The Association of Directors of Public Health
Policy Position: Health Protection

Key Messages

- Health protection goes beyond Covid-19. Sustained funding and effort are required to protect people from communicable diseases and environmental threats to health (including radiological protection) on an individual, group and population level.
- There should be a whole system approach where roles and responsibilities of different parts of the local, regional, and national health protection system are clarified.
- Directors of Public Health (DsPH) and local public health authorities[1] play a vital role in the health protection system and should work closely with regional and national public health authorities[2].
- Good practices in health protection should be shared locally and internationally.
- The health protection role of local DsPH should be fully recognised by regional and national public health authorities.
- A workforce strategy should be in place to ensure sufficient health protection and environmental health expertise in every local area.
- Good data sharing arrangements should be in place to support local health protection action.

ADPH Recommendations

National

Health inequalities: Health protection cannot be treated in isolation from social and commercial determinants of health. Health protection plans should consider the needs of different population groups to avoid widening existing inequalities.

A whole system approach: There should be a high degree of interconnectedness across the system at local, regional and national levels which takes collective responsibility for protecting the public's health. National policies should be co-designed with local public health teams.

Investment in public health: Funding for services that affect health protection (eg sexual health, drug and alcohol) should receive inflationary increases. Funding should also be identified for outbreak situations and allocated to relevant organisations. This could be for vaccination, workforce or for wider issues such as decontamination.

Adaptation to loss of funding after Covid-19: Health protection and infection control received an increase of short-term funding throughout Covid-19. The removal of this funding with an increased expectation of local public health should be addressed to ensure services and individuals are not compromised as a result.

[1] By local public health authorities we mean bodies with statutory local responsibility for public health functions (eg upper tier local authorities in England, Health Boards in Scotland and Wales, Public Health Service in Northern Ireland). These differ across the UK, Crown Dependencies, and associated territories. We have published a separate headline explainer on public health in each of these systems.

[2] By national public health authorities we mean bodies with statutory national responsibility for public health functions (eg UKHSA and DHSC in England, Public Health Scotland in Scotland, Public Health Wales in Wales, Public Health Agency in Northern Ireland). These differ across the UK, Crown Dependencies, and associated territories. We have published a separate headline explainer on public health in each of these systems.

Clarity of roles and responsibilities: The health protection system should be locally led with clear responsibilities laid out for where accountability in the system lies at local, regional, and national level to prevent unfunded work.

Workforce: There should be sufficient health protection and environmental health professionals to ensure expertise in every local area. Flexibility in workforce movement around the system is vital in ensuring that critical skills are not lost.

Data sharing arrangements should be in place to enable local health protection action. DsPH should have timely access to all data relating to the health of their local population by right. This includes patient identifiable data (PID).

Learning from Covid-19: Covid-19 has resulted in surge capability, new knowledge and skills. This capacity should be strengthened and maintained for future health protection resilience.

Local

Workforce: There should be sufficient health protection expertise at a local level. The local knowledge of DsPH should shape health protection decisions, reflecting local demographics and diversity.

Resources and support: A set of standards should be in place to ensure that different parts of the system have what they need in place, including funding commensurate with level of need.

Background

Health protection is the protection of people from infectious and environmental hazards on an individual, group and population level. This includes identifying, mitigating, and preventing the impacts of communicable diseases and environmental threats to health, as well as implementing continued surveillance and management measures such as through vaccination programmes, particularly for infectious disease outbreaks.[1]

The Covid-19 pandemic and the UK Mpox outbreak brought to the forefront the need for health protection measures. Vaccinations and non-pharmaceutical interventions (eg mask-wearing, home isolation and social distancing measures) were widely used measures to control both outbreaks. Covid-19 also highlights the importance of addressing health inequalities in health protection plans. During the pandemic, deprivation was a major determinant of mortality rates, with mortality rates being three to four times higher in the most deprived areas of the UK.[2] This is in part due to Covid-19 exacerbating disparities in life expectancy rates and cuts to public health expenditure prior to the pandemic.[3] [4] [5]

Sustained funding and effort are required to protect people from communicable diseases and environmental threats to health (eg radiological protection) on an individual, group and population level.

ADPH Position

A whole system approach to health protection

Health protection cannot be treated in isolation from social and commercial determinants of health. A whole system approach to prevention is crucial to protect the health of the population and will require a high degree of collaboration across the system (local – regional – national; organisations – sectors – professions) which together takes collective responsibility for protecting the public's health. Public health,

environmental health, primary care, sexual health, drug, and alcohol services, and Voluntary and Community Sector (VCS) organisations all play a role. There should also be an integrated whole system and evidence-based approach and shared methodologies to quality improvement, evaluation, and audit.

Two-way communications between national, regional, and local levels and mechanisms to provide effective feedback loops are vital to effective delivery and partnership working. This includes providing advanced notice of policy changes, particularly where there is a local impact, and improving mechanisms for quality assurance of information from central government to minimise errors. National public health authorities play an important role in system leadership. DsPH also have a frontline leadership role in health protection, providing a vital role in enabling system-wide efforts to secure better public health.

Adequate funding is required to improve health outcomes

Funding is a major constraint on health protection, both on directly commissioned services and in outbreak situations when there is a need for increased investment. In the past years, funding for services that affect health protection outcomes, such as sexual health and drug and alcohol services have not received inflationary increases, meaning they have struggled to keep up with demand and progress with strategies such as the elimination of Hepatitis C. Governments across the four nations should adopt a 'health in all policies' approach with a commitment to long term, consistent public health funding that focuses on primary prevention.

For DsPH to fulfil their health protection assurance responsibilities, all parts of the system commissioning and delivering health protection interventions (including vaccination, food safety, communicable disease control and emergency planning) require an appropriate level of funding. Funding should also be targeted to reduce health inequalities in health protection. Adequate funding should be a key part of the DPH health protection assurance arrangements, with escalation processes in place to highlight concerns and seek action. In England, health protection requires a ring-fenced allocation within the Public Health Grant to ensure it receives the uplift required to expand on the health protection element of current services as well as maintaining those that already exist.

Health protection received an increase of short-term funding throughout Covid-19. The removal of this funding (eg Contain Outbreak Management Fund (COMF) in England) should be addressed to ensure services and individuals are not compromised as a result. This includes support and compensation for people to isolate given certain conditions.

Preventing inequalities in access to health protection services

Covid-19, together with every communicable disease pandemic before it, have shown that the impact of infection fell differentially on populations and that most variations were caused by wider risk factors such as employment, housing etc. Health protection interventions should be considered in the context of wider determinants of health. Inequalities in access to health protection services should be accounted for when assessing the effectiveness of their impact. All partners in the local health protection system should be aware of and responsive to the health protection needs of vulnerable and disadvantaged populations. Improved data collection and dissemination can assist the provision of targeted services and proactive engagement with communities. Care pathways relevant to identified care priorities should also be considered.

The importance of local health protection response

While there is no doubt that some elements of health protection response needed to be done nationally

at scale, there should have been greater recognition of the role of local action. The skills, expertise and capacity of local public health was undervalued, particularly in the early stages of Covid-19. DsPH and their teams have extensive knowledge of their communities and the wider health and social care system. They have made critical contributions in developing approaches that work on the ground, reflecting the diversity of communities and the range of needs that exist. It is crucial to reinforce the line of accountability with DsPH as system leaders to allow them to fulfil their assurance role and enable a whole system approach with local flexibility. There should be clear indications around funding for local health protection, especially in major incidents or emergency situations. There must also be clear acknowledgement of appropriate variations in local health protection services due to differing demographics and community needs.

The importance of vaccination

No infection in living memory has achieved population immunity without vaccination. DsPH have a key role in quality assurance and safety; as well as reducing health inequalities. The role of public health in increasing vaccine coverage and uptake is particularly important. It is essential that LAs and DsPH are front and centre in national and local planning for vaccine roll out and are supported with sufficient resourcing and the necessary flexibilities. Vaccination must be seen as part of a balanced combination strategy for preventing and suppressing infection.

There is a risk that pre-existing health inequalities worsened by infections can be further exacerbated by poor vaccine rollout strategy. It is important to work proactively to reduce health inequalities by addressing barriers to access and uptake of vaccination in the operational design and implementation of vaccination programmes. Data on vaccine uptake and screenings is important and should be shared in a timely manner. Accessibility and convenience of vaccination services are important determinants of vaccine uptake. Ensuring that there are good direct transport links to vaccination sites, in particular via public transport, is crucial. National campaigns to increase uptake should also be supported with targeted local community engagement strategies that are culturally competent and specific to reduce vaccine hesitancy. Communication strategies should utilise the full breadth of social media channels.

Data sharing arrangements to support local health protection action

Governments across the four nations must ensure robust and complete data flows with geographic granularity, patient identifiable data (PID) and timeliness to support local action and meet the needs of local users including DsPH. DsPH have clearly demonstrated that data, including PID, can be handled safely and that legal arrangements can be put in place to support increased data sharing between national and local. The availability and release of data items such as Unique Property Reference Numbers, genomic data, and data on vaccination coverage and uptake should also be normalised. National and local databases should adopt a co-design approach where appropriate, to ensure that the users of the data are involved in the decisions about the data system and the data requirements and are able to provide continuous feedback to support improvement. In England, Public Health England's surveillance data has been vital in supporting DsPH and their teams to fulfil their public health responsibilities and must continue to be provided through UKHSA.

Sufficient health protection expertise is required to improve health outcomes

It is critical to ensure there is sufficient health protection expertise at a local level. This should include both public health and environmental health professionals, within local public health authorities, and should be separate from the role of the Consultant in Communicable Disease Control (CCDC). These public health specialists should be involved in all local discussions regarding health protection. There should also be

sufficient health protection expertise at a regional level to support local public health teams and DsPH.

Flexibility in workforce movement around the system will be vital in ensuring that critical skills are not lost. This should be facilitated through the use of secondments (national and regional to local and local to national and regional) as well through greater parity of terms and conditions. Consideration should also be given to the professional development opportunities of staff, particularly those who were deployed to support the Covid response, to accredit, retain and enhance their health protection skills.

Learning from Covid-19

Surge capacity for outbreaks and emergencies should be made easily accessible for local teams, including from regional health protection teams, the NHS, and wider deployment of resource through Local Resilience Forums. Much of the Covid-19 response has been based on building new processes and organisations, using needed but time limited resources, rather than providing resources to build on local systems. Surge capacity must build on local systems and be in addition to what is currently available locally, and should not be seen as a substitute for sustainable, long-term investment in local public health teams.

Since 2020, the wider public heath workforce has had a significant refresh of their health protection knowledge and skills through Covid-19. The infection prevention and control (IPC) and health protection support and response capability that was built up over the pandemic must be strengthened and maintained for future health protection resilience, not lost. There is an opportunity to utilise this skilled workforce for future health protection resilience, enabling a sustainable and flexible local response.

Prevention of non-communicable diseases

Although not infectious, the impacts of non-communicable disease on the population and health system are no less important and are a crucial element of health protection. Early intervention has a clear benefit to the patient and the health system, with better outcomes and ultimately less dependence on healthcare.

Health Checks and screening to pick up previously undetected diabetes, cardiovascular disease, increased risk of stroke, dementia, or kidney diseases, are a simple early intervention measure. However, funding for the checks continues to be challenging in England. Behavioural and clinical interventions delivered to one person at a time can also result in intervention generated inequality. For example, people from less deprived communities with higher education level are more likely to take up the offer of health checks. Therefore, it is crucial to shift from individual change to a change in policies and system so that there could be health improvement for many instead of for few. This could enable a joined-up approach to cater for population needs.

Prevention of non-communicable diseases is not just about health checks. Structural interventions that act on commercial and social determinants of health (eg tobacco and food environment) and shift population behaviour will be cheaper, more equitable and will have more of an impact. The focus should move from downstream treatment to upstream preventative action. There should be a whole system approach involving planning, safe and affordable housing, health, education, meaningful and appropriately paid employment, and businesses to create a healthier environment.

About ADPH

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It represents the professional views of all DsPH as the local leaders for the nation's health.

The Association has a heritage dating back over 160 years and is a collaborative organisation, working in partnership with others to strengthen the voice for public health. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

This policy position statement has been developed in collaboration with the ADPH Council and the ADPH Health Protection PAG.

References

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