hope that OHID being housed in the DHSC will allow it to exercise greater influence and have a closer collaboration with ministers could prove to be successful. However, this could be an overly optimistic goal, which is likely to be the case when considering past outcomes. There is a risk that OHID could disappear into Whitehall and become invisible, even losing the little independence PHE had. To succeed, OHID must be visible and have allies inside government, including the CMO for England, who also need to be visible. Perhaps if UKHSA and OHID had been established with some distance and autonomy from government they would have had greater independence from government and freedom to speak out. Indeed, such a status was enjoyed by the former Health Protection Agency that was integrated into PHE when it was established. Sadly, the advantage of having a degree of independence from government appears to be a key lesson that has not been heeded.

A further issue concerning the governance and working style of both agencies, but especially OHID, centres on their ability to operate effectively across government. Public health comprises numerous so-called wicked problems, which are made up of public policy challenges that are “complex, hard to resolve, keep shifting, have multiple causes and solutions, and cut across jurisdictions”.²² Confronting these problems will be especially challenging in a government that, for all its rhetoric about levelling up (ie, a desire to improve the economic performance and health status of regions outside London and South East England), is topic-focused and department-focused, operating in silos rather than concerned with cross-governmental issues.²³ Much will depend on the success of a new cross-governmental ministerial board for prevention. However, experience from previous arrangements of a similar nature does not offer much hope. Therefore, OHID is a long way from leading a transformational agenda across the wider determinants of health, which demands an approach that involves the whole government. Because of governmental delays in tackling child obesity and insufficient implementation of a national food strategy, achieving this goal is made even more difficult. Instead, and in keeping with the prevailing political ethos, there is a renewed focus on individual behaviour change and lifestyle choices

rather than tackling the influence on health of commercial interests via taxation and regulation.^{24,25} If substantial inroads into the population health agenda are to be made, then confronting powerful vested interests in, and lobbying from, the food and drinks industry and supporters within government that are involved with these industries, which is known as institutional corruption, cannot be avoided.²⁶ Whether OHID has either the backing from government or the competence for such a struggle remains doubtful in the extreme.

Indeed, the scale of the challenge shows that, if a public health system that is truly up to the task facing it is to be created, then the issues to be fixed go far beyond the structures and governance arrangements of individual agencies and their relationships. More broadly, the UK faces larger constitutional problems that the past decade or so has amplified.²⁷ These systemic weaknesses can best be summarised as arising from the phenomenon of constitutional casualism, by which governing elites are able to make constitutional changes that benefit their own electoral chances and their friends, lobbyists, and donors with minimal checks and accountability.^{28,29} Such practices are also inclined to emphasise short-term fixes at the expense of long-term planning. Given that the challenges facing public health require planning ahead and an acceptance that change will demand sustained commitment over many years, it is unlikely that the UK's broken political system is up to the challenge. Yet, without major systemic change aimed at overhauling the UK's dysfunctional political system, public health challenges will remain unmet with a risk of further deterioration in the state of the public's health.

Conclusion

Once again, public health finds itself at a crossroads. The funding cuts that the sector has faced (especially at a local scale), the absence of a coherent joined-up strategy for tackling public health problems, the disproportionate emphasis on the NHS, the backlog of elective care, and the overstretched workforce do not bode well for the re-consideration of public health that the UKHSA and OHID could offer. The choices for the future are either to continue to work with a broken political and public policy system that is not fit for purpose or to construct a strong and confident public health system that is well placed to confront the challenges facing it. The aftermath of COVID-19 should make the choice of options self-evident. But is this choice self-evident? Perhaps the findings from the UK COVID-19 Inquiry will point the way forward in making future choices. However, for these choices to become clear we urgently need the findings from the inquiry.

Contributors

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Declaration of interests

We declare no competing interests.

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