

Title: Death by a thousand cuts: Office for Health Improvement and Disparities restructuring is a further step in the wrong direction for tackling health inequalities

Stand first: *Yet more cuts are being made to our public health infrastructure in a time of rising health inequalities*

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Last week, the Department of Health and Social Care (DHSC) made big staff reductions at the Office for Health Improvement and Disparities (OHID) as part of an internal restructuring. According to reports [\[1\]](#), this includes the loss of several senior and experienced officials – with some reports claiming that OHID has been “decimated” with up to 50% of the central workforce now cut [\[2\]](#). Concerns about these further reductions in England’s public health capacity post-covid has been expressed by sector leaders and by former health ministers – James Bethell and [Philip Hunt \[2\]](#). The DHSC have responded to these reports to say that prevention will be embedded across DHSC – but questions remain about how this can be done with few people left with any expertise and who now has leadership over reducing health inequalities.

These cuts come at a time when the UK Public Inquiry into covid-19 [\[3\]](#) is still examining the appropriateness of the UK’s pandemic response – including our public health infrastructure, and at a time of rising health inequalities and stalling life expectancy [\[4\]](#). It is also a further cut to our public health systems on top of massive reductions in local public health and related funding over the last decade and the abolition of OHID’s predecessor Public Health England in the midst of the pandemic in 2020.

We were appointed as independent expert witnesses to the first module on pandemic preparedness of the UK Public Inquiry into covid-19. We produced an extensive evidence review [\[5\]](#) covering issues of health inequalities in terms of the UK’s planning. Based on this evidence, we concluded that the UK was wholly unprepared for how the pandemic would expose and amplify the underlying inequalities in society [\[6\]](#). We noted that improving health and reducing health inequalities in “normal” non-pandemic times is the best - and only way - to account for inequalities when preparing for future pandemics. This was not done in the

UK in the decade preceding 2020 and these further reductions in the central public health function of OHID bodes badly for the future.

The UK entered the pandemic in a poor state of health. Between 2000 and 2010, health inequalities decreased but over the decade since 2011 they increased again [7]. Further, life expectancy for men and women living in the most deprived quintiles flattened out and stopped improving. This is concerning because it is a reasonable epidemiological expectation that life expectancy should continue to improve. But, in the decade after 2010, life expectancy fell for the poorest 10% of people living outside London [7].

Relatedly, there was a slowdown in health improvement for the UK overall. Until 2010, life expectancy in the UK had been increasing by about one year every four years. This trend had continued for all of the 20th century, with small deviations. In 2010/11, there was a break in the curve—the rate of improvement slowed dramatically and then stopped improving [7]. This slowdown in life expectancy growth during the decade after 2010 was more marked in the UK than in any other high income country, except Iceland and the US.

Something had changed in the UK in 2010/11. It coincided with the election of a new Conservative government, whose stated ambition was austerity, cutting public expenditure in response to the 2007/8 Global Financial Crisis.

Since 2010, public health budgets were reduced by 24% [8] and local authority budgets (including social care) by almost 29% [9]. When adjusting for demographic change (a larger proportion of older people) and inflation, then the NHS budget in England shrunk by 0.07% from 2010 to 2015; and by 0.03% from 2015 to 2021 [10]. There were also significant reductions in other public services and the monetary value of welfare benefits. Together, these cuts disproportionately affected low-income households of working-age, families with children, minority ethnic and female headed households, the North of England, and the most deprived areas of the country [11].

It is plausible that these cuts in public spending and their regressive nature contributed to the increase in health inequalities over the last decade. Indeed, there is evidence for a correlation at local level in England – the greater the cuts in local government expenditure the greater the adverse effect on life expectancy [12].

In short, the UK entered the pandemic in a poor state of health with its public services depleted, health improvement stalled, inequalities increased, and health among the poorest

people in a state of decline [5]. This was a low baseline with which to enter a pandemic. To better prepare for a future pandemic we need to do what should be done anyway: *take steps to improve the public's health and reduce inequalities*. The opposite was done post-2010 and the recent “restructuring” and reductions to OHID are a further step in the wrong direction.

Before the next pandemic, we must improve our funding of public health - to reduce health inequalities and improve the health of *all* communities.

References

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