

In this issue

- > Interview with *Spirit Level* author Richard Wilkinson
- > Simon Singh on life after his libel victory
- > Why Henry Featherstone wants more tax on smoking



The magazine of the  
UK Faculty of Public Health  
[www.fph.org.uk](http://www.fph.org.uk)

September 2010

# Public Health Today



**Coming home**

Is local government the place to be?

## Contents

**Up Front** 3

**Interview with Richard Wilkinson** 4

**Special Feature: Local Government and Health** 6

Building new bonds 6

It's local action that drives public health in Europe 7

Let's grab this chance to work more closely 7

Debate: Is local government the home for public health? 8

Protect and survive 9

'It's important to avoid a silo mentality' 10

Councillors can take the public with them 10

Breaking the barriers 11

Ghosts of the past 12

The ins and outs of health outcomes 13

How Glasgow has improved health through spatial planning 13

The pleasures and pitfalls of a unified public health service 14

'It helps to see it as one job not two' 14

**Books & Publications** 15

**Endnotes** 16

**Noticeboard** 19

**The Final Word** 20

## Welcome

**M**y first months as President have been an exciting and demanding experience. First there was a hugely successful annual conference on 7 July, which attracted a record number of delegates, provoked an enormous amount of useful discussion and generated a number of newspaper headlines following Secretary of State Andrew Lansley's speech. If you weren't able to attend the conference, you can catch up by listening to various sessions on our blog: [www.betterhealthforall.org](http://www.betterhealthforall.org).

Almost immediately after the conference, the Government launched its NHS White Paper for England, and by now you should have completed the FPH membership survey and perhaps even seen the beginnings of some of the changes that it intends to bring about. The papers released by the Department of Health surrounding *Equity and Excellence: Liberating the NHS* have been dominating the thoughts of most public health people in England for the past two months or so. They will have profound implications for public health. FPH is committed to responding to these robustly and thoroughly. Your guidance and advice is vital to this process.

Our themed section on local government in this issue of *Public Health Today* grapples with some of the thorny issues presented in those papers. Joint appointments have long been a feature of the public health system, but not for over three decades have public health specialists been given such top billing in local government. We examine where this integration has worked well, both in the UK, on pages 13 and 14, and abroad, on page 7, what it is like to work in local authorities, on page 14, and, on page 12, what we can learn from pre-1974 experience. This is a timely discussion as policies around the 'public health service' for England are crystallised and the new public health system it supports begins to take shape. On page 8, two public health specialists set out the arguments for and against making local government the home of public health.

I have been engaging with the process by meeting ministers and senior officials both privately and in the full glare of a



King's Fund debate on what place public health should have in this new landscape. Work will continue with politicians and the Department of Health in the next few months, not just on this White Paper, but also the forthcoming one on public health. We are aware that if we don't engage now, we are at risk of being left behind as change sweeps all around us.

One of our strengths as a UK organisation is the ability to draw on the experience of all four countries in developing our policies and responses. Public health services in Wales and Northern Ireland have recently undergone similar transformations, and we will be examining those lessons as we work to shape the future in England.

Alan has done a tremendous job as President, not least in putting FPH firmly on the media map and in setting us on the path to college status. FPH staff and officers are working hard at this and will soon be applying formally to the Privy Council. This is great news and an important step towards our becoming a Royal College which I am determined will be widely respected:

- for setting high standards
- for assessing standards robustly
- for helping its members attain and maintain those standards
- for supporting its members in their daily work
- as an authoritative public health voice.

I look forward to working with you to meet the challenges ahead.

**Lindsey Davies**

# How Singh became the face of the libel law reform campaign

**Science writer Simon Singh tells Suvi Kingsley about life after libel action and the importance of knowing when to eat humble pie**

A lot has happened to Simon Singh this year. In April he won his appeal over a high-profile libel case brought against him by the British Chiropractic Association. A month earlier he'd become a dad for the first time. The tireless campaigning and the sleepless nights have clearly had an effect on him. Sitting in a central London cafe, he looks a little dazed.

But mention the word libel and Singh gets fired up. He is hopeful that in the next 18 months the Government will reform English libel law, regarded by many as archaic: "Of course no-one wants to get rid of libel law, but there has to be a balance between one's right to reputation and another's to free speech. Right now the law is on the side of the claimant, and hostile to those who want to speak out, such as scientists and academics."

It wasn't just the science community which stood up for Singh. Celebrities such as Stephen Fry have added their names to the now 50,000-strong list of signatures petitioning for change. Why such widespread support? Singh is visibly humbled. He thinks it was the devastating preliminary ruling against him that shocked

**“The law is on the side of the claimant, and hostile to those who want to speak out, such as scientists and academics”**

people into realising that English libel law could be used to silence, not just spurious tabloid allegations, but genuine scientific debate.

"One case will never change the law," he says and brings up the "horrendous" action against the cardiologist Dr Peter Wilmshurst, which is still ongoing after two and a half years. "Who wouldn't get scared by what's happened to Dr Wilmshurst, an award-winning scientist? He disagreed with research by an American company at a conference in America and



**FIRED UP:** Simon Singh says the law stifles debate

his comments were reported in an American online journal. But he was sued on English soil because of our flawed libel laws," Singh says.

"The situation is such that editors are too scared to speak out. Scientists are self-censoring before they write anything. For the half a dozen court cases involving science in the last year or so, there are 10 times as many settled out of court, and 100 times as many where editors water down papers before publishing them for fear of a libel action. This affects the public's right to have access to information. That's the chilling effect of libel law in England," he continues.

But Singh is ultimately optimistic about the future of scientific debate: "Most lawyers and judges back reform. It will happen." But until then Singh's advice to other scientists is to be careful. "If you are facing libel action, you need to get serious legal advice, and if it is to back down, apologise and eat humble pie, then do it."

The case has meant a mighty burden of stress for Singh, a year lost from his career, and, what is more, it is likely to leave him £40,000 out of pocket. Now he's intending to continue campaigning for libel reform and catch up on the huge backlog of work. "And that," he says wryly, "is a happy ending. Not everyone is so lucky."

## News in brief

**Young gay men ignoring HIV warnings, study says**

Public messages and campaigns about the dangers of unsafe sex do not appear to be getting through to young gay men in Europe, *The Guardian* reports. By investigating the genetic profile of the virus in more than 500 newly screened patients over nine years, scientists in Belgium have identified clusters of people with type-B virus – not the one that is most prevalent in Africa. Those infected are almost all white, male, gay and young and also tend to have other sexual diseases which suggests that they practise unsafe sex.

**Health boards 'should have licensing powers like police'**

Health boards will be given powers to object to a drinks licence under government plans to enhance Scotland's campaign against the damaging effects of alcohol. Justice Secretary Kenny MacAskill told *The Herald* an amendment would be brought forward to the Alcohol Bill that would include a proposal to put health boards on a footing with the police in notifying them of all licensing applications.

**Greece bans smoking in public spaces**

A ban on smoking in enclosed public areas has come into force in Greece. Offenders will be fined up to €10,000 (£8,260), and tobacco advertising will also be prohibited. Some 42% of Greeks over the age of 15 smoke, well above the European average of 29%. The campaign will include the distribution of anti-smoking board games to children.

**Two per minute admitted to hospital over alcohol**

The number of hospital admissions caused by alcohol has risen by two thirds in the past five years because society is "turning a blind eye" to Britain's drinking culture, public health experts have warned. At least a quarter of drinkers in England are exceeding healthy weekly limits for alcohol consumption, said Mark Bellis, director of the North West Public Health Observatory. There were 954,469 alcohol-related admissions in the year ending March 2009.

**Share your experiences**

Recently completed an interesting or challenging piece of work? FPH members are being encouraged by the Public Health Commissioning Network to share lessons learned during the process with colleagues around the country, through an online 'Casebook'. Entries need only be brief, but are an excellent way of sharing knowledge. To view the Casebook and submit an article visit: [www.phcn.nhs.uk/casebook](http://www.phcn.nhs.uk/casebook)



His bestselling book *The Spirit Level*, co-written with Kate Pickett, argues that inequality adversely affects health on every level of society. Here Richard Wilkinson tells *Public Health Today* how he hit upon the idea, what he says to his critics and whether his warnings are being heeded

**What was the motivation behind writing *The Spirit Level*?**

It came out of research on the social determinants of health over the last 20 or 30 years. It combines the growing awareness of the important psychosocial links between health and social position with research I had been doing on income and health. The shape of the relationship between individual income and health made me think that more equal societies might have better health, but when I first looked at the data the relationship was much closer than expected.

Our book is not, as some people have dubbed it, a theory of everything; it's a theory of problems with social gradients. A lot of people imagine that social gradients in different problems result simply from social mobility acting as a sorting mechanism so that the vulnerable end up at the bottom and the resilient at the top. But that cannot explain why we found problems with social gradients to be anything from twice to 10 times as common in more unequal societies.

The other common view is that these problems are caused directly by material circumstances – by overcrowding, damp housing, poor diets or air pollution. However, the fact is, among the most affluent nations, average living standards are no longer a key determinant of health or wellbeing. But almost all the problems with social gradients seem to be sensitive to the scale of inequality within each society. I think we have to regard them as responses to social differentiation itself. That's the key to our work.

**Does that build on Peter Townsend's work?**

Yes, in that he recognised the importance of relative income and relative poverty. But we differ a little: Peter emphasised the importance of social participation, whereas I think it has more to do with our concern for status – the effects of ranking systems in many primate species.

Members of the same species have the same needs, so there is always potential for an Hobbesian conflict of 'each against all'. But as well as having the potential to be each other's worst rivals, human beings can also be each other's best source of co-operation, security, assistance, love and learning. Social hierarchy, like pecking orders among animals, is fundamentally about the pursuit of self-interest and power to gain access to scarce resources. Friendship is the opposite of that. It involves recognition of each others' needs and is marked by sharing and mutuality. This is the root of the human sensitivities which crop up repeatedly in the social epidemiology: friendship as protective of health and low social status as damaging.

**It's not just about deprivation, it's about social hierarchy.**

Yes, even if the whole society was three times as rich, inequality would be just as divisive. Although about 80% of Americans below the Federal poverty line have air conditioning and a third have dishwashers, they experience even more of the problems associated with low social status – such as violence, drugs, shortening life expectancy and teenage births.

**There's been a lot of criticism recently of *The Spirit Level*. You've responded extensively on the Equality Trust website, but could you provide a concise rebuttal?**

Basically, our critics argue that the relationships between inequality and various health and social problems reflect the influence of outliers or selection of countries. But actually we use the same set of countries throughout all our analyses. Countries are only missing when an outcome measure is unavailable from the source. However, our work should not be seen as just a collection of individual relationships between inequality and different outcomes. What we are showing is a repeated pattern across different problems with social gradients. At one point we combine them all into one Index of Health and Social Problems. If you take the countries they complain are outliers in one analysis or another – Scandinavia, USA, Japan and so on – and exclude them all at once, our index is still significantly related to inequality. It is galling to be accused of cherry picking the data when we have an absolute rule not to do that, and our critics then try to falsify our work precisely by selectively removing or adding data points.

Another tactic our critics adopt is to pretend we are the only people ever to have demonstrated any of these associations and therefore criticism of our work removes all the evidence. The relation between inequality and health has been demonstrated in over 100 papers using data from different settings – from the

It is galling to be accused of cherry picking the data when we have an absolute rule not to do that, and our critics then try to falsify our work

regions of Russia or China to the counties of Chile. Similarly there must be 40 or 50 papers reporting relationships between violence and inequality. Even if they were valid, criticisms of our work would be irrelevant to the rest of this work. One is left thinking, "Which Chinese provinces would they want to exclude to make these relationships go away, and what excuse would they invent for excluding them?"

**It's interesting that the criticisms are not from epidemiologists.**

It comes from political sources. A recent work by one of our critics was a diatribe against tobacco control and the evidence on secondary smoke. I've just been reading a book by Oreskes and Conway called *The Merchants of Doubt*. It documents the attempts to undermine the evidence on climate change, on acid



# The great leveller

rain, on second-hand smoke and so on. The same individuals and institutions were often involved in each of these campaigns. They are a serious obstacle in the relationship between science and public policy and very different from the important and legitimate role of academic criticism.

**David Cameron has made reference to your book, but do you think the Coalition Government has taken on the challenges in *The Spirit Level*?**

Most of it will be no more than lip service, but I'm glad Cameron is setting an example by not taking all his own salary and has proposed a maximum of a 1:20 income ratio for the public sector. If you think back to Thatcher and how she helped inequality to rise by lowering top tax rates and weakening trade-union power, then his position represents an important shift. Most of it has happened since the financial crash and reflects a powerful shift in public opinion. There may be serious difficulties for the Government if it insists on very major cuts which are seen as 'unfair'.

**You wrote a booklet in the mid-1990s called *Income and Health* and concluded that, without significant income redistribution, there was not much that could be done to address health inequalities. Is there anything beyond that that can help?**

Although inequality affects the poor most, greater equality benefits even the better off. This means greater income equality doesn't do quite as much to reduce health inequalities as you'd expect. More equal countries tend to have much smaller absolute differences in death rates between social classes but the relative differences maybe almost as large as elsewhere. That's important. When Britain had the presidency of the EU, the Government asked Johan Mackenbach to review health-inequalities policy throughout Europe. Although he concluded that Britain had the best policy,

we know that health inequalities haven't narrowed much. Many of the attempts have tried to stop income differences affecting health, rather than reducing relative deprivation itself. The mistake we in public health have made has been to talk as if the health benefits were the only benefits of greater equality. We should be making common cause with people working on violence, drugs, teenage births, education and all the others. Inequality affects them all.

**Do you think health inequalities efforts are just fiddling around the edges then?**

No. In parts of our society things are really falling to bits. On the worst estates there are high levels of crime, mistrust, educational failure, drugs, lack of cohesion and fear. Anything that can help put the pieces together again is important, and some interventions have been shown to make a real difference. But unless we reduce income inequality we will need expensive and inefficient remedial work forever. Instead, we should try to improve the quality of life for everyone, by reducing income differences in the population. Until then, sticking-plaster interventions are necessary.

**You triggered the Black Report. Have we learnt anything since then?**

A huge amount! Before then you could talk to doctors and senior people in the NHS and they didn't know whether class differences in death rates were higher at the top or the bottom. Now, everyone knows. There's been a constant trickle of information into the media which has slowly changed public perceptions. There's been a rising tide of awareness. Although from time to time there have been reversals in policy, the general trend is in the right direction.

**Interview by Peder Clark**



# Building new bonds

This special feature looks at the implications of plans to place public health within local government and the new partnerships that must be formed as a result

Public health in England is set to return to its 19th-Century roots in local government. This issue's theme explores what this could mean in the early 21st Century.

We must not allow organisational change to take our eye off the ball – that of reducing health inequalities. Many of our contributors' pieces stress the major opportunity to reinvigorate the influence of local government on the wider determinants of health. It could be, as the Marmot Review put it, a chance to change "the conditions in which people are born, grow, live, work and age".

History suggests this may mean a political revival of local government as the, in John Ashton's words, "convenor, leader and community organiser" in responding to health-related social and environmental concerns. Indeed, opportunities may abound. Public health specialists may have a chance to exert influence across all local authority priorities. Public health departments could become the focus for ensuring the provision of multidisciplinary frontline services, ranging from child development to environmental health. Enabling national and local legal frameworks (a new Public Health Act?) and other regulatory tools could provide the means for developing and assuring public health quality standards.

Some of the articles suggest that this 'reinvigoration' or 'revival' might be a natural next step in many places where organisational boundaries have already



Amanda Killoran and Andrew Furber are the guest editors for this issue's special feature on local government and health

been decreasing in importance. The experience of Public Health Wales suggests a new unified public health service can ensure that a comprehensive set of public health resources and expertise can be organised and effectively deployed. We also look to Scotland for possible lessons to be learned and examine what approaches other European countries have taken.

But our contributors have also raised many legitimate questions about how public health fits into the whole, newly configured system. For instance, the public health role in commissioning healthcare in England remains unclear. Neither do we know what implications the eroding of organisational boundaries, as mentioned by Tony Hunter, will have on public health teams.

Alan Maryon-Davis, on the other hand, warns of the complexity of linking public health budgets to achievement of outcomes and the potential for widening inequalities. Although ring-fenced public health funds may sound attractive, this could be the crucial factor that takes our eye off that all important ball.

**Dr Amanda Killoran**  
Public Health Analyst  
National Institute for Health and  
Clinical Excellence

**Dr Andrew Furber**  
Director of Public Health  
Wakefield District

# It's local action that drives public health forward in Europe

There is no homogenous approach to how public health is organised – or even how it's defined – across Europe. A European Commission study mapping capacities for public health across the EU member states, run by EuroHealthNet and other leading international networks, will report within a year. It should provide a basis for future investment and planning, although responsibility for organisation and delivery of services remains firmly with the member states. Transferability is a major issue for international considerations: despite myths about the single EU model, there are at least four economic and social models identifiable within the EU.

The national ministries of health remain the dominant force in setting policies and strategies, although their remit is differently defined within and beyond healthcare systems and often include welfare elements such as family or social policy. The WHO Europe Tallinn Charter process demonstrated the difficulty with finding common definitions, and of course most EU states operate and fund systems differently from the NHS anyway. However, everywhere there is a significant and growing role for sub-national governance and multi-stakeholder delivery processes, particularly in promotion and behavioural aspects. Core public health protection measures are variably, but statutorily, provided with increasing reference to European requirements or standards.

Devolution of responsibilities in the UK mirrors powers of autonomous authorities at regional levels in Spain, Germany, Italy and more lately France. Regional governments play a crucial role and are increasingly recognised in the EU context as the responsible tier in service provision. Many states support powerful foundations or institutes at national and regional levels. Decisions in England concerning regional bodies plus reviews of national agencies raise questions about strategic decision-making and implementation beyond the Cabinet. A projected 'national public health service' would be watched with interest elsewhere.

The role of such bodies, usually but not always located in the health sector, includes monitoring and coordination of research and policy based on strategic frameworks or targets, such as in Finland



or Sweden, and bringing together regional or localised initiatives through committees, review bodies or specialist networks, such as in Spain or Germany. The effectiveness of these processes is variable. Evidence of outcomes is often lacking when comparative studies are made, so measures to judge progress, alongside social and care outcomes and the metrics applied, will be of particular interest abroad, especially to those envious of NICE.

But initiatives depend on local levels, where public health is grounded, and finds synergies with other sectors. There is growing evidence from WHO Healthy Cities, or from EU networks such as Eurocities or European Regional and Local Health Authorities (EUREGHA), of powerful mayors, authorities or specialist organisations driving actions based on specific circumstances. From environmental protection in German municipalities, through community mental health provisions in Spain, food and health in rural Slovenia, housing migrant communities in Hungary, service access in northern Italy or chronic disease reduction in Scandinavia, it is local action that can be said to be driving public health forward amid relatively little evidence of lasting national campaign success.

Given few examples of successful scaling up, huge questions remain about structural drivers of health and social equity and how to optimise public health. But we can increasingly examine what works. Whether policy makers use evidence-based choices is another matter.

**Clive Needle**  
Director and Policy Advisor  
EuroHealthNet

## Let's grab this chance to work more closely

At the dawn of yet another reorganisation of public health, I would like to indulge in a little wishful thinking in the hope that we can learn from the past and carry the best of previous experience into the future.

Before 2003, many consultants in Communicable Disease Control (CCDC) worked alone. Today the main source of health protection advice to local authorities and healthcare trusts is merged teams of medical, nursing and information personnel employed by the Health Protection Agency (HPA). These units provide better service resilience and geographical coverage and allow access to regional and national microbiology, immunisation, and chemical and radiological expertise.

On the downside, having health protection in an arms-length body, separate from other public health services, means that its practitioners have no real power. A return to closer working with Directors of Public Health (DPH), as was the case pre-2003 with the DPH and health protection team accountable to the same body, should avoid duplication and empower both to work to their strengths. Nothing is more frustrating than a DPH being diverted from an already full schedule to organise an urgent screening or immunisation intervention, while a CCDC with many years' experience can only stand by and advise.

This frustration is even greater in regard to local authorities. Although CCDCs have usually been appointed as Proper Officers for the purposes of communicable disease control, their ability to influence local government policy has been even more limited than in the NHS. If they are working closely with a local authority-appointed DPH, there is a major opportunity for input into the prioritisation of local authority work in, for example, the investigation of food-borne diseases, emergency planning and Port Health at a time of severe budgetary restraint.

I have one final wish. Now that the political structures are in place, a fully integrated IT system allowing data from local authority, NHS and public health sources to flow securely between organisations could dramatically increase efficiency by producing 'information for action'. But that is just a wish.

**Sally Millership**  
President  
Public Health Medicine Environmental Group

## DEBATE: Is local government really the natural home for public health?

Paul Edmondson-Jones and Corinne Camilleri-Ferrante put forward the arguments

## Health must be improved via local democracy

Local government is undoubtedly our natural home and where we belong – advocating, influencing, championing and leading programmes to improve the social determinants of health, such as housing, education, employment and crime. We have somehow managed to survive the past 25 years in the NHS – never at ease, never certain of our role or position, always vulnerable to the uncertainty of organisational change or financial challenge. But we have learned to adapt and have formed natural partnerships, and sometimes some uneasy alliances, that have enabled us to deliver considerable benefit to local populations.

The Association of Directors of Public Health defines the role of the director of public health (DPH) as “to provide public health leadership in partnership with others to ensure that the local population’s

needs are assessed and addressed through public health programmes”. It is surely clear this can only be delivered from within the wider democratic base of the local authority and not the restrictive environment of the NHS.

For nearly 150 years, from 1848 to 1974, the medical officer of health was an integral member of the local authority, chairing the local health board. The move



to the NHS in 1974 significantly reduced the influence and authority of the DPH, although it helped establish and strengthen the integral role of public health in commissioning cost-effective, safe, high-quality health care. Since 2001, that influence and authority has been partly restored by establishing the DPH as a statutory member of the Primary Care Trust Executive and the subsequent

move to joint appointments.

The future NHS will be drastically pruned back to its core function of providing health care to meet the (clinical) needs of the population – to do anything more would be ‘nanny state’. Before it is cut out, public health needs to get out and re-establish itself as a leading force in local government, closely aligned to adult and children’s services. We need to embrace once again the concepts of localism, progressive universalism, personal responsibility, local voice, informed choice and total place (none are new – just re-branded). We need to use the levers of overview and scrutiny, statutory health and social wellbeing boards, joint strategic needs assessment, DPH annual report, and the power of local democracy to further improve the health of the local population and reduce health inequalities from within our natural home in local government.

**Dr Paul Edmondson-Jones**

*Director of Public Health & Primary Care  
NHS Portsmouth & Portsmouth City Council*

## It will be seen as just health promotion

The NHS White Paper for England suggests aligning public health to local authorities, with a view to increasing local accountability and cooperation with other branches of local government. Laudable aims, but is this a sensible, or coherent, approach? I shall argue that it is not.

Public health is, fundamentally, about populations. We strive to improve health by promoting healthy choices, by protecting populations from diseases and by ensuring that, when ill, they can receive high quality healthcare. And we do this within the cost envelope provided by the state from general taxation.

I see three potential challenges in aligning public health with local authorities: that it will cease to be seen as an integral and important part of the NHS; that it will come to be seen as

synonymous with health promotion and lose the other two arms; and that it will fragment.

The White Paper portrays the NHS and public health as separate entities. Removing the public health voice from the outcome quality agenda is potentially disastrous. Who, if not public health, has the skills to assess the outcomes for patients (not diseases) and weigh them with affordability?



By removing them, we are in danger of allowing the NHS to become the treatment arm of a health service driven by ever increasing demands from secondary care.

There is a possibility that public health will come to be seen as just health promotion. If commissioning is seen as a GP responsibility, and health protection moves back to the Department of Health, public health

departments in local authorities will be left with the inequalities agenda and health promotion. While this work is essential and core public health, it is not all of public health.

Which brings me to fragmentation. Splitting an already small and overstretched workforce into separate parts is a retrograde step. One value of public health has always been that the whole is greater than the sum of its parts. Thus we enhance and support each other’s work, reducing duplication while continuing to learn from each other. This is a real advantage.

Public health is a robust and resilient speciality, and the work is there to be done. Whatever happens, we shall make it work. But I believe that a strong department of public health, seen as a core NHS service, remains the best model for a coherent and effective service.

**Dr Corinne Camilleri-Ferrante**

*Consultant in Public Health  
Medicine  
Derbyshire County Primary Care Trust*



# Protect and survive

The London Olympic Games are just two years away but one of the key players is under threat. We must protect health protection, says John Middleton

I opened my copy of the Health Protection Agency's (HPA) first Olympic newsletter the same day the arms-length review came out. With two years to go to the greatest show on earth, the Government casts a doubt over one of the principal agencies charged with public protection. The HPA staff, who should be devoting all their attentions to planning for terrorist outrage or for the communicable diseases associated with the mass movement of people, will undoubtedly be preoccupied with their personal and professional futures, joining, dare I say, the 'NHS uncertainty club'.

In parallel, the transformed community service of London looks like a fractured, multicoloured mosaic, with every available combination of management being pursued in time to be at its least coherent for the Olympics. There will be community foundation trusts, mental health-led and hospital-led community trusts and a social enterprise or two. Primary Care Trusts (PCT) will still be responsible 'Category One' responders, but will have no power, troops or resources to coordinate or command anything.

The public health community needs to support and protect national specialist expertise in health protection. We need to have capacity for the major national incidents that demand it – the Buncefields

and Litvinenko – but health protection at local level cannot grind to a halt for low risk, high profile national incidents.

The new public health service must restore the connection between the highly professional HPA and the managerial ethos of local public health. Managing outbreaks has always been about communications, mobilising resources and politics, once you know what the microbiology is.

Health protection needs to reconnect with the common, undramatic infections of everyday public health: STIs, scabies, immunisations, TB and so on. So yes, we need the presence of our local consultants in communicable disease control.

Local public health practitioners need to maintain and develop their health protection skills and competence. But the whole health system must see health protection as important. We need to develop expertise in GP commissioning for infection control and immunisation. The recent bleating by foundation trusts that they can't meet infection targets is indefensible, sitting as they are on £3 billion of unspent taxpayers' cash.

We need high-quality intelligence for infection and environmental hazards. And we need a serious outcome focus: levels of TB are a national disgrace and we must set ambitious goals for reduction. We could eradicate measles and hepatitis B.

Local authority relationships should be strengthened through the new public health service. Public and environmental health services should reunite. The 'cleaner, safer communities' agenda is common to us – people don't take exercise in unsafe, dirty communities. Air pollution is still a major cause of coronary deaths and is now almost entirely related to traffic. Land contamination will limit local efforts to develop community food growing projects.

Finally, there is the much bigger question of resilience and climate change – the goals of reducing carbon emissions apply to health promotion and health protection. Healthy, caring communities with good housing and education will be less reliant on cars, imported food and paper money and will be more resilient in the face of food and water shortages, fuel strikes, extremes of weather and the collapse of the banks. The commissioner/provider split in UK health services looks ever more ridiculous in the context of climate chaos, superbugs, civil unrest, financial instability and population ageing and movement. 'Big public health' needs to be a united front and argue and plan for healthier, more resilient and safer communities.

**Dr John Middleton**  
*Director of Public Health*  
*Sandwell PCT*



Tony Hunter (Picture courtesy of North East Lincolnshire Council)

## 'It is important to avoid a silo mentality'

**Public health in North East Lincolnshire has been within the council since 2007 as part of an innovative Care Trust Plus arrangement. Guest editor Andrew Furber asks Chief Executive Tony Hunter about the lessons for other local authorities**

**What were your expectations when you took public health into the council?**

The move was a natural extension of our view that organisational boundaries were withering away. The council recognised that health improvement was critical to the future of North East Lincolnshire and that having a public health perspective informing the full range of council priorities was going to be really important.

**Is there anything, with hindsight, you would have done differently?**

We have some excellent public health staff who have really contributed to our agenda. It may have helped them in the early days if we had emphasised how irrelevant organisational boundaries have become, such as using the NHS brand where this adds value and gives the public confidence.

**Any pitfalls other local authorities should be aware of?**

Avoid a silo mentality. The term 'public health' can be a bit of a turn-off because it risks conceptualising the function too narrowly. There is a danger that the public health contribution of other functions, such as housing or employment, is not recognised.

**Budget decisions will be better if they are informed by a public health perspective**

**Have you ever noticed any tensions between elected members' democratic mandate and the public health advocacy role?**

We've had no such tension in North East Lincolnshire. We've had a really good director of public health (DPH) who related well to elected members. Members want to see healthy, vibrant communities, so the skill is in aligning the agendas.

**How can DPHs appointed to councils be most effective corporately?**

Have an outcome focus. As long as health is improving and inequalities reducing, does it matter if this is through better access to leisure facilities or better employment? Councils will have to make some difficult budget decisions, but these will be better decisions if they are informed by a public-health perspective.

**Finally, what is your top tip for local authority chief executives looking at the proposed public health arrangements in England?**

Downplay the relevance of organisational boundaries. Don't let them limit the contribution everyone can play to improving health and reducing inequalities.

## Councillors can take the public with them

Public health is coming home to local councils. The White Paper, *Equity and Excellence: Liberating the NHS*, provides huge opportunities to strengthen local work on health improvement.

The consultation document, *Local Democratic Legitimacy in Health*, sets out the Government's aspirations. It discusses the importance of council leadership for better health: the involvement of patients, carers and local communities, and partnership and integration across public health, social care and the NHS. Through the vehicle of health and wellbeing boards, partners are to assess local needs, promote integration and partnerships for better outcomes, and take on the scrutiny role for service redesign. While the scrutiny proposal has caused anxiety, many of the other proposals build naturally on recent developments and fit well with the Marmot agenda, the new 'localism' and reinvigoration of local government, and the idea of the Big Society rooted in individual, family and community action.

Local councils of all kinds and in all parts of England have been working to improve health for a long time. In spatial planning, housing, economic development, social care, transport, environmental protection, sport, culture and leisure, education, consumer protection and regulation, they have been strengthening the building blocks for good health. They have also been seeking to influence health behaviours across the lifecycle. Local councillors, as democratically elected representatives, know that they have to take people with them when they are seeking to help them change their lifestyles. This is a big challenge. However, they have a wealth of experience. Councils have been involved in health improvement from the emergence of the Healthy Cities movement, through to the Communities for Health pilot and the Healthy Places, Healthy Lives programme.

In the new landscape, councils will have to ensure more comprehensive and systematic effort. There are two new tasks for them: to build productive alliances with primary-care consortia, and to reach new participants, especially in business. *Equity and Excellence* puts local councils right at the heart of health improvement.

**Liam Hughes**

*Vice Chair of UKPHA and National Adviser for Healthy Communities at Local Government Improvement and Development*



# Breaking the barriers

There is a great opportunity for environmental health practitioners to change behaviours and make a difference to public health, says Stephen Battersby

The announcement of a new approach to public health provides challenges but also provides an opportunity to address inequalities and improve the health and wellbeing of all citizens through more effective local strategies. The changes should not be just a cover for expenditure cuts.

Environmental health practitioners (EHPs) are part of the public health workforce whether they work for local authorities or commercial organisations, such as large supermarket chains. Think of the opportunities for these to change behaviours and make a difference to public health in 'the big society'.

Local authorities, it is said, will lead on joint strategic needs assessments (JSNAs) and housing is a key determinant of health. Work for the Building Research Establishment Trust has estimated that hazards in homes cost the NHS alone in excess of £600 million annually. Yet, housing and housing conditions rarely figure directly in JSNAs, and too often EHPs have not been involved. Effective use of the Housing Health and Safety Rating System by EHPs can address the greatest risks arising from housing deficiencies and contribute to improved public health – including public mental health and giving children a better start in life.

In the context of housing, the Chartered

Institute of Environmental Health (CIEH) has been seeking to provide EHPs with the tools to demonstrate the potential contribution to improved public health and encourage joint working with PCTs. Local Government Regulation (previously LACORS) has also tried to provide encouragement and support. Efforts to foster closer working have largely proved problematic, and the proposed changes will need to overcome some of the hurdles

**“The changes will need to overcome some of the hurdles relating to differences in culture and terminology”**

relating to differences in culture and terminology. EHPs currently working in PCTs will have a considerable part to play in this.

The transition may be easier in the unitary authorities, but that also depends upon attitudes. Environmental health has become just a 'regulatory' service for some. A narrow approach means that the potential is not being fully realised. The proposals will provide an opportunity to

unlock this. For instance, a programme called Alive 'N' Kicking has been commissioned by the Sutton and Merton PCT working closely with London Borough of Sutton to tackle child obesity. EHPs can contribute to such initiatives by looking at any housing factors and developing skills for safe food preparation.

The Marmot Review said that tackling social inequalities in health and tackling climate change must go together. In many local authorities, EHPs have been at the forefront of measures to adapt and mitigate climate change. Environmental health addresses other key factors, such as air quality, pest management and vector control, health and safety in the workplace, litter and noise (which impacts very much on mental health). The contribution of EHPs to the ban on smoking in the workplace is well known.

The CIEH has also proposed a Chief Environmental Health Officer for England and a National Public Health Forum to oversee implementation of the Marmot recommendations and the new public health structures since there will be no Audit Commission to monitor this.

**Stephen Battersby**  
*President*  
*Chartered Institute of Environmental Health*



Detail of an 1854 engraving of the Grim Reaper on the dangerously polluted River Thames

# Ghosts of the past

Local government was the birthplace of public health. We must learn the lessons of history if we are to create a system for the future, says John Ashton

The rise, fall and rebirth of local authority public health is now central to all of our concerns. I argue that in moving forward we must know our history if we are to avoid mistakes from the past.

The involvement of local government really began in the 1840s with the advent of the Asiatic cholera epidemic. Then as now, the claim that “if the people lead, the leaders will follow” was shown to be true. The Health of Towns movement, led by community activists from the church and business communities with the odd doctor in tow, campaigned for sanitary reform on the back of Edwin Chadwick’s *Report on the Sanitary Conditions of the Labouring Population of Great Britain*, published in 1842. In 1846, Liverpool passed the local Sanatory (sic) Act giving it the powers to appoint William Duncan as the city’s first Medical Officer of Health who began work in 1847. By 1848, the first Public Health Act was on the statute books – it was to be 30 years before the fragmented, parochial system was replaced by what became the local authority-based Public Health System, not just at home but throughout the British Empire.

The success of industrial towns in organising themselves and mobilising their communities – a form of ‘the big society’ – gave local government the legitimacy to move into the wide range of services that

they subsequently did, taking over areas such as education and social services from the church as they went. Many in local government today seem still to think that the main purpose of local authorities is to provide direct services. This earlier role of convenor, leader and community organiser has been largely forgotten, but may well be due for revival as we explore the public health contribution of local government again.

As a footnote, the use of parliamentary powers and local bylaws by local government to effect health conditions is at last back on the agenda. Examples include 20-mile-per-hour speed limits, closing unruly licensed premises and prohibiting fast-food outlets near schools. Also, Liverpool and other cities actively pursued the use of bylaws during the recent tobacco legislation debate and now Manchester with regard to the minimum price of alcohol.

There are other salient dates in this story. In 1906, child health reforms began, following the Boer War fiasco of unfit working class recruits. Such reforms included school health services provided by local authorities. The year 1911 saw Lloyd George introduce the beginnings of state-provided primary care. The comprehensive tripartite NHS itself was established in 1948: hospitals, family practitioner and

related community health services, and the often overlooked local authority public health departments with their extensive staff of health visitors, community nurses, social workers, environmental health officers and many others, a good proportion of whom currently reside in primary care trust provider units. And then there was the disaster of the 1974 local government reorganisation, which dismantled the public health service on a mistaken assumption that the task was complete, and that the future lay with pharmaceuticals and specialist healthcare. The changes were driven in part by the multidisciplinary challenge of various emergent professional groups within public health departments.

An understanding of the whole public health story is essential if we are to craft a public health service fit for purpose in the 21st Century. Such a service, if it is to be robust and responsive, must be comprehensive, multidisciplinary, integrated and take a whole-systems approach. It is unlikely to be successful, if it is the creature of any one organisation, such as local government, swapping one unsatisfactory situation for another.

**Professor John R Ashton CBE**  
Cumbria Director of Public Health and  
County Medical Officer

# The ins and outs of health outcomes

**Linking public health budgets to the achievement of outcomes could widen inequalities, argues Alan Maryon-Davis**

So, from now on it's going to be all about outcomes. According to the Coalition's draft Structural Reform Plan for the NHS in England, public health funding will be "linked to outcomes achieved in improving health". Local authorities will be rewarded with a "health premium" for tackling health improvement challenges among disadvantaged communities, and for targeting public health resources on those with poorest health.

Precise details and mechanisms are still to be thought through and a draft outcomes framework for the NHS, *Transparency in Outcomes*, is currently out for consultation. But the key principle is that ringfenced public health funding will be distributed through local authorities and geared to success in achieving outcomes, particularly in reducing health inequalities. I'm sure I'm not the only one to see all sorts of problems with this approach.

First is the obvious one of unintended consequences. Rewarding those areas where the health inequalities gap is closing will further stigmatise those areas where it is not. Many Spearhead areas are struggling to close the gap. Are we to understand that in future, unless they do so, they will be stripped of their extra funding and the money diverted to other more 'successful' areas? There's a real danger that the areas finding it hardest to reduce inequalities will repeatedly lose out in terms of resources and will spiral downwards becoming 'sink' areas.

Another issue is the perennial one of measurement. How do you demonstrate success? What outcomes are to be measured? Are the metrics valid in the sense of reflecting what's really going on in the population? To what extent are changes attributable to public health interventions? How sensitive are they? All these questions are particularly pertinent to health inequalities.

For example, mortality-based indices such as life expectancy and all-age-all-cause mortality are notoriously difficult to attribute to public health inputs, particularly changes in health behaviours such as smoking. Based on age at death, they reflect the whole gamut of risk factors and interventions occurring over each

individual's lifetime superimposed on their genetic predisposition. They are therefore essentially historical and, across the population, measure the combined effects of a multiplicity of factors extending back over many years. Very blunt instruments indeed – and certainly not much use for real-time monitoring.

Another problem with outcomes is population 'churn' due to movements in and out of the area. This can be a powerful confounder, particularly in inner-city areas where there is a high level of population mobility. In the London borough of Southwark for example, where I was DPH for five years, about one third of the population came in and went out each year – mostly young families, single people, new migrants and students. Many people who grew up in Southwark would move out to Bromley and other suburban boroughs to bring up their families. Other people, often with higher levels of deprivation, would move in to take their place.

This churn distorts monitoring of public health outcomes. Historical trends in mortality data have to be carefully

**“I'm sure I'm not the only one to see all sorts of problems with this approach”**

modelled with demographic changes to make any sense at all – and even this approach is nowhere near sensitive enough to pick up what's really happening at very local level.

We could be doing all the right things, and doing them really well, but still apparently 'failing' to deliver the health outcomes as currently measured. Very dispiriting for us as public health professionals, but also, if linked to resource allocation, very unfair for our populations.

We need to make sure that the forthcoming White Paper doesn't lock us into an outcomes-based incentive scheme that perversely diverts resources from where they're most needed, and actually worsens inequalities.

**Alan Maryon-Davis**  
*Hon Professor of Public Health*  
*Kings College London*

## How Glasgow has improved health through spatial planning



Glasgow can demonstrate growing success in integrating health considerations into planning. This reflects involvement in the WHO Healthy Cities movement and close working between the council corporate health policy team, the Glasgow Centre for Population Health (GCPH) and the Council's planning service.

A health impact assessment (HIA) of the draft spatial strategy in the East End of Glasgow led to a strong focus on community participation by local residents and specific recommendations that influenced the final strategy. From this experience Glasgow planners developed the Healthy Sustainable Neighbourhood (HSN) model as a spatial planning specific approach to identifying relevant issues and addressing health and wellbeing.

The Glasgow City Council corporate health policy team has an opportunity to influence council policy 'from the inside', and also to lead specific pieces of work such as HIAs of plans for the Commonwealth Games and the Local Housing Strategy. The appointment of a joint director of public health provides high-level leadership.

GCPH aims to generate evidence and provide leadership for action to improve health and tackle inequality, providing greater resource for inter-sectoral work than is available in NHS public health departments.

Willingness within Glasgow City Council to work on planning and health has grown over time as the added value has been demonstrated. Glasgow now has a Scottish Government funded Equally Well site which is testing ways of integrating health considerations into planning processes.

**Margaret Douglas**  
*Chair*  
*Scottish HIA Network*  
**Etive Currie**  
*Senior Planner*  
*Glasgow City Council*

# The pleasures and pitfalls of a unified public health service

**Chair of Public Health Wales, Professor Sir Mansel Aylward, explains what the principality's public health model can teach England**

## What is Public Health Wales?

We are a unified service that includes all public health organisations at national, community and local level, covering public health advice, healthcare quality, health protection, communicable disease control, child protection, surveillance, and screening and registries. We were set up in October 2009.

At local level there are seven local health boards. Each has a director of public health who receives public health support from Public Health Wales. The boards combine NHS Trust provider and commissioning functions. As an NHS Trust, Public Health Wales has a separate budget allocation from government and in addition, health boards commit resources on public health activities.

## What are the benefits of the new service?

The service brings together a wide range of experience, skills and expertise in an organised way to exploit and make best use of the public health resource and expertise. It's exciting and there is a great corporate sense of commitment and enthusiasm across the organisation.

We have direct influence on policy at national level through ministers and senior civil servants as well as delivery at local

**“It's exciting and there is a great sense of commitment and enthusiasm across the organisation”**

level. We also have strengthening relationships with local authorities, academic departments and the third sector.

In October this year, we'll be launching our new strategy for the organisation. The strategy is intended to give much greater focus on reducing health inequalities through action on the wider determinants of health, including transport, housing, employment and education. We wanted to give the issues highlighted in the Marmot

review renewed focus. Early years is an important priority and improving the health of children is seen as a focus for reducing the social and health inequalities over the longer term.

## Could you give me a couple of examples of specific projects?

Early progress has been made in a number of areas, for example on improving healthcare quality. Our 1000 Lives Campaign was set up to improve patient safety and increase healthcare quality to save 1,000 lives and avoid up to 50,000 episodes of harm in healthcare in two years. Public Health Wales also demonstrated an effective response to the swine-flu pandemic.

The Supporting People programme is an example of how Public Health Wales is working with local government and the Welsh Assembly on housing issues. The programme is supporting many disadvantaged groups living independently in their own homes, including those who are mentally ill, older people, those involved in alcohol and substance misuse, and ex-prisoners.

## What are the pitfalls?

A difficulty for the service is its wide span of responsibilities and the potential for resources to be spread too thinly, and therefore prioritisation is critical.

An important challenge is that Public Health Wales is a discrete organisation still separate from local government. However, we are working hard to strengthen relationships with local authorities. I understand the sound rationale for the proposed move of public health to local government in England.

## What are the lessons for England?

It's important to understand that Wales is a very different country and our approach does not necessarily transfer to the English situation. Wales is small enough with a population of just under three million to allow Public Health Wales to have a role in both influencing national policy through direct links with ministers as well as delivering locally in communities.

Furthermore, Wales has a very different political context to the Coalition Government in England. As a nation, Wales has a distinct heritage and sense of identity which brings a sense of joint commitment among partner agencies.

However, Public Health Wales shows how public health experience, expertise and capacity can be organised in a focused and cost-effective way to have real influence and impact. But the measure of our success will be the impact on closing the gap in health inequalities.

**Interview by Amanda Killoran**

# 'It helps to see it as one job not two'

## A Day in the Life of...

**Chris Bull, CEO of Herefordshire Council and Primary Care Trust**

### 1. What's on the agenda for today?

I'm going to lead a debate this afternoon about spending reductions in the autumn.

### 2. What do you spend most of your day doing?

Talking to local politicians, the NHS, senior managers, the public and outside organisations. I also try to make time for frontline staff.

### 3. Is there such a thing as a typical day?

No. I might start the day with talks about the big regeneration project in Hereford City and finish off with planning the delivery of community health services.

### 4. How do you juggle the responsibilities in both jobs?

It helps to see it as one job, not two. Like any senior management post, I'm in charge of helping people with development and strategy.

### 5. What keeps you going?

The job's fascinating and it has the potential to make a difference.

### 6. What do you lose sleep over?

I don't!

### 7. How do you get your teams to work together?

Encouraging them to talk to each other and to understand their common objectives.

### 8. Do you think integrating health services in local government is a good idea?

Yes, but it's important that it isn't seen as a take-over, but as the health service and local government working together towards their common objectives.

### 9. Any tips for public-health staff for making the most of local government relationships?

Respect the views of local politicians, talk to people to understand what local government can add to the public health debate. Try hard not to be defensive.

### 10. How do you relax?

Sailing and watching Arsenal.

**Interview by Suvi Kingsley**

## Saving working children is a labour of love

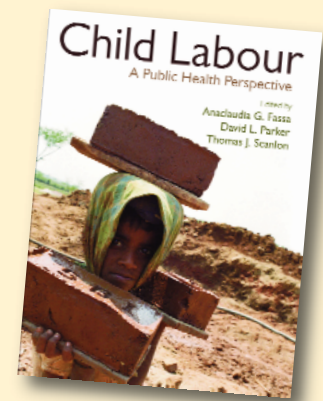
To many of us based in the UK, the term 'child labour' will evoke faded images of soot-covered children working in mines during the Industrial Revolution. But far from being confined to Victorian Britain, child labour remains a significant issue across many parts of the world today.

*Child Labour: A Public Health Perspective* provides an insight into this complex issue which spans disciplines ranging from public health and education to law and economics. Children have always worked, both within and outside of the home, and in an appropriate environment, work can be conducive to children's development and their transition into adulthood. But mostly, child labour is problematic and causes significant mental, physical and emotional damage. Estimates suggest that worldwide, there were 211 million working children aged 5-14 years in 2004, and, unsurprisingly, the majority of this burden

is carried by deprived and low income populations.

Enforcement of national and international legislation against child labour is variable, but rather than point the finger at lax governments for ignoring the issue, the authors acknowledge the many interacting and conflicting forces at play. Using a series of case studies, they illustrate the role that local culture, societal norms and economics play in driving and perpetuating the existence of child labour. Insightful examples are given of situations in which families living on the brink of poverty have no other option but to send their children to work. In some regions, cash transfers to families of children who attend school have been successful in reducing the prevalence of child labour, but the authors warn against one-size-fits-all approaches. Long-term and sustainable solutions, they argue, will require multi-agency action which takes account of local cultural and economic contexts.

The authors, whose backgrounds range from public health through social work to economics, are united not only by their expertise in child labour but also by their rights-based and life-course approach to their analyses. They succeed in highlighting the central issues without overlooking or downplaying the



overarching complexities involved.

Their book makes a compelling case for an important public health issue requiring urgent and multi-organisational action.

**Gracia Fellmeth**

### **Child Labour: A Public Health Perspective**

Edited by Anaclaudia G Fassa, David L Parker and Thomas J Scanlon

Published by Oxford University Press  
ISBN 978-0-19-955858-2  
RRP: £29.95

## Fiery Dorling preaches to the converted

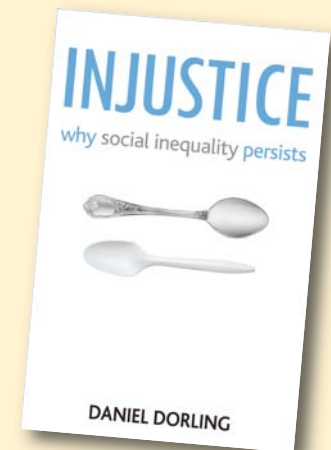
Reading the recent press coverage of the attacks on this month's interviewee Richard Wilkinson and Kate Pickett's *The Spirit Level*, I was struck by a particular phrase that Wilkinson used. He feared that the criticisms from right-wing thinktanks scuppered any chance that ideas about inequality would ever escape "from the left-wing ghetto". Danny Dorling's latest tome doesn't do much to allay those fears. Unashamedly partisan, *Injustice* is a polemic, preaching (albeit convincingly) to the converted.

That's not to say that it's not a well-delivered sermon. Dorling's prose is passionate, punchy and peppered with examples and pop-culture references. For a concise primer on the roots of inequality, and why it matters, there is little better. In the wake of swingeing public sector cuts and a Coalition budget that the Institute for Fiscal Studies damned as "regressive", certainly the publication of *Injustice* could

not be more timely. Persuasive arguments about how deficit reduction measures should not widen our already gaping inequalities are sorely needed. Dorling's thesis is that injustice is ingrained in a society where "greed is good" and prejudice against immigrants or the poor is natural, and Dorling certainly has the evidence, and compelling anecdotes, to back these assertions. Dorling is a geographer by training, but *Injustice* leans more towards a historical treatise. Impressively drawing links between everything from depictions of the Victorian poor, to the mapping of contemporary global income distribution, it's an impassioned and informed plea for greater social justice.

However, *Injustice* will do little to persuade naysayers. There is scant effort to disguise the indignant tone of Dorling's voice, and this haranguing tenor can become quickly tiresome, even for those sympathetic to his presentation of the evidence. Where Wilkinson and Pickett's analysis is cool and calm, Dorling's is fiery and fuming with barely suppressed anger at those he holds responsible for the prevalence of "injustice".

As he revealed in the last issue of *Public Health Today*, Dorling has had audiences with both the current and present administrations, but one is left



wondering if the important messages contained in *Injustice* might be even more influential if they were couched in less strident terms.

**Peder Clark**

### **Injustice: Why Social Inequality Persists**

Daniel Dorling

Published by Policy Press  
ISBN 978-1-84742-426-6  
RRP: £19.99



## From the CEO

As we head out of the summer, there are uncertain times ahead. Public health is to be reorganised once again. The Government's plans for the NHS and a new 'public health service' mean that FPH has a vital role to play in helping to shape and secure an effective public health delivery service to meet the needs of the population. We have been

working hard to ensure that we influence the expected White Paper on Public Health, to be published later this year. It is important that you as members feed in your views so that these can be included in the negotiations that we are currently having with government ministers. Please contact your local board member or simply write to FPH so that we can fully represent your concerns.

We will be doing all we can to ensure that the future public health service is fit for purpose and can protect the public whilst giving a clear and attractive career structure to public health specialists. We may only have one opportunity to do this — so make sure we know what your thoughts are.

Another area where we continue to move forward is in our application for Royal College status. I am pleased to report that the membership endorsed the Board's resolution at this year's AGM and we are ready to submit our proposal to the Privy Council. We hope to be able to report on our

**We will be doing all we can to ensure that the future public health service is fit for purpose**

progress in early 2011.

We welcome Lindsey Davies, our new President, who has had a busy first three months and is committed to meeting as many members as possible by visiting regions and countries over the next few months. FPH Local Affairs Committees are being arranged to enable this to happen.

FPH will be using its recently redesigned website, e-bulletin and mailings to keep you up to date as developments unfold – but please contact us if there are issues you wish us to raise on your behalf.

**Paul Scourfield**  
Chief Executive

## Policy updates

### Regulation

A recent FPH/YouGov survey reveals a broad consensus for stronger, more decisive government action across a number of public health priorities.

Among the proposals which would receive the highest level of public support are a ban on smoking in cars with children on board (74% in favour), mandatory information about alcohol units and calories on bottles and cans (82%), compulsory two hours a week of games or sport in schools (81%), and a simple front-of-pack 'traffic-light' food-labelling scheme showing fat, sugar, salt and calorie content (78%). Public opinion for and against minimum pricing of alcoholic drinks was more evenly divided with the over-55s being more in favour (50%) than 18-34 year-olds (38%).

The survey, based on a panel of 1,448 adults across Britain, also revealed that people would welcome a far higher proportion of the health budget to be spent on prevention and health improvement than currently. Altogether 71% of respondents thought the

proportion should exceed one fifth of the NHS budget – six times the current spend.

Co-written by Alan Maryon-Davis and Rachael Jolley, *Healthy Nudges: When the Public Wants Change and the Politicians Don't Know It* makes challenging reading for Andrew Lansley, the Healthy Secretary for England and a strong advocate for the non-regulatory approach. It suggests that the public are far more accepting of government action than he might suppose, and that they see such initiatives as a key part of the public health mix.

The Health Secretary has rightly emphasised the importance of evidence and we hope these results will be used to inform the White Paper on public health.

**Coverage:** *The Guardian*, *BMJ*, *Metro*, *Marie Claire* (online), *NICE News*

### School food

A letter highlighting potential threats to children's nutrition has been sent to Health Secretary Andrew Lansley. FPH signed the letter, alongside 30 other organisations including the National Union of Teachers, Royal College of Physicians and the Children's Food Campaign, expressing concerns about recent criticisms of Jamie Oliver's initiative to improve school dinners, and prospective plans to widen corporate

involvement in the Government's Change4Life programme.

### Tobacco control

Action on Smoking and Health (ASH) placed an advertisement in *The Independent on Sunday* on 5 September, reiterating the need to protect children's health by not rolling back legislation to put tobacco products out of sight in shops. The advertisement was signed by FPH, alongside over 60 other organisations, including Cancer Research UK, RCPCH and RCGP. The proposed measures are currently under intense tobacco industry pressure, and the advertisement appeals to the coalition government to implement the legislation.

### Urban cycling

With the advent of London's bicycle-hire scheme, FPH urged other cities to follow suite and invest in better cycling infrastructure such as secure storage and improved cycle lanes. FPH Vice President John Middleton said: "We want cycle schemes to be adopted across the country and everyone to be given the chance to see for themselves how easy, fun and beneficial to health cycling really is."

**Coverage:** *Sheffield Telegraph*

## Will YOU relate to the FPH responsible officer?

For some months now, FPH has been letting members know that it will become a designated body for revalidation and will have a responsible officer.

The draft regulations have now been laid before Parliament and come into effect on 1 January 2011. Although revalidation will continue to be piloted for another year, the duties of responsible officers will begin from the beginning of next year.

The regulations stipulate how individual doctors will relate to responsible officers. Each doctor will relate to ONE responsible officer. Individual doctors will not have a choice but automatically relate to a specific designated body depending on their employment setting. If, as a member, you relate to FPH as your designated body and will need to use the services of the FPH responsible officer, you now

need to let FPH know so this can be recorded on our systems. FPH will have a duty to ensure you take part in an appraisal and clinical governance systems from 1 January. Ensuring you are revalidated is an individual responsibility and while FPH will continue to remind members to register, FPH can only take reasonable steps to ensure you connect to us.

If you think you will relate to FPH's responsible officer please email Laura Webb, Head of Professional Affairs, at [laurawebb@fph.org.uk](mailto:laurawebb@fph.org.uk) in the first instance with the subject heading "RO". She will then confirm your personal circumstances and record you on FPH systems, if appropriate.

### Full system pilot for revalidation

If you are going to be using FPH's responsible officer, please do sign up for our full system pilot, comprising appraisal, MSF and audit. FPH will be piloting from the Autumn.

If you are interested and have not signed up yet, please email [laurawebb@fph.org.uk](mailto:laurawebb@fph.org.uk) with the subject heading "full system pilot". The system pilot will also be open to non-medical members who FPH will expect to revalidate in the same way. The pilot is fully funded and will be available at no cost to participants.

## Annual Public Health Lecture and Awards Ceremony

We are delighted to announce the new programme for the FPH Annual Public Health Lecture and Awards Ceremony on 6 October 2010 from 6.30pm. This prestigious event will take place at One Great George Street, London.

This is a free event – open to all members and non-members.

FPH is honoured to welcome Zsuzsanna Jakab, WHO Regional Director for Europe, to present the FPH Annual Public Health Lecture. This will be followed by the FPH Award Ceremony to celebrate the admittance of new members and fellows, recognise members' achievements and reward excellence and innovation in public health.

You are then invited to join us for a reception, providing the ideal opportunity to meet with friends and colleagues.

To attend please email [events@fph.org.uk](mailto:events@fph.org.uk) providing your full contact details. Places will be allocated on a first come, first served basis.

## In memoriam



**Sampangi (Sam) Ramaiah**  
1948 – 2010

Professor Sam Ramaiah was widely respected and well liked by all in FPH, where he held many offices during his career. Sam qualified in medicine from the University of Bangalore, India, in 1972 before coming to the UK to take up a post of Senior House Officer at the North Wales Hospital in Denbigh in 1974. By 1978 Sam had decided to pursue a career in what was then community medicine and started his training as a

registrar in Clwyd Health Authority in 1980. His career continued to progress, and he obtained his first consultant appointment in 1983, also at Clwyd Health Authority. In 1987 he moved to Leeds to take up the post of District Medical Officer and in 1993 a further move took him to his final post as director of public health in Walsall.

Sam made a major contribution to public health training both in Leeds, where he acted as a tutor and teacher to MPH students and to undergraduates, and in Birmingham where he was an Honorary Senior Lecturer. His commitment was valued highly by FPH, where over the years his appointments included FPH Advisor, Assistant Editor for *ph.com*, referee for the *Journal of Public Health*, membership of the Fellowship Committee and, most recently, Assistant Registrar.

Sam was a wise and lovely man and a tremendous role model. He will be greatly missed by many people, not least for his integrity, his professionalism, his deep commitment to public health and training, and his readiness to go the extra mile to help others.

Sam died unexpectedly from a heart attack at his home on Monday 6 September. Our thoughts are with his family and friends.

### Konrad Jamrozik

1955 – 2010

After qualifying in medicine in 1977, Konrad Jamrozik came to Oxford from Australia to undertake a PhD on smoking cessation in general practice, working with such luminaries as Godfrey Fowler, Richard Doll and Richard Peto and kindling a lifelong interest in the epidemiology of smoking.

Returning to Australia via Papua New Guinea he was appointed professor of public health at the University of Western Australia where he led the Perth Community Stroke Study, demonstrating for the first time that the lifestyle factors known to increase the risk of heart disease also applied to stroke.

After further professorial stints at Imperial College London and the University of Queensland he settled in Adelaide as head of the School of Population Health and Clinical Practice, developing an international reputation and playing a key role in WHO's MONICA project monitoring cardiovascular disease in 22 countries.

Author of nearly 300 scientific papers and chapters, Konrad was a consummate researcher, winning a number of national awards. On his early death from cancer at the age of 54, a colleague wrote that it felt as if "public health in Australia has lost a limb".

## Minister's visit



Minister for Public Health Anne Milton visited FPH on 28 June. It was the first ever visit by a serving health minister to 4 St Andrew's Place. She is pictured standing between the then FPH President Alan Maryon-Davis and the current President, Lindsey Davies.

## Education and Training update

### The 2010 Public Health Specialty Training Curriculum

The curriculum details the knowledge and skill requirements for public health training and was recently re-approved by the GMC and UKPHR. There were no major changes, but improvements include:

1. The Medical Leadership Competency Framework (MLCF) – developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement – has been mapped to the learning outcomes in the curriculum. The MLCF outlines the leadership competences required to enable specialty registrars to increase their involvement in the planning, delivery and transformation of services for patients and the public.

2. The GMC's Good Medical Practice (GMP) has also been mapped explicitly to the learning outcomes. GMP sets out the principles and values upon which good practice is founded which, when combined, define medical professionalism in action. The curriculum continues to be mapped to Good Public Health Practice (GPHP), which itself has been updated. There is a clear relationship between GMP and GPHP.

3. The guidance for the Workplace-Based Assessment (WpBA) criteria has been integrated into each key area of the curriculum. Greater clarity and detail has also been added to the sections on feedback, WpBA and remediation. This gives SpRs and those supervising training more guidance on expectations and good practice.

4. Navigation has been greatly improved

with more links, a document map and table of contents.

All new specialty registrars from 1 August 2010 will follow the 2010 curriculum.

Although minimal changes have been made, technically the curriculum constitutes a new curriculum and therefore we recommend that all SpRs transfer to take opportunity of the greater clarity and guidance contained within the 2010 curriculum. Existing SpRs should transfer in consultation with their TPD. FPH and the relevant Deanery should be formally notified of transfers by 1 January 2011.

## Deceased members

The following members have sadly passed away:

**Martin Briggs**  
**Kenneth Brotherston**  
**John Irvine**  
**Konrad Jamrozik**  
**Sarah McEwan**  
**James Mercer**  
**Sam Ramaiah**  
**Margaret Slater**  
**John Smith**

**ETSC**  
European Transport Safety Council

**PACTS**  
Public Health  
Advisory Council  
For Transport Safety

21st PACTS Westminster Lecture  
and ETSC's 12th European Transport Safety Lecture

**ROADS, CASUALTIES AND PUBLIC HEALTH:  
THE OPEN SEWERS OF THE 21ST CENTURY?**

**DANNY DORLING**  
PROFESSOR OF HUMAN GEOGRAPHY, UNIVERSITY OF SHEFFIELD

Tuesday 23rd NOVEMBER 2010  
6pm - 10pm

ONE BIRDCAGE WALK,  
LONDON SW1H 9JJ

£100 + VAT  
To book contact PACTS at [admin@pacts.org.uk](mailto:admin@pacts.org.uk)

We are seeking motivated individuals to join our rapidly expanding team within one of South Africa's premier research institutes at the University of the Witwatersrand. As a WHO Collaborating Centre, RHRU is an internationally recognized research organisation primarily focused on research into the clinical and public health aspects of sexual and reproductive health, HIV and related diseases. The working environment is multidisciplinary and the opportunity exists for further studies and training.

**RHRU**  
Reproductive Health & HIV Research Unit  
of the University of the Witwatersrand, South Africa

We are seeking to recruit a dynamic and experienced person to provide leadership in aspects of study design, sampling, analysis, reporting and publication of research results within the institute.

This MEDICAL STATISTICIAN position requires the following;

- Postgraduate qualification (PhD level) in medical statistics or epidemiology & demonstrated record of experience by publication record
- Practical experience of data analysis and ability to analyse longitudinal data & data from randomized controlled trials
- Demonstrated competence with statistical software & data management packages; eg. STATA

Visit [www.rhru.co.za](http://www.rhru.co.za) for more information on these positions and to learn more about RHRU

A cost-to-company remuneration package will be negotiated in accordance with qualifications and experience. Should you be interested in applying for this position, please send your detailed CV and covering letter to [Recruitment2@rhru.co.za](mailto:Recruitment2@rhru.co.za)

**Only shortlisted candidates will be contacted.**

## Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between May and September 2010

### New diplomate members

Glenda Augustine  
Gayle Dolan  
Felix Greaves  
Thomas Hall

### New trainee members

Elsbeth Anwar  
Helen Asquith  
Claire Bayntun  
Liann Brookes-Smith  
Sarah Day  
Durka Dougall  
Matthew Harris

### New members

Bernadette Alves  
Kerry Bailey  
Anna Richards  
Kyla Thomas

### New fellowships

Khalid Anis  
Joanne Cameron  
Kath Childs  
Emer Coffey  
Denis Cronin  
Fiona Day  
Sharon Daye  
Andrea Fallon  
Susan Lloyd  
Dona Milne  
Jennifer Mussard  
Emmanuel Okpo  
Bharat Pankhania  
Shantini Paranjothy  
Thomas Porter  
Catherine Pritchard  
Richard Puleston  
Kriel Ramcharitar  
Andrew Taylor  
Kathrin Thomas  
Catriona Woollcombe  
Yuk Wong

### Honorary members

Claire Barley  
Nicola Close  
Alison Patey  
Di Roffe

### Honorary fellows

Muir Gray  
Walter Holland  
Li-ming Li  
(Ernest) Alwyn Smith  
Mysore Sudarshan

### Membership through distinction

Mary Bussell  
Nick Cavill  
Myer Glickman  
Abdelmalik Hashim  
Modi Mwatsama  
Laura Stroud

### Fellowship through distinction

Fatma Al-Maskari  
Mohammed Al-Thani  
Zouhair Amarin  
Elsheikh Badr  
Sheila Beck  
John Carnochan  
Alan Dean  
Peter Farley  
Ken Fox  
Hua Fu  
Charmaine Gauci  
Alison Giles  
Brendan Girdler-Brown  
Gustavo Gusso  
Samer Jabbour  
Paul Jennings  
Donald Li  
Meng-kin Lim  
Xiao Ma  
Awang Mahmud  
Karyn McCluskey  
Alan Mitchell  
Lars Moller  
Mary Morgan  
David Pattison  
Jennie Popay  
Gurch Randhawa  
Yaser Salamah  
Abbas Vosoogh Moghaddam  
Chit-Ming Wong  
Jeannette Young

## UK Public Health Register

### Through Defined Specialist portfolio assessment

Keith Aungiers  
Jennifer Hall  
Robert Nelder  
Ian Scale  
Andrew Taylor

### Through Generalist Specialist portfolio assessment

Mark Bellis  
Denis Cronin  
Fiona Gailey  
Beverley Henderson

### Through the standard FPH Generalist Specialist training route

Bruce Bolam  
Sarah Johnson-Griffiths  
Edward Kunonga  
Piers Simey

## Committee member sought

**Do you have an interest in risk management and/or finance? If so, we want to hear from you.**

The FPH's Risk Management, Audit and Finance Committee is seeking an energetic and committed FPH member to join its team. For further details, contact Herbert Thondhlana, at [herberthondhlana@fph.org.uk](mailto:herberthondhlana@fph.org.uk) / tel 0207 935 0243.

## Health, Culture and Scotland: New Opportunities

Committee of the Faculty of Public Health in Scotland  
Annual Public Health Conference

Date: 11-12 November 2010

Venue: Dunblane Hydro Hotel, Scotland

How can the public health community identify and secure the changes that are needed to improve Scotland's health? How might the recession affect our thinking? How can we better understand the effect on health of cultures in Scotland? And how can we impart the importance of the early years in improving health and tackling inequalities?

These are just some of the questions to be explored in this year's programme which will feature keynote presentations from influential national and international speakers.

For more information contact [publichealth@shscevents.co.uk](mailto:publichealth@shscevents.co.uk).  
To book a place please visit SHSC events at [www.shsceventsbookings.co.uk](http://www.shsceventsbookings.co.uk)



## The full cost to society of smoking is not covered by the current tax on tobacco. The principle of ‘the polluter pays’ should be applied more vigorously, argues Henry Featherstone

Do smokers need to cough up?

There are a vociferous few who argue that tobacco taxes are too high. Indeed, of the £6.29 price of a packet of cigarettes £4.83 is taken in taxation which in turn contributes £10 billion annually to HM Treasury. However, £6.29 is only an amount which is deemed acceptable by the Government, retailers and the tobacco industry; there is no consideration of the wider costs to society.

The ‘polluter pays’ principle is an increasingly popular way for governments to deal with the unintended consequences of a particular market. If the negative ‘externalities’ of a particular product cost more than the revenue derived in taxation then, according to the economist Arthur Pigou, the market is inefficient and there is over-consumption of that product. Our research finds that the UK market for tobacco is inefficient, or to put it another way, tobacco taxes are too low.

Using official data from the Office for National Statistics, NHS Information Centre and peer-reviewed scientific journals as well as sources such as the Royal College of Physicians and the Tobacco Manufacturers Association, we calculate that the costs to society from smoking are £13.74 billion, which is much greater than the £10 billion raised in revenue. Every

cigarette smoked is costing the country money – about 6.5p each time someone lights up.

These societal costs comprise not only the cost of treating smokers on the NHS (£2.7 billion) but also the loss in productivity from smoking breaks (£2.9 billion) and increased absenteeism (£2.5 billion), the cost of cleaning up cigarette butts (£342 million), the cost

of smoking are recovered through taxation. The cost of a packet of cigarettes should be at least £7.42. Cigarettes are being under-taxed by £1.13 per packet which amounts to £2.47 billion in lost revenue for HM Treasury. This increase in tax should be recovered through the duty escalator; but in the first instance, tobacco tax should be increased by at least 5% at the next Budget – this would raise about £400 million for HM Treasury.

And there are other reasons for tobacco taxes to go up. First, a packet of cigarettes today is as affordable as it was in the early 1970s when about 45% of the population were smokers – it is relative rather than absolute measures that matter. Second, tobacco smuggling is being brought under control by the work of the World Health Organisation, although it should be noted that smuggling is more a function of corruption and complicity than price. Third, elsewhere around the world tobacco taxes are being hiked up, especially in Australia and New Zealand. Fourth, in these times of austerity, raising revenue through tobacco duty is the most popular form of tax increase.

**“ A packet of cigarettes today is as affordable as it was in the early 1970s when about 45% of the population were smokers ”**

of smoking-related house fires (£507 million), and also the loss in economic output from the deaths of smokers (£4.1 billion) and passive smokers (£713 million).

In order to balance the income and costs of smoking, we suggest that tobacco duty should be increased over the course of the next Parliament until the full societal costs

**Dr Henry Featherstone**  
*Head of Health & Social Care Unit  
Policy Exchange*

## Information

ISSN – 2043-6580

**Editor in chief**  
Alan Maryon-Davis

**Managing editor**  
Rachel Jolley and Lindsey Stewart

**Commissioning editor**  
Suvi Kingsley

**Books editor**  
Peder Clark

**Production editor**  
Richard Allen

**Editorial board**  
David Dickinson  
Andrew Furber  
Catherine Heffernan  
Amanda Killoran  
Ashish Paul  
Premila Webster  
Matthew Day

**Contact us**  
news@fph.org.uk

**Address**  
Faculty of Public Health  
4 St Andrews Place  
London  
NW1 4LB  
Switchboard: 0207 224 0642

Education: 0207 224 0642  
Policy & Communications: 0207 935 3115

**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**

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