



BMA response – Transforming the public health system: reforming the public health system for the challenges of our times

About the BMA

The BMA (British Medical Association) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Securing our health: The UK Health Security Agency

What do local public health partners most need from the UKHSA?

The COVID-19 pandemic has demonstrated the need for a well-resourced and professionally led health protection function. We welcome that UK Government, in light of the pandemic, has shown a renewed focus on health protection. It is however vital that concentration on potential future communicable disease pandemics is not to the exclusion of existing and emerging public health issues. It is important that UKHSA has the capacity and resources to concentrate on issues such as antimicrobial resistance, air quality and climate change.

We remain concerned that the separation of health protection from health improvement and healthcare public health will lead to a fragmented approach to improving and safeguarding the public's health. Tackling the wider determinants of health is critical to preventing and managing communicable disease and other health hazards. This will require vertical and horizontal integration across the whole system in a way that allows collaborative working across organisational boundaries at local, regional and national levels.

UKHSA must provide professional leadership and expert support to local and regional public health partners as well as to individual public health specialists. Access to a central hub of scientific insight and analysis as well as national and international data and evidence would add significant value to the on-the-ground operations of local public health teams, which can in turn feed valuable local insights and data back to inform national strategy. UKHSA also has an important role to play in collecting, storing, articulating and disseminating best practice, which can enhance local services and local delivery. To support this UKHSA must have local presence, capacity and capability to work closely with local authorities and NHS staff.

How can the UKHSA support its partners to take the most effective action?

It is vital that UKHSA takes a collaborative approach to working with other local and regional public health structures, as well as structures in the devolved nations. To achieve this, there must be complete transparency and close working between local public health teams and more centralised functions, supported by UKHSA local presence. This will ensure engagement and open lines of communication with Local Authority public health teams and local/regional Directors of Public Health as well as integrated care systems (ICS), enabling health protection expertise to be made available at every level while allowing flexibility in how it is used locally.

The COVID-19 pandemic has also made clear the importance of data integration to enable rapid access to local data at a sufficiently granular level to guide interventions. In many cases, local public health teams are best placed to deliver and commission public health services on behalf of their populations. However, access to strategic intelligence and support from UKHSA is integral to this work. Actors at all levels therefore require the autonomy to make their own decisions to ensure responsiveness to local need, with vertically linked data and intelligence to support decision-making provided by UKSHA.

Public health is a continuum, and it is important that this principle is maintained, with the UKHSA working across the whole public health system. The Government must ensure that the new structures do not lead to silo-ing of expertise which would create a lack of cohesion between health protection and health improvement campaigns at a national, regional or local level. UKHSA therefore needs to retain some presence in health inequalities and healthcare public health.

How do you think the health protection capabilities we need in the future should differ from the ones we have had to date?

Pre-pandemic, Local Authority and PHE funding across all the domains of public health was inadequate. This created difficulties in ensuring sufficient human resource – especially specialist staff – at all levels, and particularly at the local level, to carry out essential health protection functions. It also meant the UK entered the pandemic with insufficient health protection infrastructure, such as laboratory capacity. These capabilities need to be properly resourced and able to be scaled up to effectively prepare for and respond to future threats to health, not only from infectious diseases but also wide-ranging challenges such as climate-related health issues.

International collaboration via WHO and directly with national health protection agencies will be vital for global preparedness and resilience against future health threats, many of which can only be addressed through cross-border solutions. These include taking a coordinated approach to data sharing, supply chains, removal of tariffs and easing of intellectual property restrictions on critical products.

Of particular importance to the UK is effective collaboration with ECDC (the European Centre for Disease Prevention and Control). The BMA is concerned by the lack of clarity over how the UK, via UKHSA, will collaborate and share intelligence with our closest neighbours. Switzerland's experience of seeking special access to ECDC's Early Warning and Response System during severe regional disease outbreaks raises particular concerns that delays to information sharing would limit disease

tracking and could render analysis on rapidly changing outbreaks out-of-date.^{1,2} It is vital that the UK agrees a comprehensive memorandum of understanding with ECDC to maximise continued access to data and planning arrangements.

How can UKHSA excel at listening to, understanding and influencing citizens?

It will be critical for the UKHSA to learn lessons from the COVID-19 pandemic about the importance of working closely with local Directors of Public Health in designing effective interventions and public messaging to serve the communities they know best. UKHSA must however recognise the limitations of an approach centred on personal choice and re-focus on more impactful societal and environmental interventions. For example, there has been an excessive focus on so-called ‘pandemic fatigue’ and its impact on adherence to COVID restrictions, which has placed inappropriate responsibility on individuals and hampered implementation of more effective structural action. Fears of prematurely triggering such fatigue were cited as a reason to delay the first lockdown in March 2020, a decision we now know led to many thousands of unnecessary deaths.³

Significant resource has been put into behavioural research on factors which undermine adherence to restrictions. Experts cite cognitive overload from frequently changing rules, unclear public messaging (including lack of targeted, accessible and culturally/linguistically appropriate communications), and a lack of clear goals to collectively work towards.^{4 5} The UKHSA must incorporate this into its approach to influencing citizens as well as political decision-makers, ensuring it has a strong grasp of how best to communicate health security risks and restrictions. Public health research, informed by the views of patients, the public and public health professionals close to local communities, should underpin the development of new policies and strategies.⁶

Improving our health

Within the structure outlined, how can we best safeguard the independence of scientific advice to Government?

The COVID-19 pandemic has demonstrated the vital importance of decision-makers receiving independent public health advice. This is critical to ensuring politicians make better, more informed decisions and that their asks of the public have greater credibility. To achieve this, structures must be in place to allow public health professionals to advise openly and honestly. The ability to speak truth to power and provide sometimes critical, independent analysis must be present at all levels, whether advising a minister, a Local Authority leader, health and emergency planning partners or communities themselves.

Independence of voice is essential for public health professionals to be able to act in the interests of the health and wellbeing of the nation. Public health professionals must therefore have the freedom

¹ Politico (15 Feb 2018) [Why Brexit could be bad for your health](#)

² Reuters (28 January 2020) [Swiss seek access to EU early-warning system as coronavirus spreads](#)

³ Guardian (29 April 2020) [Revealed: the inside story of the UK's Covid-19 crisis](#)

⁴ BMJ (2021) [The public aren't complacent, they're confused—how the UK government created “alert fatigue”](#)

⁵ Institute for Government (2020) [Lockdown compliance and pandemic fatigue](#)

⁶ NHS Health Research Authority (2019) [Principle 2: involve enough people](#)

to publish their independent, evidence-based advice and provide their considered, professional view to local populations, the public and the media.

The BMA had longstanding concerns about PHE's lack of organisational independence and ability, as an executive agency of DHSC, to challenge Government on political decisions that may not be in the best interest of health. This is unlikely to be rectified by moving PHE's health improvement and healthcare functions further into DHSC and UKHSA remaining a civil service rather than health service organisation. While cross-Government reach and ministerial access are important, clear mechanisms must be in place to ensure that public health advice is not subject to political interference. This should include more powers and a direct line of sight for the CMO, as well as a role within OHP (Office for Health Promotion) with the ability to correct the record in public, in the same way as the UK's Chief Statistical Officer.

Where and how do you think system-wide workforce development can be best delivered?

Workforce leadership from senior staff with a medical background is essential to ensuring the proper functioning of the public health system. The restructure of PHE must be done with the workforce in mind, as it is their expertise that will allow the system to meet the Government's ambition of longer and healthier lives. As public health specialist training should cover all three domains of public health, workforce planning must take place across the system as a whole. Financial resource must also be made available to implement workforce decisions.

Previous re-organisations have had a serious impact on the workforce,⁷ and under the current system there are significant structural barriers to workforce mobility due to fragmentation of organisations and functions. If existing issues around terms and conditions for Public Health Consultants and doctors are not improved or worsen due to the restructuring of PHE, we are concerned this may lead to public health workforce attrition both in the immediate and longer term.

The current restructure and wider health system reforms set out in the White Paper on the future of health and care present an opportunity to promote better integration and mobility for public health professionals. In addition to improved mobility for doctors working in the public health system, mobility during training is vital to ensure grounding in all three domains and develop into well-rounded consultants. The BMA remains concerned that the division of public health functions between the UKHSA and OHP will create an artificial divide with the potential to silo expertise, and inhibit the emergence and capability of the public health leaders of the future. Development of a unified training offer, already in place in the devolved nations, is essential.

How can we best strengthen joined-up working across government on the wider determinants of health?

We welcome the Government's intention to re-focus on health inequalities through joined-up action on the wider determinants of health, and creation of the new cross-government ministerial board on prevention. As a member of the Inequalities in Health Alliance of more than 170 organisations, we have called on Government to develop a comprehensive cross-government strategy to reduce health inequalities as a matter of urgency. This incredibly important work must not be overshadowed by

⁷ BMJ (2020) [The demise of Public Health England](#)

the health protection agenda in the context of the pandemic. Indeed, it is now abundantly clear that action on the wider determinants of health to reduce health inequalities will significantly influence how threats to public health, from pandemics to climate and environmental events, impact the UK population in the future.

It is crucial that all Government departments and public bodies adopt a mandatory 'health in all policies' approach.⁸ Every policy decision has an impact on population health: from taxation on drivers of ill health, such as alcohol and tobacco; to air pollution and ensuring that policies reduce the overall level of harmful pollution; to alleviating deprivation. If the Government is serious about levelling up the nation's health and building back a fairer and more resilient society, public health must be integrated into all policymaking.

This approach is critical to ensure that the new OHP does not over-focus on individual responsibility and personal choice, and rightly targets the structural drivers of ill health and their societal determinants. This must include investment by local and national Government in programmes to create healthier physical environments for all, such as reducing air pollution, ensuring access to decent housing and facilitating active travel.

How can we design or implement these reforms in a way that best ensures prevention continues to be prioritised over time?

Doctors have long advocated the need to prioritise prevention to address longstanding health inequality. This approach must acknowledge that many of the causes of health inequality which contribute to chronic disease, including smoking and unhealthy diets, follow the social gradient, leading to pervasive inequity.⁹ Disadvantaged populations need more health care than advantaged populations, but receive less. People from deprived and marginalised groups are also more likely to access healthcare only in emergencies, with an underuse of preventative medicine.¹⁰ It is therefore critical that access to preventive services is better facilitated, including through earlier presentation to primary care.

Many of the factors that influence health are shaped by the social, economic and physical environment in which people live and are not simply a product of individual choices. A comprehensive public health approach is required to address these determinants and prevent ill health during childhood, education, employment and into later life. Shifting the focus of DHSC's work towards public health and, building on the 2019 Green Paper, emphasising the critical importance of preventing ill health will be vital to improving the health of the nation and ensuring an equitable recovery from the COVID-19 pandemic.

Alongside reform to the structures of the public health system, Government must ensure that the OHP as well as local public health teams are properly resourced to do the job asked of them. There is an alarming lack of recognition of the role of the public health grant in delivering the Government's ambitions. Without reversing cuts to public health budgets and committing to long-term multi-year investment in public health, it will not be possible to truly prioritise prevention.

⁸ BMA (2016) [Health in all policies: health, austerity and welfare reform.](#)

⁹ BMJ (2021) [Changing behaviour: an essential component of tackling health inequalities](#)

¹⁰ The Lancet (2021) [50 years of the inverse care law](#)

10. How can we strengthen the local authority and Director of Public Health role in addressing the full range of issues that affect the health of local populations?

The role of Local Authority public health teams has become increasingly limited to specific functions due to lack of funding and capacity. However, the COVID-19 pandemic has clearly demonstrated the value of a properly resourced and embedded local public health function, which can look across the system to identify opportunities to intervene. This will be critical if Directors of Public Health and local public health teams, including UKHSA and OHP, are to take effective action, not only during public health crises but also over the long term on the wider determinants of health.

Severe cuts to the local public health grant since 2015/16 have undermined the role of local public health in England. It is of particular concern that in April 2021, whilst still in the grips of the worst public health crisis in a generation, 20% of Local Authorities in England suffered a real terms reduction in per capita public health funding, and a further 46% received no increase in funding, after accounting for new funds earmarked for anti-HIV pre-exposure prophylaxis (PrEP).¹¹

Cuts are a false economy - in the Government's own estimate, every £1 spent on public health prevention returns £14 in related benefits.¹² The BMA has long called for a reversal of these cuts, to ensure that public health has adequate funding and capacity at the local level. This would require a funding increase of £1 billion to the public health grant to return funding to 2015/16 levels. This must be accompanied by additional investment year on year, increasing to £4.5 billion by 2023/24.

How do we ensure that future arrangements encourage effective collaboration between national, regional and local actors across the system?

It will be critical to take a whole systems approach as the detail of the future structure of the public health system is developed further. Lines of communication and professional accountability should facilitate partnership working between the different public health functions and agencies, and enable public health specialists and practitioners, data, and research to move between the three domains with ease. This horizontal integration, enabling the system to function as one without structural barriers, is essential to achieving vertical integration and close collaboration at all levels.

Central agencies must recognise the primary role of local public health delivery in improving population health. Delivering on the White Paper ambitions to improve health in place requires resourcing and supporting capacity at the local level. ICSs will play an important role in establishing a public health link between the NHS and Local Authorities. This is not well articulated in the White Paper – particularly in respect of how the proposed ICS NHS Body and the ICS Health and Care Partnership will interact. Public health and prevention must be embedded in the development of ICSs and new approaches to the planning and delivery of care. This could include appointing a Director of Public Health to both NHS ICS Body and Health and Care Partnership boards.

¹¹ Labour Party (5 April 2021) [1 in 5 local authorities have had public health budgets cut while still faced with high infection rates](#)

¹² HM Government (2019) [Advancing our health: prevention in the 2020s](#)

The regional tier of public health has an essential role to play in ensuring effective coordination across Local Authorities and all three domains to deliver integrated interventions and pathways at scale. To achieve this, Directors of Public Health must have a central role in ICSs, to ensure that a focus on prevention and action on the social determinants that underpin inequality in health outcomes is embedded throughout the system.

What additional arrangements might be needed to ensure that regionally focused public health teams best meet the needs of local government and local NHS partners?

The regional tier of public health is vital to ensure co-ordination and a coherent structure linking the responsiveness and detail of the local level with the specialist expertise and high-level insights available at national level. Regional Directors of Public Health have been invaluable in our response to the pandemic, and will play a vital role strengthening collaboration between key stakeholders across local government, city regions, the NHS, ICSs and both the UKHSA and OHP. To deliver on this crucial role, regional teams must be adequately staffed and financially resourced.

A longstanding issue is the lack of co-terminus boundaries between different public health stakeholders, such as NHS Trusts and Local Authorities that operate over different geographies. This can pose challenges when commissioning services. To overcome this, the regional tier of public health should work with local public health teams to enhance both vertical and horizontal integration. It will also be essential to embed public health within ICSs, Health and Care Partnerships and NHS ICS bodies.¹³ The regional presence of both UKHSA and OHP should be co-located and, ideally, jointly led together with regional NHS offices which, alongside local public health teams, are best placed to co-ordinate with ICSs.

Regional Directors and public health teams will need the independence to develop regional approaches, as well as access to timely and complete data and expertise from both the local level and the centre, to enable scaling of effective solutions. This should be based on a supportive relationship rather than performance monitoring and should not preclude a 'bottom up' locally-led approach.

¹³ HM Government (2021) [*Integration and innovation: working together to improve health and social care for all*](#)