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# Public Health Today



**Open with care**  
Issues behind the white paper

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# Welcome

**I**N OUR response to the NHS white paper\*, FPH gave a cautious welcome to the establishment of Public Health England (PHE) and the proposed move of directors of public health (DsPH) to local authorities (LAs). We also emphasised the importance of ensuring that, in the new system, all three public health domains – health protection, health improvement and health care – were addressed, roles and responsibilities were defined clearly, academic public health was strengthened, and resources were sufficient.

But it now seems that our early confidence may have been misplaced. The public health white paper doesn't address the three domains adequately and, in the current cold financial climate, all public-sector resources are under threat. Future responsibilities and lines of accountability are unclear; the white paper pays little attention to the relevance of equitable, effective and appropriate health services to the public's health; experienced staff are being made redundant; and, if the health bill is passed as currently drafted, a DPH need have no public health training at all.

PHE's remit, in particular, requires much clearer definition. It could be a tremendous force for good health, but it could equally become little more than a slimmed-down Health Protection Agency, part of the civil service and with no independent voice, rather than the comprehensive expert support service, employing the majority of England's public health specialists, that many of us envisaged and remain ready to embrace.

Rescuing the situation requires clear thinking and concerted effort. The present uncertainties are fuelling anxiety. Nationally we need, urgently:

- A clear, agreed description of responsibilities and accountability in the new system. We need to know who is responsible for protecting and improving the local population's health and, in emergencies or outbreaks, who provides the expert advice and who takes the decisions that will affect the lives – and deaths – of thousands of people. Without this underpinning framework, the health bill makes little sense and cannot be debated cogently.



- A coherent and comprehensive framework for the appointment and regulation of public health professionals. This must be articulated before the health bill enshrines a system exposing the public and LAs to significant risk.

- Pragmatic definitions of 'front line' services which, while acknowledging the need for economy, limit the risks to safety and efficacy.

- Clarity on the contractual framework for staff whose functions are transferring from the NHS or arms-length bodies to LAs or the civil service.

In the meantime, it's vital that public health professionals seize the initiative locally, consolidating relationships with GPs and local government and working with them and with NHS managers to develop plans for the future.

FPH is ready to help, wherever we can. We welcome the appointment of Anita Marsland to take forward national implementation and we look forward to working with her. We're taking every opportunity to contribute to national thinking and can intervene locally if standards of public health practice are threatened. We have recently done this with some success in London, resulting in agreed definitions of 'public health specialists' which are widely applicable\*.

Building on what's best in the white papers, and on the people and strengths of the current system, we have the potential to construct a first-class public health system and service. But there's a long way to go and a lot of work for us all to do to make that a reality.

Lindsey Davies

\*[www.fph.org.uk/public\\_health\\_white\\_paper](http://www.fph.org.uk/public_health_white_paper)

# Cutting domestic violence services puts extra pressure on NHS

**Despite recent progress, the health response to domestic violence across England is inconsistent, and this can only be exacerbated by the Government's cuts and health proposals, says Deborah McIlveen of Women's Aid**

DOMESTIC violence impacts enormously on the health and wellbeing of victims and their children. A recent survey for the Women's Aid Federation found that 50-60% of users of women's mental health services had experienced domestic violence, with up to 20% experiencing current abuse. Recent Home Office figures show one in nine women experience domestic violence each year with an average of two women killed every week. The cost to the NHS of dealing with the physical injuries alone is £1.2 billion a year.

Health professionals have a vital role to play in offering support, enabling disclosure and providing early intervention. The Coalition Government's national strategy, A Call to End Violence Against Women and Girls, and the Department of Health Action Plan make a number of specific commitments in relation to health including:

- funding e-learning for GPs to raise awareness
- exploring how health visitors may have a greater role in identifying the signs
- training front-line professionals to respond, including working with the Royal Colleges to expand existing training and guidance
- developing a robust platform for commissioning local services.

Public health led by local authorities, with an integrated approach to wellbeing, is a promising model for addressing the safety and support needs of domestic violence victims and managing perpetrator risk. A specific outcomes framework will be needed to assess the quality and effectiveness of service provision for victims and their children, as well as programmes to prevent domestic violence. Most incidents are not reported to the police and, of those that are, most result in no further police action – so support services, particularly refuge and outreach, are required in every area.

Although the Government's public health

proposals acknowledge the importance of domestic violence, local authorities and commissioning consortia will be driven by the needs of the market and the impact of cuts. In struggling to meet their statutory duties, they may fail to prioritise services for domestic violence victims. Women's Aid is particularly concerned that domestic violence will not be identified as a local priority and, without the voluntary-sector specialist services to participate in strategic partnerships such as Joint Strategic Needs Assessments or community safety partnerships, support services will not be commissioned. There is a real risk that the very useful recommendations from the Alberti review of violence against women and the Marmot review of health inequalities will be overlooked.



Many of our 400 member services across England have already had cuts of between 10% and 40% and some have closed. Cutting domestic violence services will risk more lives – with more terrified women and children being forced to stay unsupported in unsafe homes. This will put extra pressure on statutory services including the NHS and will increase social and economic costs in dealing with the long-term harm to children exposed to domestic abuse.

We urge all in public health to do what they can to support the Women's Aid Saving Survivors' Services campaign. For more information visit [www.womensaid.org.uk](http://www.womensaid.org.uk)

**Deborah McIlveen**  
Policy and Services Manager  
Women's Aid

## News in brief

### Obesity admissions up 30%

THE number of people admitted to hospital in England for obesity-related reasons rose by more than 30% last year. But NHS statistics also show the increase in obesity rates in adults may be flattening out.

The number of weight-loss hospital procedures (bariatric operations) carried out in England rose by 70%, from just over 4,200 in 2008/09 to just over 7,200 in 2009/10.

### Research school launched

A RESEARCH school designed to build closer relations between researchers and practitioners across Public Health England and local authorities has been launched.

The National Institute for Health Research (NIHR) School for Public Health Research will comprise leading academic centres of applied public health research. Each member of the school will receive up to £500,000 a year.

### Bed bugs 'a major issue'

HEALTH experts have warned a rise in bedbug infestations in Scotland is becoming a "major public health issue", the BBC reports.

The claim by the Royal Environmental Health Institute for Scotland (REHIS) comes as US experts said the world was on the verge of a "global pandemic".

REHIS called for improvements in how data is collected and shared in the UK so that trends can be properly monitored.

### Traffic fumes major cause of heart attacks

Travelling by car or bus triggers more heart attacks than alcohol, caffeine or over-eating, a study has revealed.

The research, published in the *Lancet*, found that time spent in vehicles caused 7.4% of all cardiac cases – more than physical exertion, at 6.2%, and alcohol and coffee, both on 5%. Air pollution triggered 4.8% of cases, negative emotions 3.9%, and anger 3.1%.

### DPH gets Vatican award

Jim McManus FFPH, Director of Public Health for Birmingham, has been awarded the Good Samaritan Medal.

At a surprise ceremony during a meeting at the Vatican's Pontifical Council for Healthcare Workers in Rome he was presented with the medal by Archbishop Zygmund Zimowski, the President of the Vatican's Health Department.

Currently four people in the UK have the medal. Previous recipients include Sir Alexander Fleming.



His review of health inequalities in England post-2010 showed a striking contrast in life expectancy between rich and poor. Here, Sir Michael Marmot, Professor of Epidemiology and Public Health at University College London, talks to *Public Health Today* about his hopes and fears for current policies on the social determinants of health

# 'Cuts will undermine

## Marmot on wellbeing and the white paper

**The Secretary of State for Health in England is committed to "improving the health of the poorest fastest". How do you see that playing out in the current climate?**

It's really very encouraging that the public health white paper gives such prominence to inequalities in health. When I was doing the review of social determinants of health in England a lot of people said to me darkly, "Your report will have the same treatment as the Black Report – commissioned by one government, reporting to another – it'll be squashed." But it hasn't been. The fact that the white paper says it's responding to my review by paying attention to the "causes of the causes" of ill-health is really very encouraging.

But we're in tough economic times. The Governor of the Bank of England has warned of a prolonged reduction in the standard of living and the Institute for Fiscal Studies has shown that the lower your income the bigger the proportional impact of the Chancellor's tax and benefit changes. The IFS also found that the public-spending changes mostly impact people lower down the income scale. The combined effect of all this is that more people will fail to achieve the minimum income for healthy living which sets a big challenge for the public health task ahead, if health inequalities are not to increase.

**And do you see any particular challenges in the proposed restructuring of public health?**

I've heard both sides of the debate – some saying it's terribly bad to be taking public health people away from PCTs and putting them in local government, and others saying it's terribly good, particularly if public health is going to have a role in the wider determinants of health – housing, education, services for older people and so on. I see it as an opportunity to strengthen public health locally, and at the same time have a close relationship with

Public Health England and the commissioners.

There will obviously be issues if you're reporting locally but are also part of PHE – but those can be worked through. I also have some anxieties about fragmentation of public health skills and expertise – and I hope Public Health England will help to solve this. There's got to be sharing of expertise and experience, and this will be much harder if public health is fragmented too much. So networking is going to be really important. I can't imagine there was anyone in public health saying, "What we need is another reorganisation – we haven't had one for weeks." But it's happening, so let's grasp the opportunity.

**How closely linked are health and wellbeing?**

I think we need to bring the two together. My own view, perhaps biased, is that health is a better measure of wellbeing than wellbeing. The argument I've been putting forward is that health, and the fair distribution of health, tell us a great deal about how society is functioning and about the nature of life for people. Problems with education, with employment, with communities – all the things that were identified in my review – are all reflected in health and the distribution of health in the population. Even a crude measure like disability-free life expectancy can tell us something about the circumstances in which people are born, grow, live, work and age. We've recently published inequality 'slopes' for every local authority in the country, to depict inequalities within as well as between different areas. Yes, there's a push to measure happiness, but I've been arguing that we need to measure health inequalities alongside that. Many of the determinants of wellbeing, not all, overlap with the determinants of health – so we should have a common agenda here.

**What's your take on the Prime Minister's Big Society?**

Well, in the Global Commission [on the Social Determinants of



# mine Big Society'

Early child development is essential to empowering people, says Marmot

There's got to be sharing of expertise and experience, and this will be much harder if public health is fragmented too much

of access, more on prevention; advocacy and cross-sector working; and measurement, monitoring and evaluation. There should be advocacy for cross-sector working at every level, from the GP at the coalface right up to the Chief Medical Officer.

I've been meeting with various royal colleges, and I'm actively exploring how we can get the doctors more involved in the social determinants agenda. Theirs is a very important voice. Just think of the impact the medical profession has had on smoking and is trying to have on alcohol.

#### How optimistic are you for progress on all this?

I'm an evidence-based optimist, and if I didn't think that we could make a difference I wouldn't be pushing so hard on social determinants.

Of course we shouldn't ignore the negatives – we have to deal with the challenges and focus on the positives. And with the public health white paper there are a lot of positives in there, given what it might have been. Let's build on that.

#### What's next for you personally?

I've been invited to do a similar review for the European Region of WHO, that's 53 countries, which will help to keep social determinants on the agenda. And of course I still have my day job as researcher and head of department.

#### What keeps you awake at night?

What would success look like? How would we know if the journey from research on social determinants of health to policy were really making any difference? I say I'm optimistic, but it's still a big challenge.

Interview by Alan Maryon-Davis

Health] we said empowerment has three dimensions: material (for example money, education, employment), psychosocial (having control over one's life) and political (having a voice). Coalition ministers have said that this fits with their Big Society idea. If so, good. But we emphasise how important early child development, education, employment – the social determinants of health – are to empowering people and giving them control over their lives.

All of these determinants require government action to get the basics right – facilities to support early child development, good schools, social services, good infrastructure, as well as good healthcare. Within that context, civil society groups are key actors. I think the massive cuts in funding to local authorities are going to make the role of the Big Society much more difficult.

#### You're also President of the BMA. What role do you think clinical doctors can play in tackling social determinants?

I stress three roles: putting our own house in order – equity



# Riding the white paper tiger

If we can cling on to the rampaging beast that is the Government's shake-up of public health, there could be good times ahead, says Alan Maryon-Davis



IT'S already a heart-stopping, hair-raising, white-knuckle ride on this white paper tiger. Even before the beast is fully out of its cage there are plenty of thrills and spills. Before the consultation has ended, and the enabling Health and Social Care Bill has been passed, the tiger is rampaging about, while we all hang on its back for dear life.

Despite the dangers, there is hope. Health Secretary Andrew Lansley loudly beats the drum for prevention, health improvement and reducing health inequalities, claiming the bill's purpose can be summed up in one sentence: "To improve the health of the people of this country, and the health of the poorest fastest."

But so many questions. What will Public Health England look like? How will its roles and responsibilities, its make-up, its links at local level shape up? How independent will

be its advice as part of the Department of Health? What functions will be pruned back or dropped completely? How safe are the observatories? What will happen to the national child measurement programme?

How will the shift of responsibility for health and wellbeing to local authorities work? What about the role and status of the director of public health, the ring-fenced budget, the links with NHS commissioners, the contribution to health protection, the impact of local politics?

What part can public health play in health-service planning, specifications, evaluation and contract monitoring? What requirements will there be to commission services in line with local health and wellbeing strategies? How will the emphasis on localism avoid a patchwork of standards and practice across the country – postcode healthcare and public health?

How will performance against public health outcomes be monitored? Who will do the scrutiny? How can the proposed health premium reward 'successful' local authorities without further disadvantaging those with more demographically challenging populations?

What will all the changes mean for public health training? How can trainees be sure of getting the right mix of experience and exposure? How can we

avoid the splitting up of public health into the three domains, with separate career pathways and loss of cross-fertilisation and career diversity?

So many questions, so much uncertainty – highlighted by the excellent contributions to this issue of *Public Health Today*. But one thing is clear: public health in England will never be the same again, even if the bill gets thrown out. Change is unstoppable now, and we must all change with it.

And that means that the Faculty of Public Health must adapt too. FPH advisors and representatives must be there, when and where they are needed, to help uphold and safeguard public health standards. We, as a profession, must stand together, arms firmly linked, despite the fragmentation that threatens to pull us apart. And FPH must help us do that through more flexible and responsive input into training, membership support, advocacy and communications.

It's going to be a rough ride on that tiger, but together we can make it through – maybe even enjoy ourselves – and continue to do our best for the health of the people we serve.

**Alan Maryon-Davis**  
*Editor in Chief*

# Every GP consultation is a chance to promote healthier lifestyles

THE lines between healthcare and public health, rightly, are becoming increasingly blurred and the far-reaching changes proposed for the NHS under the umbrella of the Health and Social Care Bill will place a greater onus on general practice to take responsibility for the health of the population, as well as for the health of the patient.

We are receiving an excellent response to the government consultation on the public health white paper, with many varied and diverse views being expressed.

A snapshot view of the responses so far shows that some members of the Royal College of General Practitioners are making the argument that GPs are there to treat people, not populations, and that linking GPs to public health campaigns could run the risk of eroding trust in their clinical judgement.

Other respondents see general practice as being at the frontline of public health. There is also a strong sense that localisation of public health is the right approach, which obviously bodes well for the commissioning of services by new GP consortia.

Whatever the outcome of the consultation, the RCGP will be working closely with the Faculty of Public Health to take forward the thinking on how GPs and public health specialists can work most effectively together to improve care for our patients. Public health specialists are central to the success of GP commissioning consortia.

Public health is a sensitive subject for general practitioners, and it is not always easy to strike the right balance between protecting people's autonomy and delivering the hard facts that changing their personal behaviours could help them prolong their lives.

GPs and their teams work at the heart of local communities. We want people to be able to live healthy, fulfilling and productive lives for as long as possible, but every day we are confronted with the sharp end of harm caused by smoking, excessive alcohol consumption and obesity.

Sensible, timely and appropriate interventions can help make people aware of the potential risks they are taking or the harm they may be doing and can change



their behaviour or prevent extensive damage.

While GPs want to do what is right by the individual patient, every consultation is an opportunity to promote the wider public health agenda by detecting early warning signs that prevent illness and advocate healthier lifestyles.

With the support of local public health doctors, we have the ability and the willingness to play a much greater role in the prevention agenda, shifting the emphasis so that the GP surgery is not just the place you go to get patched up when you're ill, but is the vital source of information and advice that stops you getting sick in the first place.

Of course, it is still early days. The consultation on the public health white paper is ongoing, and the nuts and bolts of how GP consortia will work with public health doctors to commission services has yet to be decided.

But collaboration will be the key. We have already established the RCGP Centre for Commissioning in conjunction with the NHS Institute for Innovation and Improvement to ensure that GPs are equipped with the right skills to commission services effectively and meet the challenges of the new world.

We need to make sure that we work collectively and in partnership to ensure that the public's health and public health are no longer mutually exclusive.

**Dr Clare Gerada**  
*Chair, Royal College of General Practitioners and GP in south London*

## NICE work will be much in evidence

THE 2010 white paper speaks a new public health language. Instead of individual behaviour change versus population approaches as polar opposites, a self-governing and self-regulating society is envisaged in which local action by individuals, communities, associations and businesses generate and protect health.

Health in this view is the outcome of social processes which flow naturally out of the activities of institutions and individuals. To help steer or nudge these processes, evidence-based public health activities focus on social norms and community networks. Local action leads to the establishment and diffusion of health-beneficial good practice and social integration. Resilience develops and flourishes in these circumstances, just as the opposites – vulnerability and exposure to excess risk – are endemic in the absence of a well integrated local social system. The physical and natural environments in which these behaviours take place are important both as context and as determinants of health themselves.

The white paper underlines the importance of basing this on the evidence. Against this background NICE will continue to produce guidance about health improvement and disease prevention, but will also provide evidence-based advice for Public Health England, GP consortia and local government. A framework for public health quality standards will be developed. NICE's public health outputs will be essential for the new public health service.

NICE remains responsible for NHS Evidence which allows access to evidence-based information about health and social care. Public health resources in NHS Evidence include those produced by the NICE Centre for Public Health Excellence, plus a comprehensive range of resources selected by the National Library for Public Health. Significant improvements are scheduled for launch at the NICE conference in May, including new Public Health Topic pages and unique 'pathway presentations' in key public health areas such as obesity and tobacco use. Work is also underway to produce a database of public health interventions, which will facilitate access to the underpinning evidence base that is essential for public health practitioners locally.

**Professor Mike Kelly**  
*Director of the Centre for Public Health Excellence, NICE*

## DEBATE: Will 'any willing provider' mean a better NHS? Massoud Fouladi argues there will be more innovation, while Alex Scott-Samuel predicts lower quality

### Give patients the chance to choose the best

ALLOWING any willing provider to deliver local healthcare services will unleash the forces of innovation and patient power into the NHS, transforming quality for patients and value for taxpayers.

First, innovation: in recent years, the NHS has become increasingly unsustainable as rising costs have outstripped quality gains. We urgently need new ways of working that re-engineer the NHS – delivering higher quality care at smarter value.

Much academic effort has been spent researching the drivers behind innovation. Study after study has shown that the vast majority of innovations come from new entrants to a sector rather than incumbents, be they public or private. A University of London examination of UK manufacturing showed that 80% of productivity increases were the result of efficient new entrants entering the industry

and inefficient producers leaving. It was not British Leyland that made our car industry more vibrant, but Toyota and Nissan. The IT sector also provides numerous examples of innovations originating from new entrants: Yahoo, Google, Facebook, YouTube, Twitter.

History shows that innovation does not happen simply because you ask incumbent organisations to become more innovative.

# YES

Innovation happens because barriers to entry are removed, all sorts of people are encouraged to provide a variety of solutions, and the best and most appropriate solutions are selected by customers. That's exactly what enabling 'any willing provider' to deliver local healthcare services will achieve.

Second, patient power: the test of every healthcare reform must be how far it

organises the NHS around the needs of patients. Whether it's in the business of buying a house or booking a holiday, most industries have been transformed in the past decade by expert service users making informed choices. Healthcare as a sector has been singularly exempt from this type of citizen clout. Any willing provider is fundamentally about patient power – giving patients the chance to choose the best treatment and guaranteeing that choice through economic regulation.

Everyone agrees that healthcare in this country should remain free at the point of use. Most people don't care whether the provider of that care is publicly owned, privately owned or owned by its employees. People care whether they and their family get the best possible care when they're ill, and whether taxpayers' money is spent efficiently and effectively. Increasing the number and range of providers by allowing any willing provider to deliver services can only increase the chances of the NHS achieving this.

**Dr Massoud Fouladi**  
*Medical Director*  
*Circle*

### Markets mean greater health inequality

THE Health and Social Care Bill will force all public healthcare providers into a competitive market in which price competition will allow private-sector organisations to undercut public providers who attempt to maintain clinical quality and proper conditions of service. When Thatcher privatised so-called NHS ancillary services in 1987, the result was a disastrous deterioration in hospital hygiene, accompanied by the disappearance of the caring functions of cleaners and other staff. In a much more radical move, the Government is now seeking to extend this damage across the whole clinical arena.

An optimum health service would provide publicly employed staff, in extended primary and secondary care teams, close to people's neighbourhoods, offering coordinated services meeting nationally generated

and monitored quality standards. NHS policy has steadily departed from this ideal over the past 30 years and Conservative and Labour governments share equal blame for their collusion in this. But it is the Conservatives and their neoliberal coalition partners whom history will blame for finally eliminating what remained of England's welfare society – a society created to address social needs and inequalities which persist today and which will increase as

# NO

a direct result of this bill, for which the Government has no electoral mandate. Their shame will be our communal loss, as the 'any willing provider' policy rapidly creates a chaotic national health market in which our taxes will pay the lawyers seeking to enforce European competition law on behalf of their wealthy corporate clients – many of

them former Department of Health civil servants and government advisers.

There is no evidence from anywhere in the world that competitive markets for healthcare benefit the public health; they are, however, well known to increase health inequalities. There is also much evidence that the absence of planning and integration of care, of transparency and collaboration between providers, and the loss of public trust in professionals with vested interests who can no longer be depended upon to put the patient first, coupled with enormously increased transaction costs, will result in poorer healthcare and in turn, in shorter lives of reduced quality.

The damage being created by this unwelcome, misguided policy may be impossible to reverse and will, in all probability, live with us for the rest of our lives. As with the Poll Tax, all means of prevention should be used in this disastrous and tragic situation, not of our choosing or making.

**Dr Alex Scott-Samuel**  
*Senior Clinical Lecturer in Public Health*  
*University of Liverpool*



# The state of things

The health systems in the UK and the US may be structurally different, but both need leadership, stable funding and personal responsibility, writes Georges Benjamin

WHILE the US and the UK health systems share similar goals of achieving optimal health for their populations, historically the fundamental approach has differed.

The US public health system is a federal, state and local partnership at all levels of government. It complements a robust private-healthcare delivery system that provides medical care services for the majority of the population. The public health system is locally organised and driven with federal funding and priority-setting for a range of federal programmes. The UK system has built its approach around its National Health Service.

During the past two years, both the US and England have begun implementing major reforms to their health systems. The US passed, and the President signed into law, the Patient Protection and Affordable Care Act in March 2010. This expands coverage to 32 million more people, reduces the growth of projected costs, improves quality and strengthens the approach to population health with an emphasis on the social determinants of health. Reforms of the UK system, which already provides universal healthcare coverage for all, focus primarily on strengthening the prevention and population health aspects of its system.

Both nations have embarked on similar paths to tackle the root causes of poor

health by addressing social determinants. In the case of the British reforms, the presence of existing universal coverage allowed prevention to be the centrepiece of reform; in the US, efforts to expand coverage were the central challenge. Prevention was viewed as important, but not central to the effort. Both cases represent a broader recognition and understanding that health begins long before you enter a medical provider's office. They also demonstrate the view that health-in-all policies are a viable way of improving health disparities.

Success on this strategy will require broad community engagement, developing and using evidence-based community and individual interventions, and a strong, sustained commitment by the policymakers and resource allocators.

While each approach is inherently unique, there are several lessons to be learned from the US experience. First, funding must be stable and sustained. Just because policymakers have protected the public health budget from the rest of the NHS, it does not mean that they won't slash it directly to pay for other non-health programmes. Stable and sustainable funding streams are essential for success.

Second, local engagement and control is important, but strong national leadership is still essential. Local authorities will help

ensure services meet the needs of the community. Without a national vision, however, one will end up with a patchwork of community programmes that do not work as a system. Failure to provide that leadership will leave community efforts fractured and ineffective.

Finally, engagement of the average citizen with a sense of personal responsibility for both individual and community health is essential for success. Simply telling someone to eat better and exercise more is not enough. They have to agree that it is their responsibility to have a healthy community – one that is built to make achieving health easy, one that embraces safety and health security for all, one that is willing to hold policymakers and resource allocators responsible for sound health policy over ideology that is regressive and non-evidenced-based. We have begun to do this. You should as well.

Both our nations have embarked on a wonderful adventure. If we are successful, we can be among the healthiest nations. If we fail, we will be among the least healthy. The stakes are high. Our nations have given us the framework and policy tools for success; it is up to us to use them.

**Dr Georges Benjamin**  
Executive Director  
American Public Health Association



## An 'app' is not enough to win the public over

WE welcome the Government's commitment to creating a health service that focuses on prevention while providing excellent standards of treatment when health problems do occur.

The dedicated new public health service, Public Health England, will bring together the work of various non-governmental bodies. This includes promoting healthier lifestyles and putting together the strategy for infection control. It is essential that the previous good work by individual agencies is not lost, for example on preventing the spread of hospital infections. We are concerned by the possible unintended consequences, such as the loss of the research and development agenda at the Health Protection Agency.

Giving responsibility for public health to local authorities is a huge gamble. We hear constantly this will build a stronger, healthier Britain by putting local communities directly in charge. We're told that it will be led by voluntary-sector groups, but how will they get involved, especially now that local authorities are slashing their budgets? The Government must have a clear strategy on how it plans to bring local people into public health and make it work. We know that one of the plans will be an 'app' for smartphones, but how appropriate will this be? Almost nine million people have never even been on the internet, so there needs to be a better strategy of involving people than an 'app'.

Key to the proposals in the white paper is the 'nudge' approach. This will introduce nudges to persuade people to make healthier choices. For example, a higher

“The nudge approach cannot be the only strategy”

levy will be placed on higher-strength beers while rates will be lowered for lower strength beers. The hope is that rather than people being 'nannied', they will make the right decisions themselves.

While this approach has its merits, the Government must ensure that it doesn't throw the baby out with the bathwater. Many of the legislative approaches to public health have been very successful. Since the ban on smoking in enclosed public spaces in 2007, admissions for heart attacks have fallen by 2.4%, and it is predicted that lung-cancer rates will drop by a fifth by 2020. In Scotland, the rate of childhood asthma admissions to hospital has dropped by 18%. It is clear that this has had a great effect on the health of people across the country. The Government's approach to protecting the health and wellbeing of people must be well-rounded and consider different approaches. The nudge approach cannot be the only strategy.

There are a lot of unanswered questions as there were for the NHS white paper; we hope that the public health white paper will do a better job of answering our concerns.

**Katherine Murphy**  
Chief Executive  
The Patients Association

## Counties and districts must work together

THE Chartered Institute of Environmental Health (CIEH) welcomes the Coalition Government's proposal to give the lead responsibility for public health in England to local authorities. In particular we welcome the step-change in addressing public health challenges, including the adoption of the Marmot Review agenda towards tackling the wider determinants of poor health and reducing health inequalities.

We think that the strengthened duties on the Secretary of State and local authorities to improve the health and wellbeing of the population make good public health sense.

However, there are a number of areas where we believe the proposals could go further. For example, we are concerned that with the integration of the Health Protection Agency into Public Health England there could be fewer opportunities for decision-makers to access independent advice.

The CIEH believes that a Chief Environmental Health Officer for England and an advisory committee overseeing the work of Public Health England would go some way to resolving this problem. We envision that the advisory committee would oversee the work of Public Health England and ensure that the experience and views of public health practitioners and members of the public inform its decisions and work.

In parts of England, where there is two-tier local government, the Department of Health proposes that the statutory duties and responsibilities and the ring-fenced funding will be directed to the county council. However, the environmental health workforce is usually entirely with the district councils. It is essential that the director of public health has access to this environmental health resource.

We would like to see a statutory duty to co-operate so that the county and district councils have to find a suitable way of working together. The CIEH would anticipate that there would be a variety of solutions including joint agreements, shared services and supra-local collaborations.

**David Kidney**  
Head of Policy  
Chartered Institute of Environmental Health



# Trained on the future?

The proposed new system could have serious consequences for the hitherto attractively diverse nature of a career in public health, writes Ben Anderson

SERIOUS thought is being given to public health's transition to the new landscape, but the future of public health training is being overlooked. Significant threats and opportunities exist for our specialty, and training will be key to how we ensure the sustainability of our profession through and beyond the impending transition. Although there is little clarity yet about the future, as a specialty I believe we need to give serious consideration to the following three training issues:

- sustaining the relevance of the public health curriculum
- maintaining the ability to deliver the full breadth of public health specialist training
- ensuring that public health remains an attractive specialty.

The transition of public health activity to a local-authority base will bring with it a number of new challenges for practitioners. Core public health competencies, such as needs assessment, critical appraisal, policy development and partnership working, will be as relevant as ever in this new arena, but there are new areas in which public health specialists will need to excel. Public health specialists are used to working at the interface between evidence and 'small p' politics, but now we will be interfacing more closely with 'large p' politics. Working to build consensus across party boundaries and working to electoral

timetables will be new skills for us, and the curriculum will need to adapt quickly to reflect this. Similarly, moving into a broader commissioning landscape and widening our influence on the determinants of health through relationships with other local authority directorates will throw up new competency requirements. Public health training will need to respond to these professional needs to ensure that we produce effective future leaders.

“ Training is key to how we ensure the sustainability of our profession through the transition ”

As someone coming towards the end of specialty training, I am convinced of the value of the exposure to a breadth of public health experience. There is a question as to how the new system will deliver this breadth, with a potential that future training locations will not be able to offer experience across all the domains of public health. This is likely to change the nature of training, requiring a greater number of placements. As the likely lead employer for future trainees, Public Health

England will need to work closely with FPH, directors of public health and local schools of public health to ensure that training placements continue to maximise the experience offered, while retaining the level of continuity required for registrars to develop the necessary strategic overview for delivering on priorities in the long term.

Finally, we should consider how to maintain the attractiveness of our profession to prospective trainees. The potential splitting of the domains of public health between local authorities, Public Health England, GP consortia and the National Commissioning Board, and the move away from NHS employment are concerns. Many issues have been raised elsewhere about the wisdom of such a split, but the impact on the diversity of our future careers is seldom mentioned. To me this is a key concern for the profession, as it is the career diversity offered by public health itself which attracts many to the specialty. Losing this may impact on the ability to continue to recruit the calibre of candidates required to take public health in England forward.

**Ben Anderson**  
Specialist Trainee/Honorary Lecturer in Public Health  
Chair  
FPH Specialty Registrars' Committee



# Healthy new bodies

The restructure will put wellbeing at the centre of health policy, says Transition Managing Director for Public Health England Anita Marsland

PUBLIC Health England is a new national, dedicated and professional public health service based in the Department of Health. We expect it to take on its full responsibilities on 1 April 2012, subject to the passing of the Health and Social Care Bill.

This is part of the Government's vision to raise the profile of public health, making wellness central to all we do, as set out in the public health white paper *Healthy Lives, Healthy People*.

It is my responsibility to lead the design, development and delivery of Public Health England by April 2012, and delivery of the wider public health system through local government by April 2013. This is a challenging task, and I will be drawing fully on my previous experience as Chief Executive of NHS Knowsley and Executive Director of Wellbeing Services for Knowsley Metropolitan Borough Council.

To help me shape and drive implementation, I have set up a Transition Executive Team made up of senior strategic partners involved in the creation of Public Health England and the new local public health system. The purpose of the group is to shape and drive implementation. In addition, formal governance structures have been put in place enabling senior partners to influence the overall strategic direction. A Chief Operating Officer for Public Health England will be appointed to

lead the new service from April 2012.

Public Health England will bring together a currently fragmented public health system. It will integrate expertise, action, advice and influence to ensure world-leading health protection and set challenging national objectives to improve the nation's health and wellbeing. It will have a new protected public health budget and will support local action through funding and, by providing evidence, data and professional leadership. It will fund those services that contribute to health and wellbeing (such as reducing smoking and levels of obesity) rather than treatment aimed at a cure.

Subject to the passage through Parliament of the Health and Social Care Bill, the Secretary of State for Health and Public Health England will have a national health-protection role, incorporating the existing functions of national agencies such as the Health Protection Agency. It will also incorporate the functions of the National Treatment Agency, public health observatories and cancer registries.

Public Health England and the NHS will work closely together at a national level through the Department and the NHS Commissioning Board and, locally, through health and wellbeing boards that will represent the needs of the community, as well as through links between directors of public

health and GP consortia. It will be able to ask the NHS Commissioning Board to commission public health services such as screening and the relevant elements of the GP contract.

The Health and Social Care Bill confers a new duty on local authorities to improve the health of their population and moves the requirement to appoint a director of public health from primary care trusts to local authorities, giving them the local-leadership function for public health. Local authorities will be supported by new funding, ring-fenced for public health. Directors of public health will be employed by local authorities from April 2013 but jointly appointed with Public Health England. They will be responsible for commissioning health improvement and some health-protection services using the ring-fenced budget.

A new health premium paid to local authorities will take into account health inequalities and reward progress on specific public health outcomes, and we are consulting on how we do this.

The consultations on *Healthy Lives, Healthy People*, on a public health outcomes' framework and on the funding and commissioning remit of Public Health England close on 31 March 2011.

**Anita Marsland**  
Transition Managing Director  
Public Health England

# Moves bring home difficult questions

AT THE heart of the public health white paper are new responsibilities and powers for local authorities. In principle, I welcome public health 'coming home' to local authorities.

Public health has been a core municipal concern since the nineteenth century. During the Great Stink of 1858, untreated human waste flowing into the Thames wreaked havoc and spread cholera throughout London. Even the newly built House of Commons could not escape. Sheets soaked in chloride of lime were hung from windows in an attempt to neutralise the smell. So in 1859 the Metropolitan Board of Works began constructing the first system of London sewers. Then, as now, it took local action to deal with key public health issues.



A bed-bound patient in 1880

While I support moves towards localism, I have a number of concerns which are shared by many of the public health professionals I am meeting up and down the country.

Putting public health in local government means that links with services such as education will be easier. But it will be vital that the new directors of public health are fully qualified, trained and senior enough to lead the discussion on how the budget is spent. It is also not clear how local authorities will be held accountable for achieving public health outcomes. Furthermore, there is a danger that GP consortia commissioning healthcare will

become detached from the expert advice of public health professionals. What will stop GP commissioners aiming resources solely at centralised high-profile health problems, rather than at the specific needs of the most vulnerable within the local population? In many ways, these plans threaten to fragment the small workforce in this area, and those workers with public health expertise will be dispersed across multiple organisations and sectors. It is vital that appropriate training and support is available to maintain sufficient public health expertise.

We have yet to be told how much money local authorities will get for public health. There is a danger that the new formula for public health spending will fail to sufficiently compensate deprived areas with higher health needs. There also needs to be much greater thought about which services will fall to local authorities to fund and which to the public health service or the NHS.

It also remains to be seen how effectively that money can be ring-fenced. Local authorities are facing unprecedented cuts, yet the Bill seems to leave it to them to decide what activity can be included in the public health budget. Some may be unable to resist spending public health monies on environmental health, social care or even leisure services. Rather than see exciting new public health initiatives, we will see money diverted from core public health activity.

Because of the proposed NHS reforms, there will be cuts in public health professionals. Then they (and the staff of organisations such as the Health Protection Agency) will be assimilated into the new dedicated public health service, Public Health England, within the Department of Health. But once these workers are employed as civil servants, their independence and ability to operate at an arm's length from government may be compromised.

The new localism is fine. And the public health structure suggested by government can work. But we need to know more about funding, powers and linkages with GP consortia. Until then all that this public health white paper will provide is upheaval, warm words and broken promises.

**Diane Abbott MP**  
Shadow Minister for Public Health

## A 'Rumsfeld' guide to the bill

### Known knowns

THIS is the legislation for the NHS commissioning body, GP commissioning consortia, Monitor, Healthwatch, Public Health England and local-authority public health.

It confirms duties of engagement, partnership, quality, and reducing inequalities, on NHS commissioners and public health.

It confirms PHE will be set up under the Department of Health, directors of public health will be jointly appointed by the Secretary of State and local authorities but employed by councils. There are many words about how to sack directors of public health. DsPH only have to write an annual report.

The bill uses the word "provide" but we have been told to "divest" ourselves of provision under *Transforming Community Services*. The horse has bolted, Mr Lansley.

### Known unknowns

The bill is silent on who will employ public health professionals. Healthcare public health hasn't got a home. There's nothing to regulate public health professionals and nothing to determine the level at which DsPH will operate in councils.

The bill sets up the ring-fenced budget, but we know we don't know how much it is, and we know it won't be enough.

### Unknown knowns

The Secretary of State reserves powers for all eventualities particularly in health protection and emergency planning. We should lobby for these to be exercised through DsPH.

### Unknown unknowns

In world economic recession, accelerating climatic chaos, natural disasters, mass migration, a demographic tsunami, pandemic obesity and mass starvation. Is any of this reorganisation worth a candle?

### Conclusions

The bill is poorly constructed, unintelligible, contradictory. The constant referral to the Health Act 2006 is distracting. Expecting local authorities to provide school medical services contradicts the education and localism bills. The contradictory expectations of NICE are grounds for judicial review.

We want a single, coherent specialty of public health incorporating all its domains. We need standards, powers and resources to protect health and save lives. There are not many powers here, and probably no money. The Faculty of Public Health, at least, is holding on to the standards.

**John Middleton**  
FPH Vice President

## We share the same hopes... and fears

### Local government must have the freedom to make its own decisions about public health, says Andrew Cozens

THE consistent part of the mixed response to the health reforms is the welcome that local government has given to the proposal to transfer public health responsibilities from primary care trusts to councils. It is not an unqualified welcome, but nevertheless it is genuine.

Long-serving councillors have hailed it as public health coming home after almost 40 years. Some ex-medical officers, however, have recalled unhappy experiences when their advice was not properly heeded.

The truth is that much has changed for both of us since 1974 when community and public health services joined hospitals in the integrated NHS, and local government lost its remaining role in providing health services.

Local government has been transformed. There are many more all-purpose unitary councils. Most services, having been subject to various best-value tests, are now commissioned from the voluntary and private sectors. The sometimes ponderous committee system has been replaced by the cabinet-and-scrutiny model, with senior councillors having delegated, portfolio responsibilities that enable faster decision-making and clarity of purpose.

Councils have much more of a community-leadership role, working with other local partners on whole-population challenges, such as jobs, the environment and quality of life, rather than just a focus on the direct services they run.

There is a natural extension of this wider role into our shared interest in better health outcomes and reducing health inequalities. Many councils are already working closely with primary care trusts on this; indeed the vast majority of directors of public health in England are already joint appointments. The Local Government Innovation & Development Healthy Communities programme, funded by the Department of Health for the past five years, has hundreds of examples of excellent joint approaches, and our online community of practice for colleagues in both sectors is consistently the most visited and used in local government.

It is not surprising that our recent roundtable event involving the Faculty of Public Health, the BMA and other bodies and senior councillors from the Local Government Association found a lot we agreed about and had in common. And it seems we have some shared reservations. The lack of clarity about how much NHS spending will be redistributed is disturbing, not least because we know investment patterns by primary care trusts vary, without any obvious correlation with the health needs of local populations.

We agreed there is still too little detail



about how public health will be organised after 2013. It is not clear how current functions will be redistributed between Public Health England (PHE), the Commissioning Board, GP commissioning consortia and local government. We are keen that local health improvement and addressing inequalities are not squeezed out by national functions or the needs of local health commissioners.

The LGA is concerned that the failure to specify the role of Public Health England in the bill will mean that too many powers will be vested in the Secretary of State as a proxy for PHE. We accept the need for regulation or guidance to achieve coordination of effort, particularly where health protection or emergency coordination is needed.

We recognise and value the fact that public health will be a distinct profession joining local government, something we are used to with around 600 different roles in our workforce already, many with their own identify and protected titles. Councils are comfortable with having functions they have a legal duty to provide. In most instances they have flexibility and freedom to organise themselves in how they carry them out.

The scale of the challenge to improve health outcomes is such that we need no constraints on the creativity of councils or on the influence and reach of our new public health colleagues.

#### Andrew Cozens

*Strategic Lead for Adult Social Care and Health  
The Local Government Group*

## Reform brought delay, waste and obstruction

### Patients were baffled by attempts to reshape Northern Ireland's health services, says Andrew Dougal

NORTHERN Ireland's health service revolution began in 2005, with the announcement that the number of health and social care trusts would be reduced from 18 to five, that a Health and Social Care Board would become the commissioner of services, and that a Public Health Agency would be established.

When the local health minister refused to implement reforms dictated by a direct-rule minister, several highly competent senior staff at the Health and Social Care Board took jobs elsewhere because of the uncertainty and were lost to the service – a sad waste of expertise and experience. Problems caused by this kind of political impasse may be unique to Northern Ireland, but it was not the only difficulty.

When the reforms were eventually introduced in April 2009, further delays meant that posts went unfilled (many remain so to this day), voluntary organisations were left short of funds

**We are having to send heart patients to London and Dublin for surgery**

because decisions had not been taken, relevant staff had not been appointed, and others were appointed to posts for which they had insufficient knowledge or skills. Patients and members of the public were baffled by the new arrangements.

Meanwhile, not a penny has been spent on a new respiratory-service framework, the implementation of a cardiovascular framework has been delayed, the Stroke Strategy has received only half the promised funds, and we are having to send heart patients to London and Dublin for surgery.

So there you have it: health service reform in action.

#### Andrew Dougal

*Chief Executive  
Northern Ireland Chest Heart & Stroke*

## Playing politics with the health of the nation

**Roy Baggott's tales of policies warped by outside pressures make for a fascinating read**

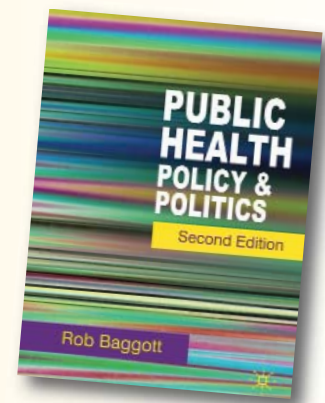
WHOEVER it was who said that health and politics didn't mix must have been living on Mars – the chocolate bar. One of the most fascinating chapters in Rob Baggott's forensic examination of the politics of public health demonstrates the immense lobbying power of the food industry. Whether it's the issue of junk-food advertising aimed at children, traffic-light labelling versus guideline daily amounts, pressure to reduce trans fats or the saga of sugary snacks and drinks in school vending machines, Baggott's balanced account of how policy can be contorted by the power politics of big business is gripping stuff. History shows how, time and again, health ministers of every hue, however well-intentioned, are got at and buffeted from all sides on virtually every issue. But few

lobbies can match the muscle of the food and drinks industries once they feel their profits are at risk.

This second edition of Baggott's book couldn't be more timely. With the coalition government in the throes of the biggest shake-up of the NHS in England since its inception, the structure and function of public health about to be split three ways from top to bottom, and central initiatives around healthy lifestyles being steered by 'responsibility deals' with the food, alcohol and physical fitness industries, the realpolitik of health is again being revealed for what it is: red in tooth and claw.

The book's main focus is the health improvement domain of public health, from basic concepts to historical context, from guiding principles to key issues, and from a critique of successive strategies to an analysis of current policies. It is centred on the UK, with frequent forays into European policy and the World Health Organization. It looks at how the Brown government's plans for public health evolved out of Blair's. And it examines the parallels and points of difference between Cameron's (or Lansley's) take on public health and those of the Thatcher/Major governments.

It took Baggott, director of the Health Policy Research Unit at De Montfort



University, three years to produce this extended and updated edition, and that enormous effort has provided us with a resource that will be appreciated by all with an interest in the policy and politics of health improvement in the UK and beyond. Perhaps even by those living on Mars.

**Alan Maryon-Davis**

### **Public Health: Policy and Politics (Second edition)**

Roy Baggott

Published by Palgrave Macmillan  
RRP: £24.99

## A nudge is not as good as a health policy

**The second edition of Jackie Green and Keith Tones' heavyweight study looks at why people make health choices, not just how**

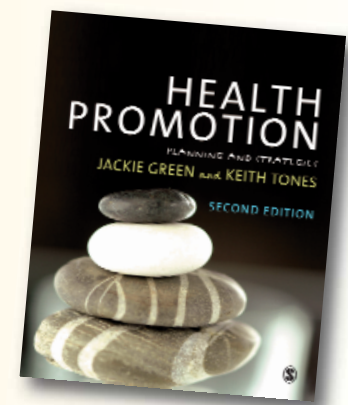
THERE has been a lot of talk in policy circles about 'nudging' recently.

One can hardly open a missive from the Department of Health without reading about how the Government is not interested in "nannying", it just wants to encourage people to make the "right" choices. Springing from the influential book by Richard Thaler and Cass Sunstein, *Nudge: Improving Decisions About Health, Wealth and Happiness*, this is such a cross-government fashion that the Cabinet Office has set up a Behavioural Insights Team, and the House of Lords has launched an inquiry into behaviour change.

Perhaps the second edition of Jackie Green and Keith Tones' *Health Promotion –*

*Planning and Strategies* couldn't come at a better time than. Obviously pre-dating this latest policy fad, the field of health promotion has long been concerned with encouraging personal responsibility for health, but the authors more accurately describe health promotion as "health education x healthy public policy". Maybe it's the latter that has been somewhat forgotten in the arguments around 'nudging'. People need a healthy and supportive environment to live healthy lives – something that Green and Tones are keen to acknowledge. Nevermind that Secretary of State for Health Andrew Lansley feels that health promotion is the only aspect of public health worth worrying about; in practice it is about the three pillars of promotion, health protection and healthcare strategy working synergistically together.

This book offers a comprehensive guide to the former without neglecting the latter two. It concerns itself not only with how people make choices, but the reasons behind why they make them. Chapters on the making of public policy, the pedagogy of health choices and the use of the media for mass dissemination of healthy choices are all particularly insightful. Using practical examples, and offering strategic planning advice,



it provides both a theoretical and pragmatic base for public health professionals that will hopefully prove to be a useful reference tool long after the word 'nudge' has left the policy wonk's popular lexicon.

**Peder Clark**

### **Health Promotion – Planning and Strategies (Second edition)**

Jackie Green and Keith Tones

Published by SAGE Publications  
RRP: £27.99



## From the Treasurer

For this edition only I have hijacked the CEO spot in *Public Health Today* as I wanted to inform members about some of the pressures and issues the Faculty of Public Health (FPH) has faced and is currently facing.

When I took up office as Treasurer in 2006, several major and unavoidable cost pressures (such as the implementation of the Southgate Review, the reorganisation of the NHS in England, the loss of Department of Health income) meant we had a recurrent deficit budget of around £100,000. By implementing a rigorous cost improvement programme and major changes to working practices, we managed to restore the budget to

balance. But the pressures did not end there.

Last year, you will recall, we surveyed you on two important issues: firstly your initial thoughts on the Government's white paper, *Healthy Lives, Healthy People*, and then in November on the level of FPH subscriptions for 2011. Both the surveys provided invaluable help in the overall management of FPH as we enter a period of transition and uncertainty. Perhaps the most concerning information we gathered from the first survey was that some 14% of you were considering leaving the specialty over the coming 12 months.

This, coupled with the increasingly bleak financial outlook, led the trustees to commission the second survey and seek views on the level of subscription increase you would find acceptable for 2011. The information gleaned led the trustees to set a budget that operated on a 10% reduction in membership. In addition to this they assumed that grant income would drop in 2011 – both prudent decisions. This has made business planning for 2011 very challenging and has forced FPH to focus on its priority functions.

To meet these challenges the trustees commissioned a review of how FPH operates to ensure that we have a sustainable organisation that is fit for purpose as we move towards Royal College status. We have been fortunate

to secure the services of PricewaterhouseCoopers to assist in this process on a pro bono basis. They have been working with the staff, the trade union Unite and with the trustees in developing a structure that will enable FPH to deliver its core responsibilities and be financially secure as we enter this period of transition. While that work continues, it is already clear that FPH will need to operate with fewer staff.

I am sure you will agree with me that the staff have done a tremendous job in reducing operating costs of the organisation while still delivering a full and demanding business plan – my sincere thanks to them all.

I demit office as Treasurer in July and feel confident that the current review will leave FPH in a position to continue to support you in your profession while securing a degree of sustainability as we work through the many changes and challenges that face public health. My personal thanks for the support that I have enjoyed from you the members during my five years as Treasurer, and also from the FPH team and my fellow officers.

Finally, I wish my successor every luck, an improving economy and a complete absence of health service reorganisations.

**Liz Scott**  
Treasurer

## FPH Annual Conference 2011

**Public Health in a Changing World**  
4 July 2011, University of Birmingham

In Birmingham for the first time, this year the influential FPH annual conference will look at how public health operates in a world of changing structures, different players in public health policy, increasing financial constraints (nationally and globally) and the increasing need for innovation in public health to meet these challenges.

We are in the process of confirming speakers so watch out for announcements in the ebulletin and on our website.

### Early-bird booking

Registration is now open. To secure your place – at an early-bird rate – go to:  
[www.fph.org.uk](http://www.fph.org.uk)

### Poster display and competition

Send your poster applications to us by 31 March, application forms can be downloaded from our website. They can be on any topic but we would like to see posters that fit with the conference theme of Public Health in a Changing World.

So book the date in your diary – 4 July 2011 – and make sure you reserve your place at one the prominent events in the public health calendar.  
For more information visit [www.fph.org.uk](http://www.fph.org.uk)

## Journal of Public Health

IN THIS month's *Journal of Public Health*, Andrew Lee, Jennifer Hall and Kate Mandeville look at whether the UK's public health training programme prepares its graduates to operate in a globalised world and find that it needs to adapt in order to retain its position as a leader in the field.

The journal also publishes research which finds evidence of a strong association between secondhand smoke and stroke, and another paper on preterm delivery and intelligence concludes that there is consistent evidence of reduced IQ in preterm babies.

## Policy updates

### NHS white paper and health bill

As the President's piece outlines, FPH is continuing to work hard on the white paper, pushing for clarity on those all-important details such as the responsibility and accountability of the director of public health, what Public Health England will actually do and how the whole system will work in practice. Updates on FPH white paper work are available from [www.fph.org.uk](http://www.fph.org.uk)

The Government has produced its Health and Social Care Bill – see John Middleton's article on page 13. FPH has voiced its concerns about what it will mean for, not only patients and the public, but also the NHS. FPH President Lindsey Davies said: "It is very important in terms of population health that what is proposed ensures good access to quality services. We don't want to see the changes disrupting healthcare and preventing public health professionals from getting on with the job in hand." Read more in our statement on [www.fph.org.uk](http://www.fph.org.uk) where you will also find a useful summary to the public health aspects of the bill.

### Tobacco



FPH is working with ASH and other health organisations to continue to lobby government not to change its position on point-of-sale advertising and cigarette vending machines. We have co-signed a number of letters to senior cabinet ministers as well as adverts in the national press calling for government to stand firm on its commitment to this important legislation.

### Alcohol

The Government has announced plans to set a minimum price for alcohol in England – but at 21p/unit for beer and 28p/unit of spirits, this falls far short of the 50p/unit minimum called for by leading

health bodies, including FPH. There is evidence that increasing the cost per unit to a 50p minimum would lead to health gains. However, FPH recognised that the move was an important acknowledgement by government that a clear link between the consumption and affordability of alcohol exists.

### Act FAST on stroke symptoms

Every year, around 110,000 people in England have a stroke. It's the third leading cause of death, and there are at least 300,000 people living in England with disabilities as a result of stroke. The Department of Health, working with the Stroke Association, relaunched their Act FAST campaign in March – to again raise awareness of the signs of stroke. FPH supported dissemination of campaign information. FAST stands for:

- Face – has their face fallen on one side? Can they smile?
- Arms – can they raise both arms and keep them there?
- Speech – is their speech slurred?
- Time – time to call 999 if you see any one of these signs.

Further information on stroke can be found at [www.nhs.uk](http://www.nhs.uk)

### Elections in Scotland, Wales and Northern Ireland

The Policy, Advocacy and Communications Department is working with FPH committees in the devolved nations to develop manifestos for their forthcoming elections, based on the *12 Steps to Better Public Health*.

### Media update

The reforms to the NHS and public health white paper continue to dominate the headlines, including concerns from FPH and other leading health and public health organisations on the reforms. *The Guardian* (15/1) reported on an NHS Confederation report, supported by FPH, that issued a stark warning on the potentially damaging effect of the reforms. FPH Vice President for Policy, John Middleton, also raised concerns in *The Guardian* (18/1) that the reforms were distracting people from getting on with the job in hand: "We are using time that could be spent saving lives."

Flu also hit the front pages, and FPH President, Lindsey Davies, took part in a lively debate on BBC Radio 4's *You and Yours* (5/1) which focused on the Government's U-turn on its decision to scrap the *Catch it, Kill it, Bin it* campaign.

John Middleton also gave his view on the public health responsibility deals for Radio 4's *Food Programme* (20/2) which included views from Simon Capewell, a former chair of our Cardiovascular Health Committee.

## FPH Board meeting in Northern Ireland



ON 17 February, the FPH Board held its inaugural meeting for 2011 in Belfast. This marked the first meeting of the FPH Board outside London since the foundation of the organisation in 1972.

The Board meeting coincided with the FPH President Lindsey Davies's first visit to Northern Ireland. Meetings were held with key leading public health figures including the CMO for Northern Ireland Dr Michael McBride and Professor Jane Wilde, Director for the Institute for Public Health in Ireland.

A well attended Northern Ireland Affairs Committee was held for all FPH members based in Northern Ireland. Chaired by Gerry Waldron, the meeting enabled the members to receive a briefing on the state of the three public health domains in Northern Ireland. An interesting presentation from Dr Carolyn Harper of the Public Health Agency was followed by a presentation to Professor Davies who also took questions from the floor. The meeting, held at the Long Gallery, Stormont, was followed by a tour of Stormont buildings.

Professor Davies said: "As a UK organisation it is important that we seek the views of all of our members – holding the Board meeting in Belfast has provided a useful opportunity to learn of the really positive developments in public health that are taking place in Northern Ireland."

Thanks to Gerry Waldron, Local Board Member for Northern Ireland, for his work to facilitate the visit and to the Public Health Agency for hosting the Board meeting.

## In memoriam



### Audrey Trevor Evans MBE FFPH 1920 – 2011

Dr Audrey Trevor Evans followed in the footsteps of both her parents in qualifying to become a doctor – it is thought her mother was the first woman doctor in Cardigan. After various house jobs, Audrey took an internship at Vassar Brothers Hospital, Poughkeepsie, New York,

which included working in a polio unit at the time of the development of the Salk vaccine. On her return, having obtained her diploma in public health, she became an assistant medical officer in Hornsey and Tottenham, rising to Principal Medical Officer for Camden in 1964. She became an area specialist in community medicine (social services) for Camden & Islington Area Health Authority and was an honorary lecturer for the Association for Research in Infant & Child Health. Her colleagues always admired her diagnostic ability and sound judgment, and she was always keen to advance her knowledge of preventive medicine.

She was a great believer in retiring at the age of 60 and used her professional experience and friendly manner to great effect in helping a variety of voluntary organisations make changes aiming to ensure volunteers were well informed and trained to deliver the high standards that were expected of them. Much to her surprise, in 1999, after 19 years of voluntary work, she was awarded an MBE in the Queen's Birthday Honours List in recognition of her services to the community, especially in healthcare in Barnet, London. She felt that "voluntary work was a benefit to retired people" and

said, "I think it helps to keep us mentally alert and physically active, and it keeps me young!"

She loved reading, including the *BMJ*, and over her life attended many medical conferences, visited numerous countries around the world, lectured in America and was an active soroptimist for 50 years. Both her career and voluntary work gave her great pleasure, and she was always delighted to make new friends.

She never married and in the latter years of her life lived near a cousin and family in Gloucestershire.

*Former Principal Medical Officer for Health for Camden, London (born 22 March 1920; qualified London Royal Free Hospital School of Medicine 1946, MRCS Eng, LRCP; 1950 DPH Eng) died peacefully in her sleep on 19 January 2011.*

### Suzanne Collett MFPH 1913 – 2011

Dr Suzanne Collett was a founder member of the Faculty of Community Medicine, the original name of FPH at its foundation in 1972.

She retired in 1978.

## INTERNATIONAL PUBLIC HEALTH ATTACHMENT IN SOUTHERN AFRICA

We are looking for an senior public health trainee who is interested in spending a 6 to 12 month attachment in Swaziland from January 2012 onwards. This is a great opportunity to develop personal public health skills and make a major impact on the health of the population in a rural African region.

### Public health programme

Over the last six years a successful public health training programme has been developed in the Lubombo region of Swaziland through a health partnership between NHS and academic public health specialists in Bradford and Leeds. The programme has been successful in assessing local health needs and planning and implementing community-based TB, HIV/AIDS and chronic disease programmes.

### Training attachment

We are looking for a motivated and dynamic individual who is interested in gaining experience and training in international public health and specifically the implementation and evaluation of TB and HIV/AIDS prevention and treatment programmes. Flights and accommodation will be paid for by the programme, with SpRs seconded on salary from their existing training programme. The programme has been accredited for training secondments by the Postgraduate Medical Education and Training Board.

For further details please contact: Professor John Wright, Bradford Institute for Health Research, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ.  
Email [john.wright@bradfordhospitals.nhs.uk](mailto:john.wright@bradfordhospitals.nhs.uk), Tel: 01274 364279



## IEA WORLD CONGRESS OF EPIDEMIOLOGY

7-11th August 2011 Edinburgh, Scotland.



### CHANGING POPULATIONS, CHANGING DISEASES: EPIDEMIOLOGY FOR TOMORROW'S WORLD

Abstracts are invited on all aspects of epidemiology, especially the conference themes below:

- Global Problems
- Cutting Edge Methodology
- Chronic Diseases
- Neglected Conditions
- Epidemiology and Policy

#### Key Dates:

Abstract submission deadline – Friday 21st January 2011  
Bursary application deadline – Friday 21st January 2011  
Early bird registration deadline – Friday 29th April 2011

For further details on the programme and a wide range of sponsorship opportunities please visit the website or contact the conference organisers:

[www.epidemiology2011.com](http://www.epidemiology2011.com)



In Conference Ltd, 4-6 Oak Lane, Edinburgh, EH12 8XH Scotland, UK.  
Tel: +44 (0)131 550 0235, Email: [epidemiology2011@in-conference.org.uk](mailto:epidemiology2011@in-conference.org.uk)

## Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to the FPH between November 2010 and February 2011

### New diplomate members

Katharine Cole  
Dominique Le Touze

### New trainee members

Balsam Ahmad  
Stella Botchway  
Sarah Carney  
Paul Fisher  
Eleanor Garnett  
Kate Glyn-Owen  
Jonathan Hobday  
Simon Howard  
Katie Hunter  
Jennifer Leslie  
Elizabeth Lingard  
Sion Lingard  
Caroline McLuskie  
Anna Morris  
Katherine Packham  
Meeta Patel  
Sarah Payne  
Richard Pinder  
Amy Potter  
Nirandeeep Rehill  
Lynne Rush  
Suneela Sajjad  
Charlotte Simpson  
Sarah Smith  
Julia Steiner  
Daniel Todkill  
Caroline Tomes  
Dean Wallace  
Claire Winslade

### New members

Victor Aiyedun  
Benjamin Barr

Deborah Chase  
Tim Fielding  
Thomas Hall  
Jennifer Hall  
Joanne McClean  
Krishnarajah Nirantharakumar  
Elizabeth Orton  
Emma Richards  
Vanessa Saliba  
Sarah Scott  
Martin Smith  
Rachel Sokal  
Jennifer Taylor  
Jayne Taylor  
Philip Veal

### New fellowships

Ishraga Awad  
Timothy Dyke  
Susan Elliston  
Diane Halton  
Christine Hill  
Maria Juneja  
Edward Kunonga  
Martina O'Dwyer  
Mark Overton  
Adrian Phillips  
Udeni Premaratne  
Kristina Routh  
Autilia Santaniello-Newton  
Patrick Saunders  
Piers Simey  
Anna Lee Smith  
Christopher Weston  
Stephen Whiteman

## UK Public Health Register

### Through Defined Specialist portfolio assessment

Julie Tolhurst

### Through Generalist Specialist portfolio assesment

Jean Gladwin  
Clare Perkins

### Through the standard FPH Generalist Specialist training route

Alison Bell  
Susan Elden  
Darrell Gale  
Sara Godward  
Susan Hamilton  
Sharon Hillier  
Siobhan Jones  
Sajil Liaqat  
Brian O'Neill  
Rachel Robinson

## CPD reminder – all FPH members

CPD returns for 2010 (or applications for exemption) must be submitted to FPH by 31 March 2011.

[www.fph.org.uk/requirements](http://www.fph.org.uk/requirements)

## Food culture event

THE Food for Life Partnership and FPH are co-hosting a free one-day conference in London on 22 June 2011 about how to sustain vital work on food culture in schools and communities in the transition to a new public health service.

Find out how we can support local public health outcomes relating to children's health, obesity and emotional health and wellbeing.

Email Natasha Moseley at [nmoseley@soilassociation.org](mailto:nmoseley@soilassociation.org) or call 0117 987 4582. [www.foodforlife.org.uk](http://www.foodforlife.org.uk)

## Good news for recruitment

RECRUITMENT for annual entry into specialty training is now well underway. FPH is supporting training programmes through the process.

Indications have shown a very encouraging 40% rise in applications to public health programmes in England and Wales compared to previous years, with approximately 650 applicants eligible to proceed to the assessment phases.

Applications to the Scotland training programmes have seen a

similar, but slightly smaller, 25% increase on the previous year with a total of 41 applicants.

This shows that there is increasing interest in the specialty and its developing role to support the new health structures across the UK. Public health remains an appealing and competitive career option for aspiring professionals.

For further updates please see: [www.fph.org.uk/recruitment\\_2011](http://www.fph.org.uk/recruitment_2011)



## Is this the dawning of a new age? Is public health about to be promoted to a pinnacle of new potential or successfully buried in the backwoods of local authorities, like a dotty auntie at a party, best left in the corner with a glass of sherry? asks Roy Lilley

THE NHS is in a profound predicament, stranded in a no-man's-land of public affection and catastrophic debt. Politicians wish they could get a divorce from this national treasure but, like most divorces, it would be too messy and is bound to upset the kids (read voters). The latest palaver, Lansley's 'liberation', is a costly and ludicrous disruption that will take us in a £3bn circle to get back to where we started.

Think about it. The Department of Health is still going to be there, poised, Damoclean and sinister. There'll be a carbuncle growing on its backside called the NHS Commissioning Board, with more power than God. To do its dirty work, the board will quietly spawn regional sub-committees, and only in hushed tones will the brave call them Strategic Health Authorities in drag. Commissioning consortia will writhe and wriggle and merge, hiring the best management talent and morphing into Primary Care Trusts in all but name.

In other words, nothing will change.

But something has to change. The NHS was born at a time when the average person worked hard, smoked hard and died quietly and quickly at the age of 58.

Today it's a life-support machine for millions living to 80 but dying expensively of something first diagnosed 17 years earlier. And we're nurturing a generation of feral families, overweight and under-educated, producing the next generation in their own image.

The focus has to shift to prevention and

**The NHS is a life-support machine for millions living to 80 but dying expensively of something first diagnosed 17 years earlier**

helping people stay healthier longer. Cue public health. But what works? Smoking cessation? Measured over four weeks? You're 'avin a larf! Obesity clinics? Most people fall off a diet in three months. Give 'em a gastric band and be done with it – it's cheaper in the long run.

No, the only thing that really works is the law. Banning smoking in the workplace

worked. Seat belts in cars worked. Crash helmets worked. Health and safety regulations are a source of amusement, but they work.

The law works. Banning smoking in cars carrying a child would work. Banning transfats would work. Taxing packet foods that hide junk would work. Stopping under 21 year olds from drinking would work.

Public health is at a crossroads. All the easy stuff has been done: adult literacy, clean water, immunisation. The rest depends on how much the Government is prepared to act as fridge police and nanny state.

Can you in public health nudge, cajole, persuade and influence the politicians, commissioners and public in time to stop us eating and drinking ourselves to death? Can the new media of social marketing do a better job than eye-watering taxes, a fine or three months in jail?

Public health is up-front, in the spotlight and ring-fenced. What are you going to do?

### Roy Lilley

*Health writer and broadcaster, former NHS trust chairman*

## Information

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### Editor in chief

Alan Maryon-Davis

### Managing editor

Lindsey Stewart

### Commissioning editor

Suvi Kingsley

### Books editor

Peder Clark

### Production editor

Richard Allen

Our thanks to Suvi and Peder, who have left FPH, for their valuable contribution to *Public Health Today*

### Editorial board

Matthew Day  
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Ashish Paul  
Premila Webster

### Contact us:

news@fph.org.uk

### Address:

Faculty of Public Health  
4 St Andrews Place  
London  
NW1 4LB

Switchboard: 0207 935 0243

Education: 0207 224 0642

Policy & Communications: 0207 935 3115

[www.fph.org.uk](http://www.fph.org.uk)

### Submissions

If you have an idea or a suggestion for an article for the next issue, please submit a 50-word proposal and suggested author to: [news@fph.org.uk](mailto:news@fph.org.uk)

All articles are the opinion of the author and not those of the Faculty of Public Health as an organisation

### Advertising inquiries to Richard Allen at [richardallen@fph.org.uk](mailto:richardallen@fph.org.uk)

