

Public Health in England

The report of the Committee of Inquiry
into the future development of the
Public Health Function

Presented to Parliament by the Secretary of State for
Social Services by Command of Her Majesty.
January 1988

FOREWORD

“The importance of the subject cannot be too highly estimated. The constant relation between the health and vigour of the people and the welfare and commercial prosperity of the State requires no argument. Franklin’s aphorism, ‘public health is public wealth,’ is undeniable.”

— Report of the Royal Sanitary Commission 1871

Although it is over a hundred years since the last major review of the public health function and in the interim there have been major changes in the spectrum of prevalent illness, the proposition quoted above is as relevant today as it was in 1871. Today as then, a great burden of premature disability and death occurs which is preventable and for which the consequent suffering and expense are unnecessary. Today as then, all sectors of society, the individual and a number of professions as well as the state have their roles to play. We hope our recommendations will improve the surveillance of the health of the nation, clarify roles and responsibilities, show how each particular skill may be brought to bear at the appropriate point in the National Health Service within the framework of general management, and taken together, will provide a structure conducive to better health for all.

As we were instructed to do, we have given greater emphasis to two aspects of our work: the arrangements for the control of communicable disease and the role of public health doctors. As far as the former is concerned, we have made recommendations which simplify the current system and will introduce clear and unambiguous lines of accountability for surveillance, prevention and control and above all improve the capacity to react quickly.

The resources which can be devoted to health care are limited. Demographic change and developments in clinical practice ensure that demand is always likely to outstrip available finance. The special training of public health doctors in epidemiology — ie the study of the distribution and determinants of health and disease in populations — means that they are qualified not only to develop policies for the prevention of illness and promotion of health but, in collaboration with others, to analyse the need for health services and evaluate their outcome. Their skills should be complementary and helpful to those of health care managers and should ensure a thorough analysis of effectiveness and efficiency thus providing health authorities with better information on which to make choices and select priorities.

We hope that the recommendations in our report will, at the least necessary cost, secure significant improvements in the health of the people of this country which will bear fruit well into the next century.

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January 1988

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CHAPTER 1: INTRODUCTION

Terms of reference

1.1 The Inquiry was established by the Secretary of State for Social Services on 21 January 1986, with the following terms of reference:

“To consider the future development of the public health function, including the control of communicable diseases and the specialty of community medicine, following the introduction of general management into the Hospital and Community Health Services, and recognising a continued need for improvements in effectiveness and efficiency; and to make recommendations as soon as possible, and no later than December 1986.”

In announcing the establishment of the Committee to Parliament, the Secretary of State said:

“The Inquiry will be a broad and fundamental examination of the role of public health doctors including how such a role could best be fulfilled.”

The Committee was set up in response to two major outbreaks of communicable disease — salmonella food poisoning at Stanley Royd Hospital in Wakefield in August 1984 and Legionnaires’ Disease at Stafford in April 1985, which had both resulted in public inquiries.^{1,2} These reports pointed to a decline in available medical expertise “in environmental health and in the investigation and control of communicable diseases” and recommended inter alia a review of the responsibilities and authority of Medical Officers of Environmental Health (MOsEH). In addition, there was continuing concern about the future role of the specialty of community medicine and the status and responsibilities of community physicians after the implementation of general management in the National Health Service (NHS) in 1984 following the publication of the report of the NHS Management Inquiry (the “Griffiths” report) in November 1983.³

Membership

1.2 Details of the membership of the Inquiry are set out at Annex A.

Definition of “public health”

1.3 At its first meeting the Committee agreed a wide working definition of the term *public health*, namely that it is:

“the science and art of preventing disease, prolonging life and promoting health through organised efforts of society.”

In the past, the term “public health” has commonly, if mistakenly, been rather narrowly interpreted and associated in particular with sanitary hygiene and epidemic disease control. We prefer our broader definition based on that formulated by the World Health Organisation (WHO) in 1952. These definitions give as much weight to the importance of lifestyle as to environmental hygiene in the preservation and promotion of health and “leave no room for rivalry between preventive and curative medicine.”

1.4 In adopting this definition the Committee accepts that the discharge by society of its public health function includes not only efforts to preserve health by minimising and where possible removing injurious environmental, social and behavioural influences, but also the provision of effective and efficient services to restore the sick to health, and

where this is impracticable, to reduce to a minimum suffering, disability and dependence. Such an all embracing concept, which could be deemed to include not only the provision of clinical and related services such as dentistry, pharmacy etc but also questions relating to the economic and social origins of health, would take us far beyond our collective capacity or the time available for our work. We have therefore interpreted our remit as being concerned principally with arrangements within the current institutional framework to do three things:

- to improve the surveillance of the health of the population centrally and locally;
- to encourage policies which promote and maintain health; and
- to ensure that the means are available to evaluate existing health services.

In view of the mandate in our terms of reference to consider “the future *development* of the public health function” we have taken a positive and where necessary a long term view. We note that the year of our publication marks the 40th anniversaries of both WHO and the NHS. The test of our recommendations, if implemented, will be the degree to which they facilitate the improvement of health in England in the ensuing decades.

1.5 We do of course recognise the multiplicity of influences which affect the health of the public (see also chapter 3). This has been clear from the wide-ranging nature of the evidence we have received — both its scope and quantity. However, the task assigned to us was not to analyse in detail the underlying determinants of the health of the population, but rather to review relevant aspects of the work of those agencies with major responsibilities for securing the health of the public. In practical terms these are the Department of Health and Social Security (DHSS) and its dependent institutions such as the Public Health Laboratory Service (PHLS) (this includes the Communicable Disease Surveillance Centre (CDSC)); the NHS at regional and district levels including Community Health Councils (CHCs) and the primary care sector; the Health Education Authority (HEA); other Government Departments; and local government. We note also the key roles of the voluntary sector, industry and the media. In addition, we are conscious that in recent years there has been a significant shift in emphasis in the perception of the determinants of the health of the public. In the context of the rise in importance of such conditions as cardiovascular disease and cancer, this now focusses far more than before on the effects of lifestyle and on the individual’s ability to make choices which influence his or her own health. Nevertheless, both the events leading up to the establishment of this Inquiry and the AIDS epidemic remind us of the crucial continuing need for an effective system for the prevention, surveillance and control of communicable disease and infection.

1.6 Except insofar as they relate to points mentioned above, the Inquiry was instructed to exclude details of those aspects of the public health function which are shared by DHSS with other Government Departments, or are discharged by the Health and Safety Executive (HSE), or the National Radiological Protection Board (NRPB). Nor were we asked to explore the complex social factors underlying health — eg housing, employment, poverty — important though we recognise these to be. Nevertheless we wish to draw attention to the fact that at present the policies of almost every Government Department can have implications for health and that consequently there is a need for effective co-ordination of such policies if health is to be improved.

1.7 As required by our terms of reference we have given particular emphasis to two aspects of the public health function, namely the control of communicable diseases and the specialty of community medicine. Bearing in mind the interpretation of public health which we have adopted and which is described above, the role of the community physician is considered both in respect of the prevention of illness and promotion of health, and in relation to the planning and evaluation of health services and the need to improve their balance, effectiveness and efficiency. At a time of growing and seemingly limitless demand for health services, techniques for evaluating outcomes are assuming increasing importance and we examine the role of community medicine in this context. We have also paid particular attention to the community physician's role within the NHS following the introduction of general management into the Hospital and Community Health Services. We support the increased emphasis on the concept of personal responsibility and accountability for particular areas of work which has accompanied the introduction of general management. We believe that our recommendations will extend this principle into the specialty of community medicine and define more clearly its role within health authorities. We have also sought to clarify the responsibilities of health authorities themselves for public health — a dimension of their work which we find to have been under emphasised in recent years.

Method of working

1.8 The Committee met for the first time on Wednesday 9 April 1986. In all we have met 24 times including 4 weekend seminars. We invited written evidence at an early stage in our deliberations. A copy of the letter of invitation is at Annex B. We received written submissions from the organisations and individuals who are listed at Annex C. We also had the opportunity to follow this up by oral evidence sessions. Those who attended are listed at Annex D. We are extremely grateful to all those who, despite their many other responsibilities, gave freely of their time and advice to assist in our deliberations.

1.9 In order to supplement the evidence which we received and to complement the background and experience of our members, we commissioned three research studies:

- "Public Health in Europe: A Comparative Study in Nine Countries." Dr Richard Alderslade, Specialist in Community Medicine, Hull Health Authority. This was commissioned jointly by WHO and the Inquiry and will be published by WHO.⁴
- "Community Physicians and Community Medicine: a survey report." Sarah Harvey and Ken Judge, the King's Fund Institute. This was commissioned jointly by the King's Fund Institute and the Inquiry and has been published by the King's Fund.⁵
- Social and Community Planning Research — Report on local authority perceptions of their public health role by Pauline McLennan. This will be published as a separate research paper.⁶

1.10 Although in our terms of reference we were asked to put forward recommendations to the Secretary of State by December 1986, this has not proved practicable. As will be seen from the following chapters, such is the scope and breadth of the public health function and such was the weight of evidence submitted to us, that we felt it was only possible to do justice to the subject in the extended timescale which we have adopted.

CHAPTER 2: DEVELOPMENT OF THE PUBLIC HEALTH FUNCTION IN ENGLAND

2.1 The first attempts to take collective action in the interests of the health of the population preceded the sanitary revolution of the nineteenth century. They included the institution of quarantine for certain contagious diseases and the organisation of elementary services to care for the sick. In the nineteenth century, a more sophisticated system grew up, the main objectives of which were the provision of safe water, adequate housing, and, later, effective immunisation services. The whole question of public health was considered by the Royal Sanitary Commission, which reported in 1871. Under central guidance, the main responsibility for developments in public health and welfare lay with the local authorities armed with legislative powers for this purpose. The Medical Officers of Health (MOsH) emerged as their principal executive agents in the realm of health.

1919: The Ministry of Health

2.2 In 1919, the Ministry of Health Act brought together all publicly funded preventive activities and health care (with the exception of services for the mentally ill) under a single system of central and local government. The Ministry carried extensive responsibilities for the control of environmental factors which affected the health of the population, including housing. The Minister was charged with the responsibility "to take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people."⁷ Prevention of illness and promotion of health were thus seen as areas of crucial importance. The activities of the municipal authorities in the health field expanded to include the provision first of infectious disease hospitals, then of general hospitals, together with a wide range of personal health services for vulnerable groups such as mothers, babies and school children and for dealing with specific diseases, eg tuberculosis. By the beginning of the Second World War, the MOH had become the accountable manager for the provision of all these services.

1948: The NHS

2.3 The NHS as it was set up in 1948 was a tripartite structure and responsibilities for the public health ranged across the three parts:

2.3.1 The Medical Officer of Health remained with the local authority. His span of responsibility was limited by the NHS Act to those services which the local authority continued to provide, ie non-hospital, non-GP services, but even so it included responsibility inter alia for environmental health, communicable disease control, the school health service, health visiting, community nursing and midwifery, the prevention of illness, care and aftercare, and certain welfare services. The MOH was one of the local authority's chief officers and accountable to the authority for the discharge of his responsibilities. Under these arrangements, the MOH had explicit and positive duties a) "to inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the county and be prepared to advise the county council on any such matter" and b) "as soon as practicable after the 31st day of December in each year make an annual report to the county council for the year ending on that date on the sanitary circumstances, the sanitary administration and the vital statistics of the county, in addition to any other matters upon which he may consider it desirable to report."⁸ The report was presented to the Council and debated in an open meeting with the press and public present. The content of the

report was specified by the Ministry of Health each year by circular. While this system was by no means perfect (and we discuss this in more detail in Chapter 4), it had the advantage of providing a positive impetus for a regular review of the key issues relating to health in the locality.

2.3.2 Meanwhile the hospital boards, regional and local, developed their own corps of administrative medical officers led by Senior Administrative Medical Officers (SAMOs). The SAMOs acted as chief medical officers to the regional hospital boards (RHBs) and were responsible for medical advice on the planning and development of clinical services, medical manpower planning within the hospitals, medical input into capital planning and medical personnel matters. In 1948 therefore, the hospital authorities ceased to look to the MOH for advice on the needs of the population as a whole or on the development of hospital provision to meet them, although in some areas the MOH remained medical superintendent of the local hospital for infectious diseases and some retained contact with the hospital service by acting as members of hospital management committees (HMCs), boards of governors or RHBs. It is ironic that the year 1948, which is usually viewed without reservation as the date in which a new era dawned for the health of the nation, was the year in which separation of much of the public health function from the rest of the NHS sowed the seeds of a confusion of roles between local authorities and health authorities which is reflected strongly and almost unanimously in the evidence we have received. We know that during the period 1948-74 the more far-sighted MOsH performed valuable and creative work striving for functional unity of the administratively tripartite NHS and emphasising the importance of promotion and prevention. They used their flexibility of policy and finance to develop the substantial range of community health services for which they remained responsible and to link them with those of family practitioners on the one hand and hospital services on the other. However, the failure of some MOsH to realise that the restriction of the range of their activities from that date was associated with the new challenges and opportunities, can now be seen as the start of the process of debilitation of the specialty of public health medicine. A further unforeseen consequence of the new arrangements, which was deleterious in the long run, was that prevention of illness, which to an increasing extent became linked with lifestyle – tobacco, alcohol, diet, abuse of drugs etc – was seen to be a function separate, financially, administratively, and in terms of policy, from the hospital service. This established a tradition which led, even after the reorganisation of 1974, to a continuing lack of emphasis on prevention in the new health authorities.

2.3.3 The provision of general practitioner services was the responsibility of executive councils (ECs). After 1948, the general practitioner services were to come to play an increasingly important role in prevention and health promotion, particularly the provision of immunisation and screening services, sharing responsibility with the services provided by the local authority. The divided responsibility led to problems of co-ordination and difficulty in ensuring coverage of the whole population which persisted through the 1974 reorganisation and which have still not been fully resolved.

1974: Reorganisation of the NHS

2.4 The integration of the tripartite NHS, which was the aim of the 1974 reorganisation, transferred the local authorities' responsibilities for personal health services outside

hospitals to the regional and area health authorities. The responsibilities of ECs were transferred to Family Practitioner Committees (FPCs). Responsibility for environmental health, together with personal social services, remained with local authorities. To assist joint planning of health and social services, area health authority boundaries were made coterminous with those of the local authorities who were responsible for the social services departments which had been established in 1971 after the Seebohm Report.⁹ The office of MOH ceased to exist. For medical advice on environmental health and its functions in respect of the control of communicable disease, the local authority was to look to a doctor employed by the health authority, who was to be known as the Medical Officer of Environmental Health (MOEH).

The Specialty of Community medicine

2.5 The Todd Report¹⁰ had recommended in 1968 the establishment of a new medical specialty to be termed "community medicine". A Faculty of the Royal Colleges of Physicians (the Faculty of Community Medicine (FCM)) was established to oversee training and standards for the specialty. In 1972, the Hunter Report¹¹ suggested bringing together within the new specialty the former MOsH and their staffs, the administrative medical officers of the former hospital boards and a third component, namely the medical staff of the academic departments of public health and social medicine. It was envisaged that health authorities would look to specialists in community medicine to advise them on their responsibilities for the health of populations. In principle, the 1974 reorganisation made possible the recreation of a role lost in 1948 for a single doctor or team of doctors (the community physicians) to consider and plan for the health needs of the whole population of a district, area or region.

2.6 The Hunter Report envisaged "a vital and continuing task for doctors working full time in health service administration." This was accepted and implemented — community physicians becoming members of the consensus teams which were responsible for health service management at regional, area and district levels. In some parts of the country community physicians seized the opportunity which was presented to them in 1974 and created vigorous departments which continue to make important contributions to the planning and development of health services for the populations they serve. In other places, some simply failed to make the transition. The out-dated approach of some community physicians, coupled with confused lines of accountability within multi-district areas (areas which contained two or more districts for management purposes), exacerbated by the paucity of resources available in some places, impeded the proper discharge of the public health function.

2.7 The failure of some community physicians to meet the expectations required by the Hunter recommendations also contributed to the failure of the specialty to establish its professional standing. Roles were sometimes unclear; for example, different health authorities and community physicians — and some clinicians — attached varying degrees of importance to the community physician's role. In too many places the distinctive contributions to health authority management which could be made by advice from clinicians (consultants and GPs) on the one hand, and community physicians on the other, were insufficiently clearly perceived. Nor were the needs of health authorities whose responsibilities included hospitals always fully met by community physicians whose background and experience had been with local authorities and vice versa. Moreover, community physicians often need to take a long term view of events which can sometimes conflict with short-term pressures on health authority management.

Consequently the net effect in some cases was that health authorities, undervaluing the contribution of their public health doctors, failed to give sufficient emphasis to public health issues. The decline in credibility of community medicine in some places undoubtedly played a part in the approach to implementation of the Griffiths Report³ when, in 1984, health authorities were permitted a greater degree of flexibility in meeting their needs for medical advice than had been the case a decade before.

The 1982 restructuring

2.8 The consultation exercise "Patients First"¹² carried out in 1979/80 produced virtual unanimity that a simplified health authority structure was essential, even at the expense of coterminosity with local authorities. The Government therefore decided to abolish the AHAs and to introduce a single operational tier of district health authorities (DHAs). The new health authorities were to have the greatest possible degree of autonomy but they were nevertheless required to establish a district management team which would include a community physician and operate by consensus. Although the administrative consequences of the changes of 1982 were far reaching, in practice, because of their involvement in management at area level, the only medical specialists to be materially affected by the restructuring were the community physicians. About 20 per cent of the total number of community physicians took early retirement in 1982 — a significant loss of experience to the service.¹³ The 1982 review, however, was far from complete when the NHS Management Inquiry took place.

Introduction of general management

2.9 "The Management Inquiry Report identified the importance of a clearly defined general management function — which draws together responsibility for planning, implementation and control of performance — as the key to achieving the management drive necessary to ensure that the standards and range of care provided in the health service are the best possible within available resources".¹⁴ The Government accepted that the absence of such a function was a weakness in the existing arrangements, which were based on the consensus management approach. A general manager (GM) was therefore to be identified for each RHA, DHA, special health authority (SHA) and unit. This changed managerial relationships at regional, district and unit level, although it made no alteration to the constitutional position of health authorities themselves or to their responsibilities. It was, nonetheless, accepted that management arrangements should be flexible and adapted to suit local circumstances. The Management Inquiry also made recommendations about the organisation of DHSS which led to the establishment of the Health Services Supervisory Board and the NHS Management Board.

2.10 The implementation of general management at a time when, for the reasons mentioned above, the nature of the public health functions of health authorities was not clearly defined, and the credibility of the specialty of community medicine had in some places become compromised, tended unintentionally to confuse its image further and sometimes to weaken the position of community physicians. For example, when the new arrangements were in place it was found that:—

- in 13 authorities there was no community physician on the District Management Board or its equivalent;
- a substantial number of management board posts held by community physicians now carried unfamiliar titles (eg Director of Planning, Director of Service Evaluation, Director of Service Quality) describing roles which did

not necessarily need a medically qualified specialist to fulfil them. These changes in titles and jobs have led both to widespread uncertainty among trained staff and trainees as to how public health duties are to be carried out and by whom, and also to anxiety about the succession when such posts are vacated.

- in some places the need for the allocation to a community physician of responsibility and accountability for the overall balance of medical advice to the authority was not recognised.

2.11 The action taken by health authorities since 1984 in reviewing their management arrangements referred to in 2.10 above, taken together with the trauma of the 1974 and 1982 reorganisations, has also had an effect on the morale of community physicians: the number of community medicine posts has been reduced and there is uncertainty about the nature and number of future jobs. Evidence submitted to us suggests that continued uncertainty is likely to mean that fewer able doctors will in future enter the specialty (although we have also been told that the quality of new recruits to the specialty is high) and some already committed may decide to leave it. This could lead to health authorities, local authorities and the public losing access to appropriate public health advice. From the evidence we have received it is striking that in those authorities where community medicine has been of high quality, it is appreciated and valued and authority members and district general managers (DGMs) cannot envisage an organisational structure in which it does not have a central position. It is no surprise that it is in those authorities where the specialty has failed to win credibility or where there have been supply problems, that its worth is questioned.

2.12 Since the changes involved in the 1974 NHS reorganisation, the public health responsibilities of local authorities have remained unaltered, although the mechanisms for collaboration with health authorities have altered several times. We discuss the public health responsibilities of local authorities in chapters 4 and 7. Although responsibility for family practitioner services has remained with FPCs, the FPCs themselves gained independence from health authorities in the Health and Social Security Act 1984 – seen by some as a fragmentation of the integrated service envisaged in 1974. The creation of independent FPCs with a planning role has added yet another body with its own geographical boundaries to the number among whom responsibility for the health of the public is shared at local level.

CHAPTER 3: INTERSECTORAL NATURE OF PUBLIC HEALTH

Public Health Today

3.1 Today, the promotion of the health of the public requires more than the best efforts of the statutory agencies which carry public health responsibilities. This has been emphasised by the World Health Organisation in the development of its "Health for All" programme. To quote the first chapter of "Targets for Health for All"¹⁵:

"One principle is true for all countries: the key to solving many health problems lies outside the health sector or is in the hands of the people themselves. High priority should therefore be given to stimulating the contributions that other sectors and the public at large can make to health development, particularly at local level. It is essential in this respect to accept the basic principle that people's involvement in health development cannot be merely passive. It is a basic tenet of the health for all philosophy that people must be given the knowledge and influence to ensure that health developments in communities are made not only for, but also with and by the people. Primary health care is the most important single element in the reorientation of the health care system and will require very strong support. It is also important to ensure more economical, effective and humane use of existing health care resources."

3.2 Although inevitably because of our terms of reference and membership we have concentrated our attention rather more on the contribution of the statutory agencies, in particular of the health and local authorities, we strongly support the emphasis given by WHO to the role of individuals in preserving their own health, to the major contribution of primary care and to the importance of policies originating outside the statutory health authorities in providing a climate conducive to health. Our recommendations should, therefore, be viewed in the context of the aims of "Health for All" with which we believe they are consistent, and which the UK Government has endorsed.

3.3 In order to meet contemporary challenges to health, it is necessary for all elements of society to contribute. These contributions range across a wide variety of interests from individuals themselves to government as a whole. Health authorities, local authorities (some of whom as we have heard in evidence from their associations are seeking to promote "healthy public policy" on the WHO model), the primary care sector, the HEA, the PHLS and its CDSC, the voluntary sector, industry and by no means least the media (which have a crucial role in promoting healthy and responsible attitudes) all have a part to play.

The international context — public health

3.4 As in the United Kingdom so also throughout the developed world, there is a growing recognition of the need for all sectors of society to take an active and positive part in securing health. In 1979, the Surgeon General of the United States of America published a report on health promotion and disease prevention which set out a national programme for improving the nation's health.¹⁶ This identified 15 priority areas and 226 specific objectives for achieving improvements to public health by 1990. The present Surgeon General has recently followed this up with "A Midcourse Review".¹⁷ This is a progress report which shows that the US is "well on the way to achieving nearly half of [the] 226 objectives. Only about one-quarter appear unlikely to be achieved by 1990, and in only eight cases is the trend actually away from [the] 1990 outcome targets". We

believe that objective setting with clearly defined targets is a useful management tool in the public health field as in other areas of health and commercial management. We refer to it frequently and hope that our report will encourage its use throughout the NHS and the relevant local government departments.

3.5 In 1986, in Ottawa, the first International Conference on Health Promotion took place organised jointly by WHO, Health and Welfare Canada and the Canadian Public Health Association. The Conference emphasised its commitment to Health Promotion and called for international action to enable the WHO aim of Health for All by the year 2000 to be achieved. In his address, the Honorable Jake Epp, the Canadian Minister of National Health and Welfare said:¹⁸

“Real health cannot be delivered by governments. It must be achieved through personal effort by individuals, families and communities Health promotion, however, does not focus only on the responsibility of individuals to improve their health. Instead, it encourages self-reliance within a supportive environment — which governments have some responsibility to maintain The goal is to move health promotion from the periphery of the health field to a central position as a corner-stone of policy. In doing so, we are moving health promotion well beyond its traditional boundaries. The primary challenge in the health field is to move beyond cure and care, without for a moment abandoning our duty to the sick and infirm. Promoting health means adding quality of life to the years we live. It is not enough just to live longer.”

The Conference endorsed this view. We wholeheartedly share Mr Epp’s objective to shift public health to the centre stage of public policy. We have framed our recommendations with this aim in mind and it is a theme to which we will return throughout our report.

The International Context — Public Health Doctors

3.6 As we have seen from Dr Alderslade’s report “Public Health in Europe: A Comparative Study in Nine Countries”¹⁴, a wide range of countries of different geographical, historical and social backgrounds accept the need for a strong emphasis on public health. They have all identified epidemiology as a key skill on which to base their public health service. (Epidemiology is the study of the distribution and determinants of health and disease in populations.) Two conclusions of the report are, first, that “Hospital services should be planned and managed in accordance with the needs of known populations” and, secondly, that “Applied epidemiology is a fundamental discipline required to achieve the organisation of health services based upon population need.” The way in which public health is organised varies from country to country but a common recognition exists that applied epidemiology is an essential ingredient of planning and management. Indeed the challenge presented to the world by the spread of the Human Immunodeficiency Virus (HIV) which underlies the Acquired Immune Deficiency Syndrome (AIDS) has pointed up even more sharply the need for this type of scientifically based analysis.

The need for a medically qualified public health specialist

3.7 Countries differ in their perception of the need for a medically qualified public health expert in their arrangements for the discharge of the public health function. In some places the epidemiological role is performed largely by non-medically qualified

staff. The reason for this may be because medically qualified specialists are in short supply or because resources are insufficient to train and support them or because the value of a medical qualification in this context is not accepted. However, there is a widely held perception that although statisticians and specialists in other fields such as health economics have an important input there is also a key role for medically qualified specialists in epidemiology. This is echoed in much of the evidence we have received.

3.8 The discharge of the public health function in England today involves not only the activities of many different Government and non-Government agencies but also a large number of different professional disciplines. In addition to those mentioned in the previous paragraph, these include the nursing profession — most particularly health visiting and school nursing — health promotion and health education officers, environmental health specialists, experts in education, town and country planners, architects and engineers. In such circumstances it may be asked whether there is a need for a medical specialty devoted exclusively to public health as we have defined it.

3.9 While the achievement of improvements to public health will require the efforts of people with many different skills, we believe that a significant part of the success of the work depends upon an understanding of the health of the individuals who make up the population of the locality, and on the measurement of those environmental, social and behavioural factors which affect the balance between health and disease. There is therefore a crucial need for a group of people whose knowledge and skills include not only an understanding of the structure and function of the human body in health and how it is affected by disease, and practical experience of clinical practice, but also special training and experience in epidemiology.

3.10 This conjunction of skills, knowledge and attitude was first seen to be necessary at the beginning of the sanitary revolution early in the 19th century and led to the creation of the role of the Medical Officer of Health. Subsequently the special additional training required was recognised by the introduction of the Diploma of Public Health as a statutory requirement for appointment as MOH.

3.11 Although in the 19th century the main emphasis of the medical specialist in public health was the control of communicable disease and the improvement of sanitation and housing, we consider that the need for specialists who combine a medical education with an understanding of epidemiology and the social and behavioural origins of ill-health is as important today as it was then. This view is supported by the evidence that we have received. It also reaffirms some of the findings of the Hunter Report¹¹ which examined the future role of these specialists at the end of the era of the Medical Officer of Health — although as 15 years have elapsed since that report was published, some of its recommendations require adaptation in the light of experience.

3.12 The expertise to which we refer above affords a firm platform for the modern public health specialist to make a contribution to the achievement by the statutory agencies of their public health responsibilities as outlined in the next chapter. The epidemiological skills are relevant to monitoring the health of the population, analysing the pattern of illness in relation to its causes and evaluating services — all of which are helpful in seeking to make best use of finite resources. Knowledge of the natural history of disease helps in both the interpretation of the implications of new developments in health care and in the critical challenge of clinical specialists on their own ground in relation to the balance of priorities and quality of work. A suitably trained doctor may

often be the best qualified person in a particular district to advocate and explain health issues to the public at large, and to challenge vested interests. He/she also has a special role in health education. Having said that, we recognise that today the public health specialist, unlike his/her predecessor, cannot expect to sit as of right at the head of a large hierarchy. He or she is but one member of a team of specialists in various aspects of public health. It is for this reason that in Chapter 8 we advocate the development of a School or Schools of Public Health, where stress would be placed on the multi-disciplinary nature of the subject.

3.13 We have had considerable evidence that the terms "community medicine" and "community physician" can and do cause considerable confusion, not only with the general public but also with organisations and fellow professionals. The problem arises from the application of the term "community" which, in addition to its use here to refer to whole populations, is also widely used to refer to non-institutional care. This gives the false impression that community physicians should only concern themselves with services which are provided outside hospital or are a kind of general medical practitioner. The SCPR report⁶ states, for example: "For many local authority officers the title community physician had little meaning and they were unable to say what community physicians do The range of different titles for doctors working in the area of community medicine and public health is seen as contributing to this confusion." To avoid this confusion and to return to a term which we believe is more readily comprehensible to a wide range of people at home and abroad, we *RECOMMEND* that the specialty of community medicine should in future be referred to as public health medicine and its qualified members as public health physicians. Those appointed to consultant career posts in the NHS in this speciality should be known as consultants in public health medicine. We believe that use of this new title will make the specialty more comprehensible to those outside its ranks and enable potential recruits to identify more precisely what is involved in adopting it as their chosen career. We invite the Royal Colleges of Physicians and the Faculty of Community Medicine to consider the name of the Faculty in the light of our recommendation.

CHAPTER 4: THE HEALTH SERVICES, LOCAL GOVERNMENT AND PUBLIC HEALTH

4.1 As we have seen in Chapter 3, contributions to the maintenance and promotion of the public health are made by many agencies and all sectors of society. In this chapter we look at the organisation of public health within the health services at all levels and within the local authorities; we examine the responsibilities at each level and make recommendations designed to improve the discharge of the public health function.

The Centre

4.2 Quite apart from DHSS, the policies of a whole range of Government departments including the Treasury (tobacco and alcohol excise duty), Department of Environment (DOE) (atmospheric and other forms of pollution), Ministry of Agriculture, Fisheries and Food (MAFF) (food safety and agricultural policy), Home Office (narcotics), Department of Education and Science (DES) (health education in schools) to name only the most obvious, influence the health of the public. We have already said that we intend, as required by our terms of reference, to deal in the main with the responsibilities carried by DHSS, but we emphasise once more that health policy involves the whole of Government.

4.3 The Secretary of State, in section (1)(1) of the NHS Act 1977 is charged with a duty:

“to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement —

- a. in the physical and mental health of the people of those countries, and
- b. in the prevention, diagnosis and treatment of illness.”

Section (3) (1) (c), which is delegated to regional health authorities, and, through them, to district health authorities, imposes a duty:

“to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements . . .

. . . e. such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service; . . .”

Although the Act does not use the term “public health”, it is explicitly stated that the duty imposed upon the Secretary of State in sections 1 and 3 of the Act includes responsibility for the improvement of the physical and mental health of the people by amongst other things the prevention of illness. This carries the implication that the state of health of the population should be assessed and progress monitored. The emphasis on the health of the people as the ultimate objective is perhaps more self-evident in the wording of the 1919 Ministry of Health Act which imposed on the Minister the responsibility “to take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people.”⁷ In practice, this was exercised through the former MOsH, who as we have seen in para 2.3.1 had a specific duty to monitor and report on the health of the population for which they were responsible.⁸ The specific duty to report lapsed on NHS reorganisation in 1974 although we believe that the general duty to monitor the health of the population still remains.

4.4 In our view, one of the difficulties facing the NHS in recent years has been the implicit nature of its objective to further health by the prevention of illness and promotion of healthy lifestyles and the fact that the organisation by which that responsibility was to be discharged has remained ill-defined. The problem is most apparent in the field of control of communicable disease and infection as we shall see later in Chapter 7. It is, however, pervasive. As the structure of the public services (central and local government and the health services) has developed and changed over the years, the focus for monitoring the health of the population, preventing disease and promoting health has tended to become blurred and to recede into the background. These aspects rarely assume the central position in policy formulation envisaged by Mr Epp in his speech to which we have referred in the previous chapter (paragraph 3.5). There needs to be a reappraisal of these responsibilities both at DHSS and by the statutory bodies for which it is responsible.

A central focus for public health

4.5 One of the things which has struck us most forcibly in examining the present framework of administration is the lack of a specific focus at the centre with the capacity to monitor the health of the population and to feed the results of any analysis into the development of health policy, strategy and management. The office of Chief Medical Officer does of course carry responsibility for monitoring the nation's health but the present administrative structure does not facilitate the exercise of this function. *We therefore RECOMMEND that a small unit should be established within DHSS, bringing together relevant disciplines and skills to monitor the health of the public.*

4.6 The primary object of creating such a unit would of course be to provide more effective support to the Secretary of State in the discharge of his responsibilities to Parliament by monitoring the health of the people of England, by defining a portfolio of indicators of health and by studying trends. Within DHSS, a major function would be to support the Chief Medical Officer in his monitoring role. The work of the unit would also need to be closely aligned with that of the NHS Management Board, and in particular its planning directorate, with the health and personal social services policy group, and with the family practitioner services group. The analyses which it would provide would contribute to the assessments on which strategy, management and policy decisions across a broad range of health issues would be based, and also to the evaluation of outcomes.

4.7 The role of the NHS Management Board is to monitor the implementation by RHAs and DHAs of Government policies affecting the health of the public. There is now a well established review mechanism, involving Ministers, whereby each RHA is reviewed annually. The regions in turn are required to review their DHAs and the districts their units. A more sharply focussed monitoring of health at the centre will assist in setting the agenda for these reviews by defining specific targets for achieving improvements in health.

4.8 More sharply focussed health monitoring at DHSS will also be helpful to the work of other Government departments. To this end, and reflecting the underlying public health responsibilities of the Secretary of State, the unit should have (echoing the approach in the Ministry of Health Act 1919) a co-ordinating brief in respect of other Government departments. In particular, it will help maintain consistency of public health policy across Whitehall, for example when other government departments are considering decisions (eg on food and agricultural policy or on tobacco and alcohol)

which might impinge upon health policy. This would require the establishment of a formal means of consultation between departments.

National surveillance of non-communicable disease

4.9 We are conscious that there is no body in the field of non-communicable disease equivalent to the PHLS and CDSC with responsibility for long term surveillance of conditions such as cancer, stroke and cardiovascular disease. To a certain extent this function will be discharged by the arrangements recommended in paragraph 4.5 above, but it might be more appropriate for aspects of this work to be contracted out to OPCS, the Department of Epidemiology or the Small Area Statistics Unit at the London School of Hygiene and Tropical Medicine, other Universities or elsewhere. An early priority of the unit should be to explore ways whereby adequate national surveillance of non-communicable diseases can be accomplished on a long-term and ongoing basis.

Office of Population Censuses and Surveys

4.10 The OPCS plays a key role in monitoring the public health by collecting, collating and analysing data on morbidity and mortality on which trends are determined and health policy analysis and management decisions are made. At present OPCS processes and tabulates data from its various sources for use by others in and outside Government. In addition it carries out its own analyses of routine data to provide statistical interpretations, sometimes linking data from different sources. Such work may be regular (eg the annual volumes on mortality, infectious disease notifications) or ad hoc (eg the recent report on incidence of cancer around nuclear installations). Finally, it also enables or contracts others to conduct research using its data whilst protecting confidentiality.

4.11 Because resources are inevitably limited and potential activity limitless, it is essential that OPCS shapes its future work to be of maximum value to the public health function as in other fields. The new central unit for monitoring public health in DHSS which we have recommended above could in our view be valuable in co-ordinating DHSS views on what OPCS should contribute in this field. Information from OPCS will, in turn, provide the majority of the data on which the monitoring function in DHSS will be based. OPCS is able to draw together data from several different sources with information which is not locally available to health authorities. In view of the importance of such data to health authorities, eg in assessing RAWP targets, it would be helpful if arrangements to make data available to health authorities and FPCs were kept under regular review.

4.12 We understand that it is currently proposed that the Registrar General's Medical Advisory Committee should be reconstituted to advise on work priorities. We welcome this, and support the proposal that the Chief Medical Officer should be represented on the Committee. We would suggest that there should be representation from the NHS at regional and possibly district level; from FPCs; and also from PHLS/CDSC, and that the Committee should be asked to advise on guidelines for access to OPCS data by health authorities. It might, for example, be consulted in the regular review referred to in the previous paragraph.

Public Health Laboratory Service and the Communicable Disease Surveillance Centre

4.13 The PHLS was established under the National Health Service Act 1946 having

developed from the emergency PHLS set up in 1939 at the outbreak of war. From its headquarters in Colindale, the PHLS administers a national network of fifty-two area and regional laboratories (four of which are in Wales), together with the Central Public Health Laboratory (CPHL), which includes a range of specialised reference laboratories, the Centre for Applied Microbiology and Research (CAMR) at Porton Down and the CDSC.

4.14 CPHL is the major reference centre of the PHLS. It gives specialised advice and assistance not only to PHLS laboratories and CDSC but to all NHS hospital laboratories as well. It supports and advises community physicians, local and central government and WHO. As a reference centre, CPHL will repeat standard tests when particular results need checking or do in-depth investigations and typing of bacteria and viruses for epidemiological purposes.

4.15 A considerable part of the work of the area and regional PHLS laboratories relates to infection in the community and the investigation of outbreaks, when necessary with the help and advice of reference laboratories and of CDSC epidemiologists. PHLS microbiologists have essential local microbiological and epidemiological knowledge and maintain working relationships with relevant individuals in their areas. The resources of the PHLS are available to all health and local authorities and their environmental health departments through the nearest Public Health Laboratory. These resources include the capacity to mount a national response, mobilising its specialist reference laboratories and CDSC, the services of which are also directly available to health authorities when necessary.

4.16 CDSC was created in 1977 by amalgamating the former Epidemiological Research Laboratory staff and functions relating to surveillance with the former DHSS function of co-ordination and advice upon the control of outbreaks. The functions of CDSC now include:

- the national surveillance of communicable disease;
- advice, assistance and co-ordination of disease investigation and control nationally;
- surveillance of immunisation programmes;
- production of the weekly Communicable Disease Report and other publications;
- epidemiological research in communicable disease;
- training and teaching.

4.17 CDSC provides a continuous source of information and advice about communicable disease and infection for enquiries by telephone, distributes a weekly and quarterly bulletin, the Communicable Disease Report to all those concerned in communicable disease control in England and Wales, publishes an annual review of communicable disease jointly with OPCS and frequently publishes articles in the medical press.

4.18 In addition to the surveillance of episodes of disease, the surveillance of immunisation programmes also constitutes an important function of CDSC. This part of the work includes assessment of the efficacy, safety and uptake of vaccines and involves both laboratory and epidemiological studies.

4.19 Evidence submitted to us demonstrates almost universal support for the PHLS and its epidemiological “nerve centre” the CDSC. Moreover there is a widespread view that CDSC is under-resourced. Although the support it provides to the field in the investigation of outbreaks is highly prized, it is not always available due to lack of trained personnel. We are concerned to learn that if there were a recurrence of serious outbreaks similar to the legionellosis in Stafford or the earlier smallpox episode in Birmingham in more than one part of the country at the same time, or if a single outbreak spread to more than one major centre of population, the current system would be unable to cope. We have made suggestions to strengthen PHLS in chapter 7.

Health Education Authority

4.20 The importance of advice and information in helping people to maintain good health and to prevent disease has been recognised for many years. For example as long ago as the early years of this century, the development of the health visiting movement was inspired by the belief that greater cleanliness in infant feeding and better child care in general were vital to reducing the high infant mortality rates of those days, and that education of mothers was one of the approaches most likely to yield results. However, it is the growing awareness of the importance of individual behaviour in determining the patterns of health and disease in the population which represents perhaps the greatest single change affecting public health in recent years. Today it is widely recognised that smoking, diet, and lack of exercise are factors which contribute to many premature deaths from lung cancer and cardiovascular disease and, together with the untoward effects of alcohol, play a major part in many other forms of ill health. Our ability to reduce such premature deaths is to a substantial extent dependent on social attitudes and individual understanding and behaviour. High take-up rates of preventive services such as childhood immunisation and cancer screening, which are crucial if the ultimate objective of such services is to be achieved, are also dependent on understanding of the issues and social attitudes.

4.21 It is of interest that the first public body wholly devoted to health education, the Central Council for Health Education, which was founded in 1927, emerged from an initiative not of government but of the public health doctors of the time, acting through the professional body which represented them, the Society of Medical Officers of Health. Financial support for the Council was obtained from local authorities and voluntary organisations. A Ministry of Health committee on health education (the “Cohen” committee, 1964), recommended that government should assume responsibility for this function and the result was the foundation in 1968 of the Health Education Council, which was set up as a non-departmental public body with independent status. As the central body for England, Wales and N. Ireland dealing with health education its functions included the following:

4.21.1 At the national level

- mounting media campaigns — press and TV
- briefing editors and journalists on health matters
- lobbying on specific public health issues such as taxation, advertising and sponsorship in the tobacco field.

4.21.2 Within the NHS

- providing information and publicity material to support the activities of health authorities in the health education field.

4.21.3 In schools

- supporting curriculum development of health education projects suitable for use by children of different age groups.

4.21.4 Liaison and support of other organisations especially local authorities.

4.21.5 Organising recognised training programmes, conferences etc. for personnel concerned with health education.

4.22 In the 19 years of its existence the HEC succeeded in encouraging an enhanced public profile for healthy living and in disseminating accurate information about health matters on a wider scale than ever before. Its striking media campaigns on the hazards of smoking are well known. Other long-term activity included initiatives encouraging a sensible approach to alcohol and a pilot programme in Wales designed to prevent coronary heart disease. The Council also co-operated with the DHSS in activities to combat drug misuse.

4.23 Since April 1987 this programme of work has been continued by the newly-established Health Education Authority which has been given additional responsibility and resources to undertake public education about AIDS. In announcing this change the then Secretary of State said, in his statement to the House of Commons on 21 November 1986¹⁹: "I also intend that from an early date it should be given the major executive responsibility for public education about AIDS . . . As a special health authority the new authority will be an integral part of the National Health Service in England. As a result, it should be more responsive than an outside body can be to the needs of the service and in turn will have more influence in setting priorities for the service and ensuring that the needs of health education and promotion are properly recognised. We envisage that the new body will also have a United Kingdom dimension to its work, particularly, for example, in relation to AIDS . . ." The Chairman of HEA now attends the bi-monthly meetings between Regional Chairmen and the Secretary of State. The Authority will also be subject to review in the same way as RHAs.

4.24 We greatly welcome this recognition by Government that health education and promotion constitute vital components of the public health function. We urge that the closer integration of the new authority into the work of the NHS at all levels which the new arrangements will permit, should be exploited to the full to ensure that more detailed attention and high priority is given in the future to the prevention of disease and the promotion of health. We urge early and close collaboration with RHAs and DHAs in nationally organised initiatives. In addition, it will need to continue to work in collaboration with other bodies such as local authorities, schools, industry and other organisations concerned with creating a healthy society, while at the same time preserving a robust degree of independence. The HEA will also need to link closely with the DHSS monitoring unit.

Health Authorities

4.25 The Secretary of State discharges his responsibilities under the NHS Act 1977 primarily through regional health authorities (RHAs), district health authorities (DHAs), special health authorities (SHAs) and family practitioner committees (FPCs). As we have already seen (paras 4.3 and 4.4), these responsibilities include duties relating to public health, although they are rarely made explicit. In our view this situation should be rectified. *We RECOMMEND that the Secretary of State should consider issuing guidance clarifying and emphasising the public health responsibilities of health authorities.* In the following paragraphs, we have attempted to define the key public health responsibilities of health authorities as a basis for the recommended guidance.

District Health Authorities

4.26 District health authorities are (except for certain specialist services) responsible for the planning and provision of hospital and community health services to local populations (these range in size from approx. 100,000-850,000, ¼ million representing the average). Teaching districts are also responsible for the provision of specialist services for larger catchment populations, undergraduate medical education and for the management of consultant contracts. All DHAs formulate both strategic plans and short term programmes for approval by regional health authorities, in the context of which they set priorities for the distribution and development of health services for their districts. Setting priorities often means making difficult choices between competing and increasing demands against a background of finite resources. This is difficult and challenging work. As Sir Roy Griffiths pointed out in his Management Inquiry Report³:

“There is little measurement of health output: clinical evaluation of particular practices is by no means common and economic evaluation of these practices extremely rare. Nor can the NHS display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves.”

It is crucial that DHA Chairmen, members and officers recognise the need for their decisions to be based on an assessment of the principal health problems of the population for whom they are responsible. It is only in this way that the value of current management processes will be maximised. Only by a thorough assessment of the problems to be tackled can a thorough evaluation of the benefit of health services be achieved.

4.27 Briefly the public health responsibilities of district health authorities can be summarised as follows:

4.27.1 To review regularly the health of the population for which they are responsible and to identify problems. To define objectives and set targets to deal with the problems in the light of national and regional guidelines.

4.27.2 To relate the decisions which they take about the investment of resources to their impact on the health problems and objectives so identified.

4.27.3 To evaluate progress towards their stated objectives.

4.27.4 To make arrangements for the surveillance, prevention, treatment and control of communicable disease.

4.27.5 To give advice to and seek co-operation with other agencies and organisations in their locality to promote health.

We consider that this is the framework within which decisions on priorities and developments should be based. The assessment of health problems will of course depend on the availability of soundly based information. (See the report of a joint working group of the Körner committee and the Faculty of Community Medicine, edited by Professor E G Knox under the title "Health Care Information"²⁰).

Reports on the health of the population

4.28 Of the responsibilities outlined above, we wish to comment further on 4.27.1. We believe that authorities should commission a report from their Director of Public Health (see paragraph 5.2) which will provide the basic epidemiological assessment on which they can base their decisions. It should be produced in collaboration with the relevant departments of the local authority and the FPC drawing on the information they have available and will parallel the work on monitoring public health undertaken at DHSS. The report, in assessing the health of the local population, will provide valuable information not only for DHAs but also for local authorities and FPCs, in the exercise of their public health responsibilities. *We RECOMMEND that DHAs should be required to commission an annual report from their Director of Public Health on the health of the population. In formulating their views about the report, they should consult local authorities, FPCs, and other relevant bodies locally.*

4.29 The report should be a public document presented to the health authority by the Director of Public Health and debated by the authority in the open part of their meeting — ie with the press and public present. We suggest that the report at this stage should be based on the professional work and judgement of the Director of Public Health in the same way as a financial report is based on the professional work and judgement of the Director of Finance. It will be for the Authority, given the advice of the DGM, to decide what action is necessary in the light of the report's findings. As a result of its presentation in an open authority meeting, the report will make an important contribution to the accountability of the health authority to the people they serve. The report will also form a part of the accountability process through RHAs to Ministers and Parliament. The report and the Authority's views on it should be a standing item on the agenda for the review of the DHA by the RHA and should inform discussion of all service issues. It should form part of the information base upon which strategic plans and short term programmes are drawn up and thus assist in the planning process. It will be for consideration in due course whether the report should replace any of the documentation currently required by the planning process. Similarly, the regional report (see paragraph 4.32) should be on the agenda of Ministerial reviews of RHAs.

4.30 There has been general support in the evidence submitted to us for re-introduction of an annual MOH style report, and we have responded by the recommendation in paragraph 4.28. The SCPR report, for example, states: "Very little information was available about the evaluation of services . . . It was suggested that some form of annual report, along the lines of the former MOH's report, would be most helpful in identifying areas of service deficiency and needs."⁶ It is perhaps salutary, however, to reflect that some MOsH did not mourn the passing of what they had come to regard as an annual chore of questionable value. In certain cases reports had become stereotyped and stale, an annual statistical exercise which diverted resources from other work. It is important that this situation does not recur. As we have already pointed out in paragraph 4.26, in a world of finite resources the importance of trying to identify the principal health problems (such as the special needs and health care problems of ethnic

minority communities) is a key step in maximising the return to be obtained from the resources available for health care. We believe that it is important that 'he reports should be regular and have therefore recommended that they should be annual. They do not need to attempt to be all-embracing every year, however. We suggest that different topics should be highlighted from year to year, perhaps those where there is the greatest opportunity to promote change. A major overview might be produced every 5 years linked to the strategic planning process. Some authorities have already made excellent advances in the production of reports, and our recommendation is in one sense simply formalising a trend. A number of reports have been produced and sent to us which could serve as models for others — well presented and accessible to the lay reader.^{21, 22, 23} We also believe that whilst central prescription is to be avoided, a minimum of guidance on the form and content of the report would be helpful, not only permitting comparisons between districts to be made but removing some of the burden of design for all authorities.

Public health responsibilities of health authority members

4.31 We note that the advice issued to people taking up office as HA members (Notes of guidance to RHA members.²⁴ Appendix 1 to HC(81)6.²⁵ "Acting with Authority"²⁶.) omits guidance on their responsibility for the health of the population in general and for evaluation of the services provided. While we recognise that many health authorities have acknowledged these responsibilities in their statements of key objectives, we feel national guidance on these issues would be helpful. *We RECOMMEND that DHSS, RHAs and the National Association of Health Authorities (NAHA) should revise the material they produce for the training and induction of members to emphasise their public health responsibilities.*

Regional Health Authorities

4.32 Regional health authorities (RHAs) are a key link in the chain of accountability between districts and the Secretary of State. Their principal tasks are to allocate resources, set objectives, review DHA performance and carry through and monitor strategic and operational planning; but they also provide — directly manage in fact — a range of specialist services for DHAs such as computing, blood transfusion, information services and capital design. RHAs have an important role in the surveillance of non-communicable disease and the setting of targets to secure improvements in its incidence. RHAs take many of the major capital investment decisions in the NHS and in doing so they must relate their decisions to an epidemiological assessment of need. They also have a key role in setting health targets and objectives for DHAs in the light of national policies and guidance. The public health responsibilities of RHAs are briefly summarised as follows:

4.32.1 To review regularly the health of the region's population. To identify the principal health problems of the region (including those relevant to regional specialist services and teaching). To define regional objectives and set regional targets in the light of national guidelines. To agree objectives and targets for the public health responsibilities of DHAs.

4.32.2 To relate the decisions which they take about the distribution of resources to DHAs and about investment of resources to their impact on these health problems and objectives.

4.32.3 To monitor DHA progress towards identified targets.

4.32.4 To make plans for dealing with major outbreaks of communicable disease and infection which span more than one district and ensure their implementation as appropriate. (See also 7.27 below).

In order to carry out these responsibilities, RHAs will need to commission a report from their Regional Director of Public Health (see para 5.22). In addition to drawing together information from the district reports, it should contain an assessment of the need for regional specialist services, development of teaching facilities and links with universities. In some circumstances it also may be the most practical way of promoting joint planning with FPCs (in view of problems of coterminosity with DHAs). *We therefore RECOMMEND that RHAs should be required to commission from their Regional Director of Public Health an annual report on the health of the population.* The RHAs' monitoring responsibilities will, in the main, be exercised through the review process, the associated follow up activities and the NHS planning cycle. In the same way the RHAs' performance of their public health duties will be monitored by Ministers. The annual reports will be of great value in this process.

Primary health care – Family Practitioner Committees

4.33 As the recently published Government White Paper "Promoting Better Health"²⁷ points out, those involved in the delivery of primary health care, and particularly general medical practitioners, are in a good position to assist the promotion of health and the prevention of ill health, and can have a significant effect on patients' behaviour. There are frequent contacts between doctors and patients and opinion polls show that people trust their family doctor's advice. There is evidence, for example in the field of smoking, that a significant number of patients respond to quite simple forms of counselling. This work can involve all members of the primary health care team. The role that teams can play has been shown by units like the Oxford Heart and Stroke Prevention Project. On an average working day, 750,000 people are seen by their family doctors, a similar number get medicines on prescription from their local pharmacist and 100,000 are visited by nurses or other health professionals working in the community. This includes not only people who are ill but also those in good health who require advice. The potential for health promotion, advice on family planning, immunisation and screening procedures is therefore immense. We welcome the Government's intention as stated in "Promoting Better Health" that it intends positively to encourage family doctors and primary health care teams to increase their contribution to the promotion of good health. This should go a long way towards meeting "the next big challenge for the NHS" as identified in the Social Services Committee Report on Primary Health Care²⁸: "to shift the emphasis from an illness service to a health service offering help to prevent disease and disability".

4.34 Since Family Practitioner Committees became autonomous it has been Government policy to expand their role in the planning and administration of contractor services, and to encourage them to co-operate with health authorities. We are impressed by recent developments in this field. We understand, for example, that a substantial number of DHAs and some FPCs are funding "facilitators" to provide support to general practitioners to enable them to develop their organisation and services in ways conducive

to health promotion. The Royal College of General Practitioners (RCGP) have taken a leading role in this field also. Reports of these and other ways of encouraging prevention and health promotion in primary care have been published.^{29,30,31,32.}

4.35 In order to maximise the contribution of primary care to public health, it is vital that there should be close and continuing co-operation between FPCs and HAs. This applies at both the strategic and operational levels. Plans for future service developments need to be compatible — the annual report referred to in paras 4.28—4.30 will provide one important basic assessment of need on which plans can be drawn up. The Director of Public Health and his or her staff should work closely with FPC staff to develop the report so as to make best use of joint information. DHAs should consult FPCs on the proposed action to be taken in the light of the report and it will often be appropriate for projects to be mounted jointly, assisted by local medical committees (LMCs). We welcome the Government's recognition, as set out in the White Paper, that FPCs will need to seek professional advice on a wide range of issues. We endorse the suggestion that in many areas, such as the development and evaluation of policy on health promotion, FPCs will benefit from the advice of public health doctors. We suggest that FPCs should consider seeking such advice from a public health doctor employed by a health authority, perhaps on a contractual basis. They will also, of course, be free to seek advice from other sources on matters such as prescribing or the design of practice premises.

4.36 At the operational level, the need for co-operation and co-ordination is no less vital, as was demonstrated in the Cumberlege report on neighbourhood nursing.³³ The differences in the organisation of general practice and the DHA-based community health staff can lead to potential gaps in service. It is therefore important that DHAs and FPCs should collaborate to ensure that the needs of the total populations for which they are responsible are covered. It may be helpful if district Directors of Public Health are invited to attend meetings of FPCs in an ex-officio capacity.

4.37 In this context, FPCs have access to a vital database, the patient register, which is not available in any other equivalent form. The register has a number of uses: it is the best denominator for measuring the extent of take up of services; it is the basis on which call and recall systems operate for screening purposes; it provides a sample frame for designing local research studies; it permits assessments of population changes between censuses. Although in some places, FPCs have already agreed to give health authority staff access to the register, this is by no means the rule. We acknowledge that there are genuine concerns about the confidentiality of information about individual patients but do not believe these are insuperable. Health authorities are well used to dealing with such information in hospitals and clinics. We welcome the recent publication of a consultation document on this issue.³⁴ We hope that our comments will be taken into account in the consultation exercise. Health authorities and FPCs share a responsibility for the good health of those living within their boundaries. If they do not, or are unable to, exchange information with suitable safeguards for confidentiality, it is patient care that suffers. *We RECOMMEND that FPCs and health authorities should grant each other access to the registers they hold in the interests of health promotion and health care.*

Local authorities

4.38 As we have already seen in Chapter 2, historically local authorities carried the principal role and responsibility for public health. Their responsibilities, which were

enshrined in a series of Public Health Acts, encompassed environmental health, community health services, housing, education and eventually municipal hospital services. More recently, specifically since 1974, local authorities' major responsibilities with regard to health have tended to centre mainly on seeking to ensure that the environment is healthy by: providing safe water and food; controlling environmental pollution; providing appropriate housing and recreational facilities; and by the provision of personal social services and education.

Environmental Health

4.39 The work of co-ordinating policies and liaising with other public health professionals is generally carried out within local authorities by the Chief Environmental Health Officer (CEHO) and his/her staff, who are specifically qualified to deal with problems relating to the impact upon health of the natural and man-made environment.

4.40 Local authorities have wide and diverse legal responsibilities in respect of health. In addition to the Local Government Act 1972, which brought about the 1974 reorganisation of local authorities, the main statutes governing their role and duties include the Public Health Act 1936, parts of which remain in force today, the Clean Air Acts, the Housing Acts 1957-85, the Public Health Act 1961, the Health and Safety at Work etc Act 1974, the Control of Pollution Act 1974, the Building Act 1984, the Food Act 1984 and the Public Health (Control of Disease) Act 1984. The subjects for which local authorities, through their Environmental Health Officers (EHOs), have responsibility include the control of noise; air and water pollution; the sufficiency and wholesomeness of water supplies; port health; food inspections and food hygiene; some aspects of animal health; disposal of waste; housing including repair and improvement; home safety; health and safety at work; the abatement of statutory nuisances; notifiable disease (see Chapter 7), and pest control.

Medical advice and collaboration on environmental health – The Medical Officer of Environmental Health (MOEH)

4.41 Traditionally it was the MOH who was responsible for all medical advice to the local authority on environmental and other health issues. It was envisaged in 1974 that the environmental health function would be assumed by the MOsEH. In practice this has not happened universally. The post of MOEH has been associated with a degree of difficulty and uncertainty since its inception and has all too often proved to be unsatisfactory from the standpoint of the local authorities it was intended to serve and unrewarding to the post-holder. There are several reasons for this, the most important perhaps is the fact that only a small minority of community physicians, usually those located in major conurbations, have been able to specialise in this field of work. Around 40 per cent of MOsEH combine the role with that of District Medical Officer often unsupported by other community physicians. Although performing tasks which, for a century at least, had been regarded as central to the public health function, evidence we have received shows that in many cases this situation has meant that the time the post-holder has been able to devote to environmental health matters has often been insufficient to enable him/her to keep abreast of developments in this field and thus to maintain credibility with the local authority and its officers. As time passed and successive reorganisations of the NHS took place, many of the remaining 60 per cent of MOsEH (ie those who were not DMOs) found themselves straddled uneasily between two authorities whilst "belonging" to neither. Many were employed in a dual capacity by health authorities which tended inevitably to give priority to the other non-environ-

mental work the MOsEH were called upon to do as specialists in community medicine. At the same time they were attempting to work in collaboration with the environmental health departments of local authorities.

4.42 It is specifically on the office of the MOEH that much of the concern expressed to us in evidence centres. This was demonstrated in both the Stanley Royd and Stafford Inquiry reports and elsewhere. In some evidence there is concern that MOsEH appear inadequately trained or qualified. In other evidence there has been a lack of clarity about what his or her authority and responsibilities are. There has been a tendency to concentrate on reactive work, in response to outbreaks of particular diseases, to the neglect of preventive work, for example in immunisation. The Public Accounts Committee in its 44th Report "Preventive Medicine"³⁵ found that since the abolition of the MOH there had been "a blurring of the chain of accountability for the organisation and development of certain preventive measures in districts." In particular, low immunisation uptake in some regions and districts seemed to be due to "blurred responsibility for prevention at local level." In this context we noted with interest the comment of one Regional Medical Officer (RMO), that MOsEH worked well on the whole "even though they were not responsible to health authorities" (although paid by them)! This lack of unambiguous accountability in turn has led to difficulties experienced by some MOsEH in gaining access to adequate facilities — staff, accommodation etc and this in turn has compromised credibility. We have received further evidence that some MOsEH do not see themselves as part of mainstream NHS community medicine. We consider the future of the MOEH in Chapter 7 where we make recommendations about responsibility for control of communicable disease and infection.

4.43 The general field of environmental health (excluding communicable disease and infection) has become increasingly technical, requiring specialised scientific knowledge. The environmental health profession has established a graduate qualification and more specialised post graduate courses. In the larger departments particularly, technical and scientific skills have been developed in response to the wide range of possible threats to health arising from developments in industry and elsewhere. Thus much of the ground can be covered within the departments themselves. When necessary they consult with other agencies. For example, collaboration with HSE and Her Majesty's Inspectorate of Pollution is normal practice. There are occasions when a focal point for medical advice at local level and a positive mechanism for effective local collaboration are still needed on environmental health issues (see below). In the main however, it is not realistic to expect the MOEH in every district to possess the whole range of technical knowledge although we recognise that some individuals have developed specialised skills in this field. Specialist advice, including medical aspects of environmental health, is available from a variety of sources, including national agencies. DHSS, for instance, is the central focus for information on adverse effects on human health of environmental pollutants. Well-run environmental health departments are familiar with these sources and make use of them as and when required. In many places, perhaps most, the MOEH plays little or no part.

4.44 There are, however, some situations where positive steps are called for, to ensure that effective liaison between health and local authorities continues to exist:

4.44.1 When further investigation of a suspicious or incompletely resolved environmental health problem requires an epidemiological input:

4.44.2 When the DHA needs to ensure that its public health spokesperson is fully informed about a local environmental problem, which appears to have a medical implication affecting the health of the public:

4.44.3 When there is a risk of giving conflicting advice to the public on matters such as healthy diet, AIDS etc where both health and local authorities have a role in health education.

These situations can only be effectively resolved through mutual local knowledge, collaborative working arrangements and the establishment of a forum for regular and frequent meetings between EHOs and consultants in public health medicine.

4.45 We believe that the focal point for medical advice in a health authority and the person responsible for ensuring effective collaboration with the local authority on general environmental health issues should be the Director of Public Health (see para 5.2). *We RECOMMEND that the DPH and the Chief Environmental Health Officer should meet on a regular basis and that they should establish channels of communication which encourage collaboration between their organisations.* We believe that many opportunities exist for the development of new initiatives, the joint planning and implementation of long term studies, and co-operation on the production of the DPH's annual report. Collaboration will assist the early detection of likely problems. Such meetings might involve DsPH and CEHOs from several health authorities and local authorities, as the issues being addressed in many cases are unlikely to be exclusive to single authorities. We would therefore welcome the extension of this concept on a regional basis so that an integrated overview of environmental health within each region can be developed and appreciated by both the local authority and NHS sectors. DHSS should establish a firm and effective line of communication with all DsPH (such as already exists with CEHOs) so that they are in a position speedily to disseminate information in circumstances such as those that occurred after the Chernobyl disaster.

General public health responsibilities – the need for collaboration

4.46 Increasingly, local authorities are becoming concerned about the need to ensure that policies on housing, education, leisure and recreation and transport support and encourage healthy lifestyles and access to appropriate services. Clearly the role of local authorities in the area of health promotion and disease prevention is vital and expanding.

4.47 We felt a need to explore in greater detail the wide range of public health responsibilities including the local authorities' own perception of their contribution to the public health function and their relationship to the health authorities. We accordingly commissioned the independent research agency Social and Community Planning Research to undertake such a study on our behalf and this will be published separately.⁶ Although we have been encouraged by the enthusiasm demonstrated in the SCPR Report with which some local authorities are seeking to develop their health responsibilities, we have been disappointed by the lack of appreciation shown by many of them of the contribution of health authorities in this field and vice versa. The Report points out, first, "there is for many departments little contact with the health authority . . . For the most part EHOs see themselves as having the relevant necessary expertise to deal with issues that arise" and secondly, "In general health authorities are not seen to give high priority to public health." There are notable exceptions, for example the collaboration between Bradford City Council and Bradford Health Authority in the preparation and delivery of their AIDS Health Education Campaign.

Unfortunately, such examples are not as widespread as we would like. We are concerned to have found a degree of ignorance, even among professionals such as community physicians and environmental health officers, of the nature and importance of each others' contribution. As far as health is concerned there is a compelling need for greater collaboration between the two main statutory arms and continuing close working relationships between trained professionals working in this field. We are not suggesting the re-introduction of a medical hierarchy into local authorities nor the creation of large departments managed by public health doctors in health authorities, but simply the co-operation of teams of professionals to maximise resources available in order to achieve improvements in health.

4.48 We recognise that the present lack of coterminosity between many health and local authority boundaries, and the complexity of local government organisation, inevitably create difficulties. Not least there is the problem of relating to more than one authority with the potential for different policies and approaches on health issues. There are no easy solutions to this and it will not always be possible to avoid duplication of effort. A collaborative attitude however, is vital. We hope that the collaboration required in order to produce an annual report (see para 4.28), the formal consultation on the DHA's decision on it, our recommendations on officer meetings in 4.45, and on training in chapter 8, will go some way towards achieving this aim.

Non-statutory agencies

4.49 As we pointed out in our introductory chapter, the task which we were assigned was to review the work of those agencies which play the major part in securing the health of the public. In this chapter, therefore, we have concentrated on health authorities, local authorities and FPCs which are (or should be) key partners in the triumvirate of interests which carry statutory responsibility for public health. But, as we have seen in Chapter 3, public health casts its net much wider than the statutory agencies. We should like to take this opportunity to underline the importance of health authorities, local authorities and FPCs developing links with CHCs, voluntary organisations, consumer groups, the local media and local industry, trade unions etc. These all have a vital contribution to make to the achievement of better health for the public.

CHAPTER 5: THE ROLE OF PUBLIC HEALTH DOCTORS IN THE ORGANISATION AND MANAGEMENT STRUCTURE OF THE NHS

5.1 In the previous chapter, we have outlined briefly the various public health responsibilities of the main statutory bodies. In spite of the existence in this country of a wide range of relevant skills and their distribution amongst a range of agencies, the evidence presented to us leaves us in no doubt that, in terms of their final product, namely better ANDhealth for our people, these skills are being deployed to less than optimal effect. In this chapter therefore we look at the management and staffing implications of these responsibilities, particularly for the employment of public health doctors by health authorities.

The discharge of public health responsibilities by district health authorities

5.2 In view of the importance of the public health responsibilities of DHAs which we set out in paragraph 4.27, and in the light of the philosophy recommended by Sir Roy Griffiths in his Management Inquiry Report³ which recommends the identification of "personal responsibility to ensure that speedy action is taken and that the effectiveness and efficiency of such action is kept under constant review," we *RECOMMEND that DHAs should appoint a named leader of the public health function in their district who should be known as the Director of Public Health (DPH)*. The DPH will be managerially accountable to the DGM. In view of the considerable turmoil resulting from reorganisations in 1974, 1982 and 1984, when community physicians in many cases had to submit to formal appointments exercises, where a DMO is currently in post, our expectation is that he/she should normally be appointed as DPH. For the reasons enumerated in paragraph 3.9, we believe that this person should be a medical practitioner with a special training in epidemiology and those environmental, social and behavioural factors which affect the balance between health and disease; in other words a consultant in public health medicine. Questions of availability are discussed in para 5.10 and the next chapter. In order to ensure consistency and avoid confusion (as referred to in paragraph 2.10 and 3.13) we recommend that a common title should be adopted. If additional responsibilities are assumed (see paragraph 5.4 below) an additional title may of course be added. But we believe that for the reasons outlined in 2.10 and 3.13, and in addition the special role of public spokesperson which the leader of the public health function is from time to time required to fill, it is important that this role should carry a readily identifiable and common title in all parts of the country.

Tasks of public health doctors at district level

5.3 The central tasks of the DPH and his/her colleagues are as follows:

5.3.1 To provide epidemiological advice to the DGM and the DHA on the setting of priorities, planning of services and evaluation of outcomes.

5.3.2 To develop and evaluate policy on prevention, health promotion and health education involving all those working in this field. To undertake surveillance of non-communicable disease.

5.3.3 To co-ordinate control of communicable disease (see Chapter 7).

5.3.4 Generally to act as chief medical adviser to the authority.

5.3.5 To prepare an annual report on the health of the population (or, to

quote the former MOH duty "To inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the [district] and be prepared to advise the [health authority] on any such matter" (see para 2.3.1)).

5.3.6 To act as spokesperson for the DHA on appropriate public health matters.

5.3.7 To provide public health medical advice to and link with local authorities, FPCs and other sectors in public health activities.

5.4 In setting out these central tasks, we recognise that in many districts, DHAs have asked public health doctors to take on additional responsibilities within the management structure adopted by the authorities post-Griffiths. (These include posts as Director of Planning, Director of Quality, Director of Information, Director of Service Evaluation etc). While we welcome this, it is important to recognise also that these posts are not confined to public health doctors. Those doctors who are appointed to them have additional abilities and/or training which qualify them for the posts but they are and will continue to be open to people without a medical background. Similarly public health doctors have traditionally had responsibilities for medical personnel matters or for dealing with clinical complaints, capital building and managing information services. In current circumstances we feel that although public health doctors will often have important contributions to make in these areas, it is inappropriate that they should be included in the central tasks at district level.

5.5 There are different views on the responsibility of public health doctors in respect of child health services. In the King's Fund Institute survey,⁵ for example, it is reported that 26 per cent of community physicians currently have no responsibility for child health, while 23 per cent said this responsibility took a high priority. We do not believe that there is any reason why the operational management of child health services should necessarily be the responsibility of public health doctors as was traditionally the case. A variety of management arrangements for this service is already in existence around the country and we believe that his flexible approach should continue. What is important, however, is that public health doctors recognise, as part of their general responsibility to report on the health of the population and to evaluate services, the need to determine whether there is comprehensive provision of preventive and surveillance services for children, under whatever management arrangements prevail, and to evaluate their effectiveness and advise accordingly.

5.6 We have received evidence that there are still places where public health consultants at district level undertake specified clinical tasks for local authorities. These include provision of medical advice under S 47 of the National Assistance Act 1948, the assessment of medical need on behalf of housing departments, and occupational health examinations of local authority staff. *We RECOMMEND that public health consultants should no longer be required to carry out this work.*

Medical advice – to health authorities, local authorities and FPCs

5.7 *We RECOMMEND that the DPH will generally be the chief source of medical advice to the health authority.* In the King's Fund Institute survey, "Fifty-five per cent of community physicians gave [this] high priority in their work practice and in their beliefs about what the specialty as a whole should be involved in."⁵ There are, of course, other

sources available, particularly for clinical advice, from, for example, the consultant and GP members of management boards, the chairman of medical advisory committees etc. But we expect general managers and authorities to look to the DPH to comment on all other advice in the context of its contribution or otherwise to the health of the authority's population. This would be most evident, for example, where different specialties were competing for resources. There will also be a need for public health medical advice to special health authorities (SHAs). DHSS, which exercises a quasi-regional function in respect of SHAs, should consider how best this can be provided.

5.8 The DPH should also act as a source of public health medical advice to the relevant local authorities and FPC. (See also paragraphs 4.35, 4.36 and 4.45). In the main, the responsibility will be exercised in the context of the preparation and presentation of the annual report and consultation on any follow-up action required. But, building on the collaboration necessary to produce the report, there will also be a need for epidemiological advice on the co-ordination of services for which responsibilities are split between more than one authority eg screening programmes, immunisation, developmental assessment of children. It is important that such advice should be available to local authorities and FPCs on a regular and routine basis. As we have already said in paragraph 4.35, we welcome the Government's recognition that FPCs should seek such advice and we suggest that they should contract with health authorities for its provision. It is not intended that this should preclude FPCs or local authorities seeking additional specialist advice when necessary. In local authorities, the chief environmental health officer, the director of social services, and the chief education officer, as the principal officers of the departments carrying direct public health responsibilities, will probably have the most frequent need to call on specialists in this way.

Managerial relationships

5.9 Since 1984, DMOs have been managerially accountable to DGMs but are entitled to give professional advice directly to the DHA. We have received evidence that the change in managerial relationships introduced by the Griffiths Report is in general working satisfactorily. There seems to be an accepted distinction between managerial and professional functions: the right to give professional advice to the authority is not only usually accepted but encouraged as an important part of the authority's work, and fears that there might be public disagreements at authority or committee meetings have proved to be largely unfounded. In view of the central importance of the health authority's public health responsibilities we *RECOMMEND* that the DPH, as the named officer responsible for discharge of the function should be part of the key decision making machinery in the district.

Supply of Directors of Public Health

5.10 There will inevitably be some districts where in the short term there will be difficulty in appointing a suitably qualified Director of Public Health. In these circumstances general managers will need to consider alternative interim arrangements which should be agreed with the RHA. Obviously such arrangements are not ideal and would not permit the development of the public health function in the way we would wish. They should be regularly reviewed. Some possible interim solutions are described in Chapter 6.

Support for Directors of Public Health

5.11 The new arrangements we recommend give Directors of Public Health clear

accountability to the authority through the DGM for the discharge of certain key duties (see para 5.3). From this will follow the need to provide them with the facilities necessary for the discharge of these duties such as adequate direct support staff (administrative and clerical) and access to facilities, expertise and relevant information elsewhere in the organisation. They will also need support both from consultants in public health medicine and from non-medically qualified staff.

Consultants in Public Health Medicine

5.12 All the evidence we have received has suggested that as in the case of other consultants it is very difficult for DsPH working single-handed to provide a professionally adequate service. Ideally, except in small districts, every DPH will require the support of at least one consultant in public health medicine to help discharge the tasks outlined in para 5.3. In some cases, of course, authorities have already decided that the task which faces them requires a larger establishment and we would expect this to continue to be the case. In realistic terms, however, we know that in the short to medium term the shortage of fully trained experienced and competent public health consultants rules out similar arrangements for all authorities. The issues relating to the future supply of these consultants is discussed further in Chapter 6.

5.13 It is desirable in order to provide a professionally competent service that in the longer term each district should have access to the advice of a team of consultants in public health medicine. This does not necessarily imply the establishment of such a team in every district. Small districts may wish to pool resources, for example sharing a team of 3 or more consultants between two districts. Moreover, it is possible, following recent changes in London, that there will be further rationalisation of the current pattern of districts over the next 10 years or so. *We RECOMMEND that every DHA should assess the number of public health doctors needed and should make arrangements for access to the advice of a team of at least 2 consultants.* They may well need more in the longer term. In view of the short supply of public health doctors predicted for the next few years however, it is unlikely that every DHA will be able to recruit sufficient consultants in support of the DPH in the short to medium term. In these circumstances and indeed more generally we urge authorities to consider engaging the services of non-medically qualified staff (eg health economists, statisticians, planners, who can make an important contribution) to support and work under the direction of the DPH.

Statutory Protection of the MOH

5.14 One area where the evidence we have received demonstrates concern among public health doctors is the question of freedom to speak out publicly on health matters affecting the population of the district. Our attention has been drawn to the statutory safeguards which then existed serving to protect an MOH from dismissal by the employing authority. An explanatory note on this matter and on the nature of the "independence" which it conferred on the MOH is included at Annex E.

5.15 We believe that there is currently considerable misunderstanding of the MOH's supposed role as an independent advocate for the public health. The MOH had the right and duty to express his professional views on key health issues involving the population he served to his employing authority and could report in Committee or in open Council meeting with the press and public present. On these occasions he was able to (and frequently did) draw attention to dangers, shortcomings and abuses in respect of health within his area and to recommend remedies which were sometimes controversial.

However, it was the Council's function to decide on the matter and thereafter the duty of the MOH to implement that decision.

The public health doctor as an advocate

5.16 We therefore reject the view expressed in some of the evidence submitted to us that public health doctors, employed in the public sector, have a duty or a right to advocate or pursue policies which they judge to be in the public interest independently of any line of accountability. In the extreme this would place them in a position above Parliament. The actual position has recently been outlined by the President of the Faculty of Community Medicine in the Faculty's newsletter (a copy of the article is at Annex F). In essence, this contends that the advisory function should be exercised by direct presentation of the issues to the health authority either in writing and/or by oral presentation. It also indicates the options open to a public health doctor whose authority does not accept his/her advice. Moreover, if our recommendation that DsPH should produce an annual report which they will present to the authority at an open meeting is accepted, we are re-establishing a formal opportunity for him/her to comment in public on the health of the population of the district.

Security of tenure and terms and conditions of service

5.17 We have found that the question of "advocacy" is often linked in evidence with concerns about the security of tenure and terms and conditions of service of consultants in public health medicine. The privilege is recalled of the former MOH who could only be dismissed following the approval of the Minister of Health. Some commentators have also pointed out that the appointments committees for consultants in public health lack the statutory force of those for clinical consultants — this particularly relates to the attendance by general managers at appointments committees and their participation in questioning of candidates and discussion of their performance.

5.18 As far as security of tenure is concerned, we feel that, as with the freedom of the MOH to make public statements discussed above, this is a theoretical rather than a practical problem. The issue is more one of confidence on the part of consultants in public health medicine that they have the right to give unwelcome professional advice direct to the authority when necessary and an opportunity annually to make a public statement on the health of the population. In any case consultants in public health medicine have similar terms and conditions of service to other consultants which include a right of appeal to the Secretary of State if they feel they have been unfairly dismissed. We consider that our recommendations that public health doctors should continue to have access to the authority and should be responsible for an annual report, which is discussed in public, cover the point.

5.19 As far as appointments committees are concerned, we are of the view that there is a significant difference between the role of consultants in public health medicine and clinical consultants. Health authorities carry public health responsibilities which are partly professional and partly of an administrative character. They look to their general manager as part of his/her management task to ensure that these are properly carried out and require him/her to arrange for the appointment of a named director of the public health function and necessary supporting staff. That person will be a part of the key decision making machinery in the district under the chairmanship of the general manager and be managerially accountable to him/her. *We therefore RECOMMEND that district general managers should be full members of committees which appoint Directors of*

Public Health. We understand that this is already the case in Northern Ireland. Where consultants in public health medicine are managerially accountable to unit general managers (see para 5.20), the UGM should be a member of the appointments committee together with the Director of Public Health.

Managerial Relationships within the specialty of Public Health Medicine

5.20 We recognise that since the Griffiths reorganisation, a variety of organisational patterns have emerged for the management of consultants in public health medicine. In some places consultants are grouped together into a single department under the professional and managerial leadership of the DMO. In others consultants work mainly within a single unit, managerially accountable to the unit general manager but with professional links to the DMO. We support flexibility of approach according to local circumstances, as long as it is recognised that there must be provision of public health medicine input in the district's central management machinery (see para 5.9) and at authority level and that professional leadership of the speciality within the district should be vested in the DPH. Whatever the managerial relationships, we believe that it is important that consultants in public health medicine in a district should come together regularly under the leadership of the DPH to meet, discuss issues and provide mutual professional support.

5.21 Many consultants in public health medicine, in submitting evidence to us, have expressed concern that the fact that they are managed by DsPH in some way undermines their consultant status. They draw comparisons with clinical consultants who do not accept a hierarchical structure and regard themselves as accountable to their patients, the health authority and the General Medical Council (GMC). Leaving aside the fact that the comparison is less appropriate than it was, as many health authorities around the country are appointing consultants as "directors of service" for particular specialties to manage resources within those specialties and therefore the access to and use by colleagues of those resources, we do not believe that the maintenance of consultant status by public health doctors should in any way interfere with a co-ordinated approach to the organisation of the public health specialty in a particular health authority or vice versa. This applies equally at district and regional level. As one RMO said: "I see myself as the professional figurehead of community medicine in this region. In this respect I am responsible for auditing the quality of the service offered to the authority and to the public, and I am responsible for career development for my colleagues". Having said that, the RMO respected the independent status of his consultant colleagues and left them to discharge their duties without professional oversight on his part. Experience in local government and elsewhere indicates that it is possible to engage a variety of independent professionals and to group them into teams from a management point of view without impairing their individual professional status or responsibility. We have no doubt that the same is true of the specialty of public health medicine and that the DPH should be responsible for the professional leadership of all consultants in public health medicine in a district.

The discharge of public health responsibilities by regional health authorities

5.22 The comments and recommendations in paragraphs 5.2-5.21 relating to the need for a named public health specialist in every authority, titles, managerial relationships with general managers and the authority and within the specialty of public health medicine, on advocacy, security of tenure and terms and conditions of service and on the provision of medical advice to the health authority, apply to regional health authorities

as well as district health authorities. We *RECOMMEND* that the named leader of the public health function in regional health authorities should be known as the *Regional Director of Public Health*. The role of the public health doctor at regional level embraces all the tasks which we have identified for the district level and we believe the case for an identified public health doctor carrying personal responsibility for ensuring that they are carried out is equally strong. The role includes additional tasks, however, notably:

- an extended leadership task not only for all public health doctors working within the Region but for all medical staff employed by the Region;
- an extended responsibility for the provision of medical advice on such issues as the development of medical technology, development of teaching facilities and links with universities and regional specialist services;
- medical manpower planning;
- liaison on strategic issues with universities and medical schools.

Responsibility for medical manpower planning does not necessarily imply detailed involvement in medical personnel issues, although some RMOs have used this as a means of building relationships, but rather acting as “honest broker” between authorities and managers on the one hand and the medical profession on the other. Medical personnel issues are already handled in different ways in different regions and we would endorse flexibility to free up the DPH’s time for other issues.

5.23 There is a need for a larger establishment of public health consultants at RHA headquarters than at district level, as the work tends to involve a greater degree of specialisation. This will be particularly true in the short to medium term when regional departments could well be called upon to intervene in or otherwise support district departments more frequently than would be expected if these departments were running at full complement. (See Chapter 6). It is important to recognise that the public health doctors at regional level will be working in a number of management roles, reflecting the RHA’s functions as set out in para 4.32, — sometimes taking part in the RHA’s managerial process; at other times leading high profile initiatives such as breast screening, and at others acting as a source of particular expertise from whom a DHA may ask for assistance.

5.24 It is at regional level that there will need to be the greatest degree of specialisation and flexibility within the specialty of public health medicine. RHAs already appoint consultants in public health medicine in some or all of the following and we envisage that they will continue to do so:

- applied epidemiology
- communicable disease control
- information design and administration and information technology
- health promotion and service development
- medical manpower planning
- services for particular care groups
- evaluation

It will be important to ensure compatibility between the number of specialists required by RHAs and the number of suitably trained applicants, and we return to this issue in Chapter 8.

CHAPTER 6: AVAILABILITY OF PUBLIC HEALTH DOCTORS

6.1 The most comprehensive analysis of the availability of public health doctors is that published by the Faculty of Community Medicine in June 1987.³⁶ Data were collected by means of a postal survey about all community medicine staff employed on 1.12.86 and the staff joining and leaving the specialty over a period of five years.

Numbers in post and vacancies

6.2 There were 534 community physicians in post in England on 1.12.86. The distribution by RHA is shown in Table 1. This represents a ratio nationally of 11.4 community physicians to every 1 million population. The regional rates vary from 8.1 per million [in Wessex] to 15.3 per million [in East Anglian]. In the survey of December 1986, there were also 83 posts funded and unfilled, and a further 32 posts for which funding had been temporarily withdrawn, indicating a vacancy rate of 21.5 per cent. This compares with an expected vacancy rate for hospital specialties of 4 per cent – 5 per cent. It is therefore extremely high.

Table 1

COMMUNITY MEDICINE ESTABLISHMENT 1.12.86

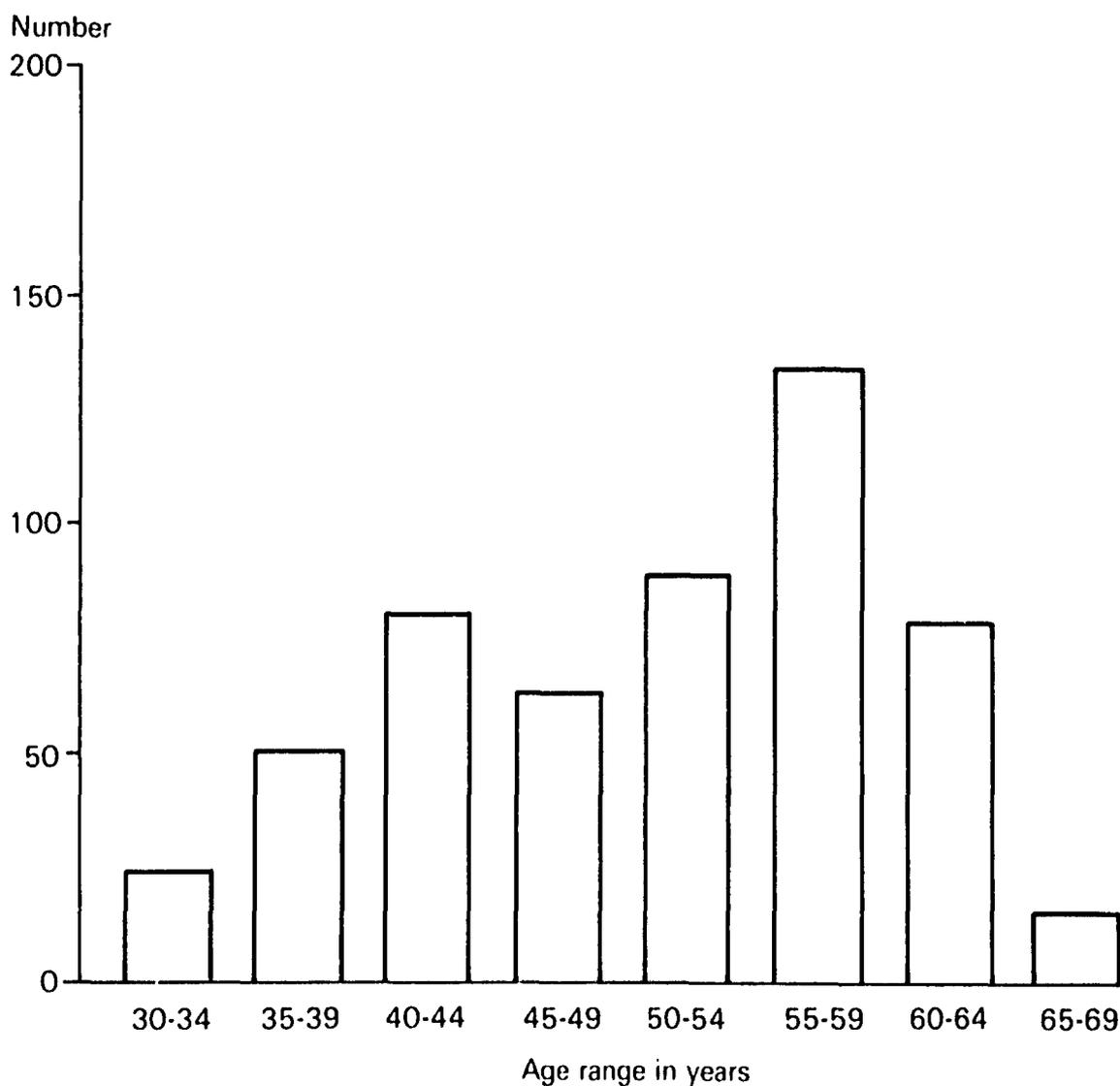
COMMUNITY PHYSICIANS IN POST 1.12.86

Region	Total in post	Posts Funded and unfilled	Vacant Funds Temporarily Withdrawn	Retirement and deaths expected by		
				1991	1996	2001
Northern	32	10	3	12	21	24
Yorkshire	44	8	6	15	28	33
Trent	45	6	3	15	26	32
East Anglian	30	1	2	10	16	22
NW Thames + CDSC + OPCS	56	3	0	17	26	35
NE Thames	47	7	0	8	22	28
SE Thames	38	6	3	16	24	28
SW Thames	37	9	1	12	25	30
Wessex	23	3	1	9	14	17
Oxford	27	3	1	6	12	15
S Western	32	4	2	7	13	19
West Midlands	51	7	6	18	28	37
Mersey	26	9	3	9	17	21
N Western	46	7	1+	12	27	33
England exc DHSS	534	83	32	116	299	374

Age profile and retirement rates

6.3 The age profile of the 534 community physicians in England is shown in Graph 1.

Graph 1
Age of community physicians in England Dec 1986



The relevant figures are included in the final three columns of Table 1. It can be seen that of those community physicians now in post, the Faculty predicts that 21 per cent will retire over the next 5 years; 56 per cent over the next 10 years; and 70 per cent over the next 15 years. In other words by the year 2001 only 30 per cent of the community physicians employed by the NHS in England on 1.12.86 will still be in post. (These figures are calculated by applying an experience based model of the chances of early retirement or death together with the assumption of an average retirement age of 63.)

Trainees

6.4 New recruits to fill the consultant posts vacated over the next 5-15 years will be recruited from the trainee grades as they complete their higher specialist training. There were 244 trainees in post on 1.12.86 and these are shown by RHA and grade in Table 2.

Table 2

TRAINEES IN POST 1.12.86

NUMBER OF NEW TRAINEES RECRUITED BY YEAR

Region	Registrars		Senior Registrars			Total in training	1980	1981	1982	1983	1984	1985	1986
	1st year	2nd year	1st year	2nd year	3rd year								
Northern	3	1	4	2	1	11	2	1	4	3	5	4	1
Yorkshire	7	6	3	2	3	21	4	4	4	5	5	7	6
Trent	7	1	4	3	3	18	4	4	4	4	5	7	8
E Anglian	4	2	3(1)	2	4	15	4	2	3	2	2	3	5
NW Thames + CDS ^C + OPCS	4	8	2	2(1)	1	17	2	6	6	6	4	8	4
NE Thames	3	2	2	6	2	15	2	3	3	4	4	4	5
SE Thames	3	4	2	2	3	14	4	5	2	6	2	3	4
SW Thames	0	3	2	4	4	13	1	5	4	3	3	2	0
Wessex	0	1	2	2	3	8	1	3	3	3	2	1	0
Oxford	5	5	2	4	5	21	1	4	5	4	3	5	5
S Western	1	1	1	3	3	9	1	2	3	2	1	2	1
West Midlands	10	11	10	6	7	44	4	5	6	11	9	10	10
Mersey	2	2	3	2	2	11	0	3	0	6	2	1	2
N Western	6	3	6	6	6	27	2	9	7	4	6	5	6
England	55	50	46	46	47	244	32	56	54	63	53	62	59

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The recruitment of new trainees increased from 32 in 1980 to 59 in 1986 although there is considerable variation between regions in the number of trainees which they fund. Some regions are relying on training programmes elsewhere to provide their public health doctors of the future. The Faculty has calculated that the average length of training of those consultants recently appointed was 4.07 years. Past experience suggests that 27 per cent of new recruits to community medicine do not proceed to a consultant post in the NHS.

6.5 Applying the Faculty's model, it can be predicted that if recruitment of trainees in England continued at current levels (around 60 per annum) and there was no expansion in demand for consultants in public health medicine, the shortfall of available consultants would peak before 1990 (at around 140) and decrease thereafter until the national establishment was filled in 1998. (This model takes account of the vacancy factor as at 1.12.86 of 115 posts in England.)

Implications of our recommendations

6.6 We have made four main recommendations with manpower implications for public health medicine:

5.13 — every district should make arrangements for access to the advice of a team of at least 2 consultants in public health medicine including the DPH. (A further 88 posts in 75 districts would be required above current levels to meet this objective in every current district. Of these, 28 correspond to 28 of the 115 vacancies identified by the Faculty. However, as we have pointed out in para 5.13, we expect that some small districts will wish to share teams of consultants and that the current pattern of districts may change over the next 10 years. For planning purposes, therefore, we are assuming that around 30 additional posts will be required (88 minus 28 minus 30 for small districts/district rationalisations.)

7.16 — every district should nominate a district control of infection officer. (As we have pointed out in para 7.19, we would not expect every district to appoint a full-time DCIO dedicated exclusively to that district. A very rough estimate therefore suggests around 50 additional posts in public health medicine.)

7.28 — every RHA should make arrangements for adequate specialist epidemiological support (14 posts approx)

7.31 — the strengthening of CDSC (5 posts approx). In addition, we understand that DHSS hopes to recruit a greater proportion of its medical staff from the ranks of public health doctors. (10 posts approx.)

This implies for planning purposes around 109 additional posts for consultants in public health medicine. In order to estimate the number of additional consultants required (ie above the number in post at 1.12.86) we must add the 115 vacancies to the 109 posts giving a total of 224. In order to implement our recommendations in their entirety, therefore, the national establishment of consultants in public health medicine in England would need to be around 758. Such an increase would be consistent with the Government's recently announced plans for expansion of consultant posts in clinical specialties. This increase in public health doctors can only be achieved by a slow and steady build up of posts over the next 10 years or so. The rate at which the establishment

is achieved will depend on the speed at which health authorities are able to recruit and train new consultants in public health medicine. Using the Faculty model, we have estimated that it would be feasible to achieve an establishment of about 750 consultants in public health medicine by around 1998. Population estimates for that year mean that achievement of this establishment would result in a national rate per million population of 15.8 consultants in public health medicine.

Conclusions and possible solutions

6.7 We RECOMMEND that each RHA with its DHAs should urgently review its manpower requirements in the light of our recommendations and amend current policies for training public health doctors. As we have already pointed out in para 6.4 above and as is demonstrated by Table 2, there is great variation in training policies between regions. We further RECOMMEND that each RHA should aim to train sufficient public health doctors to meet its own manpower requirements with the aim of reaching a national rate of 15.8 consultants in public health medicine per million population by around the years 1998.

6.8 When undertaking their reviews of manpower requirements, RHAs will find the Faculty's manpower model helpful in selecting the most appropriate option. The FCM has advised us that it is prepared to grant RHAs access to the manpower model constructed using data from the survey referred to in 6.1. The Faculty intends to revise its database annually. Regions will need to keep their manpower predictions and training policies under constant review in the light of actual experience.

6.9 Regions should also bear in mind the flexibility which is possible within existing resource constraints. It would be possible for instance to make early progress towards the objective by accelerating the rate of recruitment of trainees for several years. The funding for these training posts could be provided in part by transferring funds from unfilled vacancies. Additional trainees, particularly in the senior registrar grade can make a significant contribution to the work of departments of public health medicine. As qualified candidates became available, the funds could be reconverted to fund consultant posts. The additional consultant posts which we have recommended could also in time be funded partly from the tapering off of trainee intake which will be required as the steady establishment of around 758 consultants is achieved.

Short to medium term solutions

6.10 Even so, we are aware that the changes which we have recommended and which involve additional manpower cannot be achieved quickly. However, there is a number of actions which could be adopted now to ease the situation. These include:

6.10.1 the provision of public health support from supra-district or regional units ie consortium arrangements (as described below).

6.10.2 improving selection techniques for trainees thereby decreasing current high "wastage" rates and increasing the numbers who qualify into the consultant grade.

6.10.3 reducing the amount of time spent by consultants in public health medicine on work outside the central tasks which we have defined in para 5.3. (See also 5.4 to 5.6).

6.10.4 encouraging consultants in public health medicine to continue working, perhaps on a part-time basis, after their intended retirement date. (The Faculty model builds in an assumed average retirement age of 63. If this could be increased in practice the shortfall would be eased.)

Consortium arrangements

6.11 A response to the staffing difficulties in the short to medium term being considered in more than one region is to link DHAs together in consortium arrangements for public health medicine in order to make the best use of the skills which are available.

6.12 In Northern Region, for example, a unit has been established (in 1985) within the Department of Family and Community Medicine at Newcastle University, using funds provided on a continuing basis by the 17 health authorities of the Northern Region. The main objectives of the unit include the provision of expertise in certain aspects of public health medicine. The unit has already undertaken a wide range of special studies in a region where there have been severe difficulties in staffing in this speciality. These include, by way of illustration:

- Perinatal mortality — avoidance factors.
- Factors influencing hospital admission rates.
- Evaluation of open-access physiotherapy.
- Appraisal of options for reorganising paediatric services.
- Value for money in chiropody services.
- Options for cervical screening.
- Measuring distress and disability.

6.13 In NW Thames RHA, by contrast, the possibility of establishing sub-regional units is under consideration, each consisting of a number of consultants in public health medicine, and of DMOs undertaking sessional work, having access to adequate support from non-medical colleagues eg sociologist, health economist, statistician and social geographer. A number of structural solutions are under discussion:

6.13.1 One option would be to leave it to individual districts to negotiate joint arrangements with their neighbours.

6.13.2 A wholly regionally managed service, in which districts contract with the RHA for DPH services and public health support. The RHA would hold all contracts, and would contract for a named consultant in public health medicine to be outposted to a DHA for an agreed number of sessions.

6.13.3 A sub-regional model in which the staff of the unit would be managed by the Regional Director of Public Health. Each DHA would hold its DPH's contract. Each district would have a basic contract with the RHA for the provision of support by the DPH and a notional or task orientated contract for specific items of service.

6.13.4 A supra-district model in which the unit would be managed by the district in which the unit is situated, with the consultants' contracts being held by that district. It would still be desirable for there to be overall regional co-ordination of the work of the units to ensure no unnecessary duplication.

6.14 Taken together the measures outlined in paragraphs 6.10-6.13 would both ease the situation in the interim and ensure that full establishment is reached as soon as possible. As we have pointed out in paragraphs 5.13 and 6.6, some small districts may also wish to continue to share resources in the longer term. In reviewing their manpower requirements RHAs should also consider the possibility of introducing such measures. As with some training posts, short term solutions can be funded in part by holding back the funds from unfilled district vacancies in a central regional pump-priming pool.

CHAPTER 7: CONTROL OF COMMUNICABLE DISEASE AND INFECTION*

7.1 As we pointed out in Chapter 1, the control of communicable disease and infection is one of two aspects of the public health function on which we were asked to concentrate and which are specifically referred to in our terms of reference. In dealing with this highly specialised and complex subject, we decided that the best way to proceed was to establish a sub-committee made up both of members of our Committee and a number of co-opted specialists. Details of the membership and terms of reference of the sub-committee are at Annex G. The main Committee wishes to record its thanks to Professor Geddes and his colleagues, particularly the co-opted members, for their valuable work on communicable disease and infection.

Epidemiology of communicable disease and infection

7.2 Although their nature and distribution have changed substantially in recent decades, communicable disease and infection have not disappeared from Britain. This was only too evident from the outbreaks at Stanley Royd and Stafford.^{1,2} Respiratory infections due to a wide range of different organisms remain common. Meningitis is a continuing cause of concern. Measles and whooping cough remain imperfectly controlled in spite of the availability of effective vaccines. Antibiotic resistant bacteria such as methicillin resistant staphylococcus aureus (MRSA) and imported infections present new challenges. Outbreaks of food poisoning are all too frequent and the trends in reported cases of salmonellosis and campylobacter infection are upwards. Severely ill patients, especially those who are debilitated or immuno-compromised, are liable to become infected while in hospital. Above all, "new" infections such as Legionnaires' disease and particularly AIDS and its underlying virus HIV, demand attention. (For a fuller account of the recent epidemiology of communicable disease see the valuable paper by Galbraith and Barrett³⁷.)

Monitoring and surveillance of communicable disease and infection

7.3 Accurate and timely information about the occurrence, cause and spread of communicable disease and infection is a prerequisite for its effective control. Relevant data derive from many sources and take the form of notifications, laboratory and clinical reports. We have received much evidence demonstrating that the processes of collating, analysing, interpreting and distributing the resulting information are vital tasks, and we include at annex H a diagram showing in tabular form the main sources and routes of surveillance information. Our appreciation of the key role of CDSC in monitoring and surveillance has been one of the factors influencing our later suggestion that CDSC be strengthened.

Organisation of control of communicable disease and infection

7.4 We have not seen it as part of our remit to consider in any detail either the clinical problems of treating individual cases or the different methods appropriate for controlling the spread of particular forms of communicable disease and infection. Our report is devoted to the organisational and administrative aspects of the subject. Evidence presented to the Inquiry makes it abundantly clear that the priority accorded

* "Infection" refers to the invasion of the body by pathogenic or potentially pathogenic organisms and their subsequent multiplication in the body. Infection occurs in many different ways. When it occurs as a result of spread of the organism from another infected person (or animal), either directly or via a vector, the resulting disease is termed "communicable".

to this branch of medicine, both professionally and administratively, has declined in recent years to a dangerously low level and we have seen it as our prime responsibility to make practical recommendations with a view to correcting this situation.

7.5 In reviewing existing arrangements, what we have found is a set of measures which have evolved over time and which, taken together, have created a system which is complicated and at times unclear, even to those who have to operate it. To others it can be positively baffling. For this reason we have felt it necessary to start by giving a fairly full account of the respective contributions of the health authorities and local authorities. The centrally-financed services provided through the PHLS have already been described in paras 4.13-4.19.

Legal responsibilities of health authorities

7.6 As we have described in paragraphs 4.3 and 4.4, provision for the prevention, diagnosis and treatment of illness is made in the National Health Service Act 1977. Circular HRC(73)34: "Transitional Arrangements and Organisation and Development of Services — Control of Notifiable Diseases and Food Poisoning", issued at the time of reorganisation, which has never been replaced and is still extant, describes the services to be provided in this field by health authorities under the NHS. This makes health authorities responsible for a range of services contributing to the prevention, control and treatment of communicable disease and infection including health education, health visiting, immunisation, hospital treatment of cases of infectious disease and other relevant health services. These services extend to communicable disease and infection generally, including those diseases notifiable under the Public Health Acts for which local authorities also carry certain responsibilities. (A notifiable disease is one which is specified as such in legislation and for which a statutory duty exists for all registered medical practitioners to inform the local authority of cases coming under their care. A list of those diseases which are currently notifiable is at Annex I.)

Legal responsibilities of local authorities

7.7 The legal responsibilities of local authorities in this field are derived from the powers set out in the Public Health (Control of Disease) Act 1984 which was a consolidating measure, drawing together the provisions of the Public Health Act 1936 and later amendments concerning infectious disease. The Public Health (Infectious Diseases) Regulations 1968 which consolidated, with amendments, virtually all previous Regulations on the notification and prevention of infectious disease, are also relevant.

7.8 The 1984 Act requires the notification of cases of the diseases specified in legislation (see Annex I) to the local authority's relevant proper officer (who must in turn notify the DHA and, in some circumstances, the Chief Medical Officer). It also gives the proper officer various powers of investigation and control, eg excluding a child from school and power to examine a person (eg an inmate of a common lodging-house) to find out whether he has, or has recently had, a notifiable disease. Local authorities are given full discretion under the Act to appoint any person to exercise the functions of a proper officer. It is usual for them to appoint the Medical Officer of Environmental Health (MOEH) for some provisions and the Chief Environmental Health Officer for others.

7.9 In practice, the main work of local authorities in the field of communicable disease and infection relates to the prevention and control of those notifiable diseases which are food or water borne. As can be seen from the CIPFA statistics at Annex J, local

authorities spend only around 3 per cent of staff time on the control of infectious diseases other than food poisoning.

7.10 For many other notifiable diseases (eg TB, meningitis, diphtheria) the main burden of work falls to health authorities, even though it is the local authority which is responsible for the receipt of the notification and for the exercise of the reserve powers under the Public Health Acts. Health authorities, together with GPs, are of course responsible for the *treatment* of people suffering from all types of communicable disease and infection whether notifiable or not. We believe that these responsibilities should be explicitly recognised.

7.11 The lack of clarity about the role and responsibilities in this field derives from the complexity of the legislation and from a misunderstanding about its interpretation. The Public Health Acts comprise a complex body of legislation stretching back for more than a century. It is difficult to gain a coherent view of what is intended. In the main, these Acts do not seek to codify the *responsibilities* of authorities in respect of communicable disease and infection but rather confer certain reserve *powers* which may be necessary in the control of some notifiable diseases when they occur. In some cases there is a mismatch between the location of powers and responsibilities. The fact is that these Acts now have little relevance to the majority of work actually undertaken in this field by either health or local authorities, although of course, the powers they confer will need to be retained for use in exceptional circumstances. We return to this in paras 7.43 – 7.45 below.

The need for collaboration

7.12 It was envisaged in 1974 that there would be close collaboration between health and local authorities so that the split responsibilities between the two statutory agencies would be exercised jointly. Circular HRC(73)34 points out that although the statutory functions under the Public Health Acts as regards the control of notifiable disease continue to lie with the local government district, this function should not be separated from other aspects of the control of notifiable diseases (such as immunisation) and the control of communicable diseases generally, for which responsibility lies with the health authorities. In practice, however, such separation of functions indeed occurred in spite of the fact that local authorities were asked to appoint as their medical adviser on environmental health, and to designate as their “proper officer” for functions relating to notifiable diseases and food poisoning, a doctor who would also be a community physician of the health authority, the Medical Officer of Environmental Health (MOEH). The community physician filling this newly created post had a duty to advise the local authority across a very wide range of environmental health issues combined with a novel and untried position within the organisational structure. Herein began some of our present difficulties, as we have already seen in chapter 5.

What is the problem?

7.13 From the evidence which the Committee has received, there is little significant criticism levelled at the operation of the current system in local authorities, from the local authorities themselves or from elsewhere. As the CIPFA statistics show (See Annex J and para 7.9 above) they concentrate mainly on the prevention and control of food and water-borne diseases which require the specialised skills of EHOs. What little concern there is about this aspect of the problem centres on the fact that local authorities have on occasion exceeded their authority by undertaking essentially medical work or have been sometimes reluctant to seek medical advice. The main area of concern is the confused

perception of roles and responsibilities within the NHS which has led to difficulties on occasions in the effective discharge of its own responsibilities. One of the main ambiguities which has led to the current confusion is the anomalous situation of the MOEH. We have already set out in paras 4.41 and 4.42 some of the problems associated with the post. The aspirations of the 1974 reorganisation were not met (see paragraph 7.12) chiefly because of the uncomfortable location of the post in the organisational structure. This, combined with the less than optimal level of training and expertise of some post-holders, the lack of sufficient training available and the need to concentrate on other more pressing duties, has meant that environmental health has become something of a backwater for public health doctors. From this has arisen a feeling on the part of the local authorities that in many cases the role/advice of the MOEH is of little relevance or assistance to them, and on the part of health authorities that they do not have responsibilities in this area.

Our proposed solution

7.14 There are no simple solutions to the problems we have identified. The microbes which give rise to communicable disease and infection do not work within statutory limits and responsibilities. They can wreak havoc across a range of authorities and agencies very quickly. It is crucial, therefore, first, to recognise above all the need for continuing co-operation and collaboration between the two main statutory agencies — health and local authorities (and others eg MAFF, HSE as appropriate). Our recommendation in chapter 4 regarding collaboration between DsPH and CEHOs will assist in this. Secondly, those responsible must be able to react quickly and decisively to problems as soon as they are identified. Thirdly, there needs to be a clear recognition of the responsibilities of health authorities for the treatment, prevention and control of most communicable disease and infection. Finally, we acknowledge the continuing role of local authorities in the prevention and control of notifiable diseases, particularly those which are food and water borne.

7.15 In the light of these general principles, and bearing in mind the fact that our evidence has not demonstrated concern about the operation of the system in local authorities (see para 7.13) our central recommendations in this chapter seek to clarify the responsibilities of health authorities. Indeed it was confusion about these responsibilities which led to incidents when the arrangements for control of outbreaks broke down, which were in turn the occasion for the establishment of our committee.

The need for an officer responsible for communicable disease and infection

7.16 For the reasons outlined in paragraphs 4.41 and 4.42 and 7.13 above, we believe that the office of MOEH should be abolished. In line with the general thrust of arrangements since the implementation of general management in the NHS, for clarifying responsibilities and holding named individuals responsible for their discharge, our recommendation focusses on the need for a more tightly defined and accountable role in control of communicable disease and infection. In order clearly to reflect health authorities responsibilities we *RECOMMEND that DHAs should assign executive responsibility for necessary action on communicable disease and infection control to a named medical practitioner who will be called the district control of infection officer (DCIO)*. As we make clear in para 7.19, this does not necessarily imply the creation of a post in every district. We recognise of course that the abolition of the MOEH will leave a gap, more noticeable in some places than others, in the sources of medical advice on non-infectious environmental health matters available to LAs. We look to the

arrangements described in para 4.43 and to the development of those proposed in 4.44 and 4.45 to ensure that this gap is filled.

Responsibilities of the DCIO

7.17 The DCIO will be the named individual within the authority responsible for control of communicable disease and infection and will normally be accountable managerially to the DPH and a member of the district's Department of Public Health. He/she will be responsible for drawing up plans for dealing with outbreaks, in consultation with other agencies as appropriate (eg the environmental health departments, PHLS, FPCs, MAFF), and for taking action when outbreaks occur (including calling in expert help from region and/or CDSC as appropriate). He/she will co-ordinate work on the control of infection between hospitals and between hospitals and the community. In this context it is important to recognise that there is a free flow in both directions of patients, visitors, staff *and* microbes between hospitals and the community outside. It is extremely important, therefore, that someone within the health authority is responsible for linking the vital work undertaken by microbiologists and control of infection teams within hospitals* with cases of infection occurring outside. The DCIO will also be expected to work with FPCs to co-ordinate preventive programmes aimed at control of communicable disease such as measles, rubella, whooping cough etc. This will be very important as family doctors become more involved in preventive services as is intended in the Government White Paper "Promoting Better Health"²⁷. Thus the stated objective of HRC(73)34 to bring together all health authority responsibility for the control of notifiable and communicable disease and infection should at last be realised (see paras 7.6 and 7.12) and the criticisms of the Public Accounts Committee met (see paragraph 4.42). The DCIO will be responsible for providing medical advice on control of communicable disease and infection to the local authority and, if they wish, for acting as "proper officer" for certain of the powers in the Public Health Acts as long as they remain. He/she will need to work very closely with the environmental health departments and to establish reciprocal arrangements for the provision of resources when dealing with outbreaks. The DCIO will require support in contact tracing and administration within the district and, in addition, there will be specialist support available to the DCIO from the region (see paragraphs 7.28–7.29). The DCIO will act as a source of public information on issues relating to control of communicable disease and infection. We have received evidence, for example, from the voluntary sector that they have experienced severe difficulties in some areas in obtaining advice on AIDS. Ensuring access to such advice should be a clear responsibility of the DCIO.

Handling the transition

7.18 The DCIO will be working at a higher level than, and within a different framework from, many current MOSEH. We do not, therefore, believe that it will be possible in all cases to continue with the current type of arrangement (which often combines DMO and MOEH posts) nor to appoint as DCIO all current postholders (some of whom are not working at the required level). We do of course recognise that some MOSEH, particularly in conurbations, have developed specialist skills in control of communicable disease and infection and we hope these new arrangements will allow them to develop their skills further in a more helpful organisational setting. The DCIO posts will in practical terms constitute a new role and should be recognised as such. In

* Practical measures for the control of infection in hospitals will be laid down in the guidelines of the Hospital Infection Working Group which we understand will be published early in 1988.

some cases, DHAs may wish to appoint current holders of the post of MOEH to the DCIO posts. In making their judgements, DHAs will need to consider the training and retraining requirements of individuals ensuring that those appointed are fully able to discharge the significant responsibilities of the new posts. A substantial training and retraining programme will be required and we return to this issue in chapter 8.

7.19 We do not underestimate the difficulty of appointing a cadre of DCIOs to cover the communicable disease and infection function in all health authorities. We have already noted the general problems of supply of public health doctors and particular problems of lack of training in this field. We would expect some current MOEH to be appointed as DCIOs. We would not expect every district to appoint a full time DCIO dedicated exclusively to that district. Providing geographical boundaries and accountability are clearly defined, we would support arrangements, particularly in smaller or less densely populated districts or in conurbations, which involve joint appointments or appointments which combined DCIO responsibilities with other closely related duties. In considering how best DCIO responsibilities can be discharged, health authorities should bear in mind the need to ensure a quick reaction time in response to and permanent cover to deal with emergencies. Depending on local circumstances, some DHAs might choose to appoint consultants from other specialities, for instance medical microbiology, infectious diseases, or the epidemiology of infectious diseases. For very rough manpower planning purposes we have assumed the creation of 50 new posts for consultants in public health medicine nationally (see paragraphs 7.20 and 6.7) in order to implement our recommendation. In order to ensure a smooth transition, and proper consideration of personnel issues etc, we *RECOMMEND that RHAs should draw up plans for handling the transition from the current arrangements in consultation with their districts.* The plan would probably need to cover a period of about 5 years in order to ensure availability of both manpower and financial resources.

Qualifications

7.20 The DCIO will be medically qualified and have the necessary expertise in subjects related to control of communicable disease and infection. Because public health training and experience links together skills in epidemiology with an understanding of both the medical and administrative aspects of control of communicable disease and infection, he/she will normally be a consultant in public health medicine, although as we have pointed out above, in a number of cases the DCIO is likely to be a consultant in another relevant discipline.

Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Disease (STD)

7.21 Perhaps the greatest challenge to public health in recent years is that presented by AIDS and HIV infection. We have therefore singled it out for special mention. It demonstrates very well the need for collaborative working between many agencies. HIV infection is for the most part related to lifestyle and therefore can be prevented by persuading people to change their behaviour. An effective campaign for prevention together with the provision of services for the HIV infected, requires the co-ordination and co-operation of a variety of agencies — health authorities, local authorities, the HEA, primary health care teams, voluntary organisations, etc. There is a number of examples of good practice in this field.

7.22 The present network of services for the treatment of STD dates back to the First

World War when in 1916 the Royal Commission on Venereal Disease chaired by Lord Sydenham recommended the introduction of measures for the prevention and control of STD, principally syphilis and gonorrhoea, which had become an increasing problem during the course of the War. Responsibility for the establishment of these services fell initially to local authorities and was transferred to the NHS in 1948. Since 1948, genito urinary medicine (GUM) clinics have operated largely as self-contained units within health authorities. This was due in part to the need to maintain confidentiality. The advent of AIDS has highlighted the need to link with services or agencies outside the clinics themselves. Although the clinics still form a vital part of the service available to those who have or suspect they may have contracted HIV infection, as we have pointed out, prevention and control requires the collaborative efforts of a great many agencies.

7.23 Health authorities have already been advised by DHSS to prepare plans for dealing with AIDS and HIV infection and many have established Committees to co-ordinate local efforts. This work will be brought into sharper focus by the AIDS (Control) Act 1987 which requires all health authorities from 1988 to publish a statutory annual report detailing, among other things, the numbers of AIDS [and HIV antibody positive]* cases known within their local population; the facilities and services available for treatment and prevention; and the number of staff employed in the provision of such services. [Draft guidelines about the implementation of the Act have been issued for consultation and it is hoped that a definitive version will be circulated shortly]. We would expect health authorities to look to their Directors of Public Health to co-ordinate the production of the reports required by the Aids (Control) Act 1987.

7.24 The DPH and his/her staff (generally the DCIO) should have a key role in consultation with the GUM specialists, the HEA, local authorities and FPCs in co-ordinating the activities of the many agencies and organisations involved in the surveillance and prevention of spread of AIDS and HIV infection and including the identification of problems arising from injecting drug misuse where there is a very significant risk of infection from the use of shared needles. It will be important for public health doctors to work closely with District Drug Advisory Committees both in identifying the scale of the problem locally and in planning services for drug users which will minimise the spread of infection. Detailed local knowledge and identification of the local meeting places of those at particular risk of HIV infection is essential in order effectively to target educational messages. The DPH will need to be alert to advancing knowledge about HIV infection which may necessitate changes in preventive and other policies.

District Control of Infection Committees

7.25 From all that we have said about the range of duties of the DCIO in prevention, including health education, and control of communicable disease and infection, and about the need to bring about collaboration between all the agencies concerned, it will be clear that the DCIO will need to draw on advice from many sources and set up arrangements to ensure co-ordination across a wide range of interests. *We therefore RECOMMEND that in order to assist the DCIO discharge his/her responsibilities for control of communicable disease and infection, an advisory District Control of Infection Committee should be established.* Arrangements for chairmanship and membership etc will vary according to local circumstances. Suggestions on possible arrangements are included at Annex K.

*Amendment proposed to include HIV antibody positive cases.

The accountability process

7.26 Within the NHS, we have no doubt that the health district is the appropriate level for accountability regarding the control of communicable disease and infection including prevention by means of immunisation where relevant. Once the revised arrangements are in operation it would seem appropriate for districts to be required to demonstrate, through the annual review system, that their management structure is such as to ensure that the responsibilities placed on them are effectively discharged. *We also RECOMMEND that the DHA should require its DCIO to contribute a section on control of communicable disease and infection to the annual report. (see para 4.28).*

Role of the RHA

7.27 The general role of RHAs and their public health responsibilities are described in paragraph 4.32. *We RECOMMEND that the guidance recommended in para 4.25 should make it clear that the RHA's duty to monitor District performance extends to ensuring that adequate management arrangements exist for dealing with communicable disease and infection both in hospital and in the general population. Specific responsibilities include: —*

7.27.1 To prepare their own plans to deal with outbreaks of infection involving several districts or regions. They should include contingency arrangements for the release of staff from their usual duties and temporary redeployment to assist in outbreak control.

7.27.2 To set up mechanisms whereby the DCIO would inform the RHA of any serious or significant outbreaks; to be responsible for informing/calling in PHLS including CDSC. We expect this to be the personal responsibility of the Regional Director of Public Health.

7.27.3 To develop an integrated information network for DCIOs, GPs, Infection Control Teams, Chief EHOs, and PHLS, to gain information on episodes of infection — subject to the provision of adequate safeguards on the question of confidentiality.

Supporting services

7.28 While we want to see managerial responsibility for control of communicable disease and infection located within the NHS at district level, we recognise that it would be neither practical nor economic for the full range of special skills and facilities required for epidemiology and surveillance to be deployed within every district. *We therefore RECOMMEND that it should be the responsibility of each RHA to ensure the provision of such specialist support services, in consultation with DHAs, LAs, PHLS and the relevant academic departments, adopting the approach best suited to its needs.*

7.29 There is a need to provide specialist services in epidemiology at something approximating to the regional level geographically although not necessarily coterminous with NHS regions nor directly provided by RHAs. Epidemiological services could be provided in a variety of ways — eg as a directly provided regional service, as a service commissioned from a university department or by out-posting from CDSC, possibly via the local Public Health Laboratory. We see no reason why with appropriate training epidemiologists at regional level should not provide expertise in non-communicable as

well as communicable disease, thereby fulfilling the role described in para 4.32. As computer technology is installed throughout the NHS, each such unit should be equipped with sufficient computing facilities to allow comprehensive data handling and analysis as well as being provided with electronic communication links with the local authorities, health authorities, FPCs and central government agencies. One difficulty is that above-district surveillance is required within boundaries which are independent of either local authorities or RHAs, whilst the service needs to be provided ad hoc – ie available on request as required. RHAs will need to decide which approach best suits their local circumstances. Each unit would serve a number of health and local authority areas and in suitable cases might be based on a county or NHS region.

Regional clinical infectious diseases services

7.30 Regional clinical infectious diseases services also need to be maintained and developed as suggested in the report published by the Royal College of Physicians in 1985.³⁸ They too could be developed in conjunction with university departments.

Developments at national level

7.31 The DHSS, including its medical department under the Chief Medical Officer, has important co-ordinating and policy-making functions in the field of control of communicable disease and infection as well as non-communicable disease. The HEA too has an important role in the promotion of public health nationally. All these central functions are described in Chapter 4. It is through the Department that PHLS and CDSC are accountable to Ministers. A national surveillance and control capability, flexible enough to be deployed promptly as and where required, is absolutely indispensable for the control of communicable disease and infection. We would like to see PHLS strengthened in a number of ways, for instance:

7.31.1 By more effective exchange of information between CDSC and its sources of data, in particular health authorities, FPCs and PHLS area and regional laboratories. This should be a two-way exchange, including the collection of data and dissemination of analysis. Greater use should be made of up-to-date electronic information technology as this becomes available to support and speed up these communications.

7.31.2 By expanding the ability of CDSC to provide a service of field epidemiology on request to health and local authorities. Development of CDSC needs to ensure:

- a. that the epidemiological support offered by CDSC in the event of outbreaks in England and Wales is based upon staffing levels commensurate with need;
- b. that surveillance data on communicable disease and infection, including AIDS, is appropriately collated, analysed and reported to provide districts, regions and others with up-to-date information relevant to infection control;
- c. that national surveillance of immunisation programmes and related research is adequately supported.

It is recognised that the required expansion will need to be phased as there is a shortage of doctors and others trained in the epidemiology of infectious disease. Training programmes need therefore to be supported to remedy this deficiency.

7.31.3 By an expansion of the practical training role of CDSC across the whole field of infectious diseases including medical and non-medical epidemiologists, public health doctors, microbiologists, nurses, EHOs and others. Linked with this is the question of training in clinical epidemiology. (see chapter 8).

This strengthening would be in line with the first recommendation of the recently published Second Report of the Committee of Inquiry into the Outbreak of Legionnaires' Disease in Stafford in April 1985,³⁹ which calls for an increase in the resources devoted nationally to the epidemiology of communicable disease and infection.

Reserve Power for CDSC

7.32 In view of experience in the Stanley Royd and Stafford outbreaks where there was some reluctance to seek the assistance of CDSC, *we RECOMMEND that DHSS should consider means by which a reserve power could be created whereby the CMO could authorise CDSC to assist in immediate investigation of an outbreak.* We do not expect that such a power would need to be exercised very often nor should local responsible officers feel that its existence undermines their own powers or responsibilities. Rather we see it as a reserve power to be used in exceptional circumstances.

National notification

7.33 In practice, PHLS acts on behalf of DHSS in respect of infectious disease control. However, there is a legal requirement (Regulation 6(2) of the Public Health (Infectious Diseases) Regulations 1968) that the Chief Medical Officer should be informed of any cases of quarantinable disease or other serious outbreaks. These regulations were of course drafted before the establishment of CDSC. *We RECOMMEND that the CMO should make arrangements to delegate the requirement to be notified in these circumstances to CDSC in the majority of cases.* There will need to be an agreement as to which circumstances require that CDSC inform CMO of serious outbreaks.

Local Notification of Infectious Disease

7.34 The statutory duty set out in the Public Health (Control of Disease Act) 1984, to notify cases of infectious disease coming under their care has been a legal responsibility of all registered medical practitioners for many years. A list of those diseases which are currently notifiable is at Annex I. Its original purpose was to provide rapid information to the locally responsible officer (originally the MOH) so that appropriate control measures could be promptly taken. It was also recognised from the earliest days that the process would also serve the purpose of statistical monitoring of the prevalence of diseases. It is important to appreciate that these two purposes remain as important as they always were and that notification still has an important part to play in each.

Who should notify?

7.35 Many observers have drawn attention to the increasing importance of means of surveillance other than notification. All sources of data, particularly the microbiological ones, have an important part to play. Some commentators have suggested that some of them, notably laboratories, should be given a statutory responsibility to notify, in an attempt to improve the coverage of notification and reduce under-reporting.

7.36 We believe, however, that the legal responsibility rests clearly upon the clinician who first sees the patient and *suspects* the diagnosis and it is impracticable that this should be otherwise because a shared legal responsibility between clinician and laboratory would result in unnecessary confusion. It is therefore a duty of the GP, the receiving officer in a hospital department or a consultant in the case of an infectious disease diagnosed while a patient is in hospital. Ideally the formal despatch of the certificate should be preceded by a telephone call to the DCIO. Notification can be followed by confirmation or otherwise of the diagnosis as additional information becomes available.

7.37 Other sources of data eg laboratory diagnosis are relevant to the overall question of the surveillance of infectious diseases and this role should perhaps be enhanced (this is discussed further in paragraph 7.40 below), but they can have no bearing on the question of statutory notification as such. A microbiologist diagnosing a notifiable infection has an ethical and professional duty to seek to ensure that the case has been notified and should be encouraged to report informally, but it would be impractical and inappropriate for the legal responsibility to be placed anywhere other than with the clinician concerned.

7.38 There is a widespread and alarming ignorance amongst medical practitioners not only of the very important continuing purposes served by notification but even of its existence as a statutory duty. We urge all training institutions to pay greater attention to it, and ensure that all medical students are fully appraised of its importance. *We RECOMMEND that as a matter of urgency DHSS should produce and circulate to all doctors a brief explanatory guide to the procedure and its purpose.* A more conscientious fulfilment of this duty by all medical practitioners on a wide scale would be invaluable in monitoring the effect of the introduction of the combined MMR immunisation (for measles, mumps and rubella), which is planned for later this year.

7.39 The speed of notification and its essentially local character which were its original *raison d'être*, remain essential for those diseases where prompt follow up action is required. It is a vital tool to enable contact tracing to get started, to initiate chemoprophylaxis or immunisation of contacts where necessary and to enable the source of the infection to be identified quickly so that action can be taken. This applies not only in cases of food poisoning but also, for example, in meningitis, psittacosis and diphtheria.

7.40 In spite of the fact that notification is incomplete, there is no substitute for this procedure in detecting trends in major infections which do not reach hospitals eg measles, whooping cough. Sentinel practices, for example, provide an immensely valuable source of information which has been widely supported in evidence to us and we believe that their use should be extended. However, they are not wholly satisfactory first because their small numbers obscure trends and secondly because, being by definition atypical, the populations of these practices are likely to be more highly immunised than those of others. Nor are laboratory reports a wholly satisfactory substitute for notification since they are biased eg by age-groups most commonly tested. It is possible to identify two very distinct categories within the list of notifiable diseases. The first includes diseases such as diphtheria and typhoid where immediate action is necessary to prevent spread of infection; the second, by far the larger, includes those diseases which are notifiable primarily, but not exclusively, for surveillance purposes eg measles, whooping cough. It is important that doctors are aware of the reasons for requiring each disease to be notified.

7.41 We therefore *RECOMMEND* that the notification system should be reviewed in the context of the general revision of public health legislation recommended in paragraph 7.43 below giving consideration to:

- the destination of notifications. In order more accurately to reflect the division of responsibilities where health authorities in practice carry the lead responsibility for control of most communicable disease and infection (excluding food and water borne disease), we believe that the 1984 Act should be amended so that notification should be made to the DHA. This would also help to underline and emphasise health authorities' responsibilities in this context. It is essential that there should be provision for immediate notification by the DHA to the local authority of cases of food and water borne infection which occur in the community. DHAs would also be responsible for forwarding information on notifications to CDSC and OPCS. There would need to be arrangements for two-way access to advice and resources between health and local authorities.
- putting the internationally quarantinable diseases (ie those which are specified in the main Act) on the same basis as other notifiable diseases.
- dispensing with the term "food poisoning" which is an inappropriate term not understood in other countries and replacing it for instance with "food and water-borne infections".
- the layout of the notification form
- the scope for the use of electronic communications
- the role of feedback to notifiers as motivation to notify
- whether the fee for notification should be increased/abolished. There is evidence that the significant increase of the fee in 1983 had no impact on reporting rates.⁴⁰

7.42 In addition to the review recommended in the previous paragraph we *RECOMMEND* that there should be regular reviews of the list of diseases classified as notifiable. *Campylobacter* infection, meningococcaemia and legionellosis are additions which we believe should be made for example. The changes only require secondary legislation. This would not remove the possibility of urgent changes to the list between reviews if necessary but would ensure that there was a positive attempt to keep the list as relevant and up-to-date as possible.

Public Health Legislation

7.43 As pointed out in para 7.7 above, the Public Health (Control of Disease) Act 1984 was a consolidation Act. It did not introduce new measures but simply brought together, in one statute, legislation which had been enacted gradually over the course of the previous hundred years. Some of its provisions now seem a little dated, making provision, amongst other things, for the handling of library books and dustbins, the keeping of common lodging houses, the restriction of wakes etc. Furthermore, since the balance of responsibility for handling many of those diseases which are currently notifiable lies mainly with health authorities, consideration should be given to the proper location of some of the reserve powers contained in the Act, with due regard to the need to make provision for individual right of appeal to a publicly elected body. In addition, if reserve powers are necessary, they should probably be available for all communicable

disease and infection and not just those which have been classified as notifiable. For these reasons we *RECOMMEND* that *DHSS* should revise the *Public Health (Control of Disease) Act 1984* with a view to producing a more up to date and relevant legislative backing to control of communicable disease and infection.

7.44 The revision will need to consider the current disposition of legislative powers in view of the actual allocation of responsibilities which we have described throughout this chapter. In particular, it will need to look closely at the powers currently ascribed to "proper officers", to establish whether these are needed at all, and if so whether they should be the responsibility of health or local authorities and which officers of these authorities should be nominated to execute them.

7.45 This legislative revision will obviously take some time to implement, principally because of the need to obtain Parliamentary time. In the meantime, however, we believe that there are significant improvements which can be made to the current arrangements for communicable disease control without the need for legislation by the implementation of the package of recommendations set out in paragraphs 7.14-7.40.

CHAPTER 8: EDUCATION AND TRAINING

Introduction

8.1 If the recommendations we have made in the preceding chapters are accepted, particularly those in Chapter 5 relating to the role of public health doctors in the organisation and management of health authorities and those in Chapter 7 relating to the control of communicable disease and infection, they will have significant implications for training particularly of public health doctors. A great deal of this chapter is, therefore, devoted to an examination of the current arrangements for their education.* No less important, however, in view of our broad definition of public health and our recognition that it can only be delivered successfully by the collaborative efforts of all those working in the field are the arrangements for the training of other health practitioners and NHS managers. This, therefore, is where we begin our review.

Multidisciplinary training in public health

8.2 In the evidence which we have received, attention has repeatedly been drawn to the fact that there is a lack of appreciation on the part of public health doctors of the work of other practitioners concerned with public health such as environmental health officers and vice versa. We believe that multi-disciplinary training should be more widely available. We give one practical example in para 8.14 below. We feel that there is a need for a review of the way in which public health, in the broadest sense, is taught in this country in order to foster multi-disciplinary awareness and collaboration throughout training which would continue into working careers. This will be particularly important for general managers and public health doctors, in view of our recommendations on the public health responsibilities of health authorities in Chapter 4. It also applies across the wide spectrum of those involved in public health, eg nurses and health visitors, health promotion and health education officers, GPs and environmental health officers. It is important, for example, that education for all these groups should be informed by an understanding and appreciation of public health in its broadest sense. *We therefore RECOMMEND that DHSS, the GMC, the National Health Service Training Authority (NIISTA), RHAs, the medical schools, the UK Central Council for Nurses, Midwives and Health Visitors (UKCC) and other training bodies/institutes should review their education and training programmes in the light of our recommendations and the need for renewed emphasis on public health issues.*

School(s) of Public Health

8.3 Widespread appreciation of public health issues demonstrates a need for strong national resource centres, providing post-graduate training of the highest quality such as exist in Europe and the USA as Schools of Public Health. We understand that this was in part the intention of the Athlone Committee⁴¹ which was established in 1921 by the Minister of Health to investigate the needs of postgraduate training in London. One of its conclusions was that teaching for the postgraduate qualification in public health should be brought together in a single Institute of State Medicine. Training, in London, for the analogous diploma in tropical medicine was already provided in a single institution, in the form of the London School of Tropical Medicine. With substantial financial assistance from the Rockefeller Foundation, the two institutes were combined to form the London School of Hygiene and Tropical Medicine, which was opened in 1929.

* We are grateful for the advice and assistance on this topic given to us by the small expert group listed in Annex L.

8.4 The School is, de facto, a school of public health. The balance between its home and overseas work has varied at different periods in its history, and there is a substantial overlap between subjects relevant to developed and developing countries. On the public health side, the possession of the Diploma in Public Health (DPH) as a former statutory requirement for all Medical Officers of Health formed the background to much of the School's work. With the evolution of the specialty of community medicine, the MSc in that subject took the place of the DPH, but on a non-statutory basis. The School also played an important role, through the DHSS funded Centre for Extension Training in Community Medicine, in helping to reorient the former Medical Officers of Health and hospital medical administrators towards their new, post 1974, roles in community medicine.

8.5 We consider it important that the London School of Hygiene and Tropical Medicine should assume a wider role, not least in relation to interdisciplinary training, as a school of public health. We understand that a Working Party, under the Chairmanship of Sir John Reid, is currently considering the long-term objectives of the School and the implications of these objectives for its academic and organisational structure; and we have been informed that the Working Party has taken evidence from a wide range of organisations, including the Faculty of Community Medicine and NHS interests. We accordingly invite the Working Party to consider the recommendations we have made in our report, including the important issue of multidisciplinary awareness and collaboration in the training of the professions concerned with the public health, with a view to strengthening the role of the London School of Hygiene and Tropical Medicine as a school of public health. In due course we would hope to see the establishment of several schools of public health in different locations around the country. *We therefore RECOMMEND that the relevant training institutions and professional bodies should discuss how best to achieve multi-disciplinary awareness and collaboration in the training of public health practitioners, including the possibility of establishing a school or schools of public health.*

8.6 We also consider that at regional level there is merit in exploring how existing academic departments which share interests in but have different approaches to the health of populations (eg community and occupational medicine, social policy, demography and medical statistics, epidemiology and health economics departments of general practice) may be strengthened by pooling resources.

Basic post-graduate training in public health medicine

8.7 The basic post-graduate training in public health medicine is a combination of practical experience gained for the most part by employment in health authorities first as a registrar then as a senior registrar in public health; together with academic training leading to membership of the Faculty of Community Medicine (FCM) and/or an MSc. Training posts for registrars and senior registrars in public health medicine are funded by RHAs. The FCM is responsible for the maintenance of training standards and the organisation of the membership examination. Academic departments of community medicine provide theoretical training. Responsibility for the training of future consultants in public health medicine is therefore shared between RHAs, the FCM and the academic departments. In making our recommendations for public health doctors, we should like to pay tribute to the efforts and achievements of the Faculty of Community Medicine since its establishment, working in the face of great difficulty and uncertainty arising from successive reorganisations of the 1970s and 80s. However, it has

become evident to us in the course of our discussions that there is often a lack of clarity about this shared responsibility, such that in some places no one body is identified as being in the lead and there is a lack of impetus for critical review of training needs and provision. *We therefore RECOMMEND that RHAs, who are responsible for the employment of the majority of trainees, should assume lead responsibility for the co-ordination of the post-graduate training of public health doctors.* We would expect them to exercise this responsibility through their Regional Director of Public Health and the Regional Advisory Committee on Training.

8.8 In the light of the renewed emphasis on public health recommended in Chapter 4 and the core tasks to be undertaken by public health doctors set out in paragraph 5.3, we have identified a number of areas where the current arrangements for training will need significant amendment. We were greatly concerned, for example, to learn that a number of current trainees (and according to their account their trainers) felt unclear about the role and purpose of the speciality. In spite of their uncertainty, however, they demonstrated great motivation, particularly in their commitment to health promotion and prevention. We believe there is a need for thorough re-examination of the training requirements for public health doctors. *We RECOMMEND that representatives of the RHAs, the FCM and the academic departments should undertake an urgent review of the requirements in the light of the general principles which we outline below.*

General principles of the review

8.9 The current training requirements for the MFCM, as set out in the “Green Book” are extensive.⁴² They are widely drawn and permit a great degree of selection on the part of individual trainees. Whilst this has both educational and practical advantages it can also lead to a lack of emphasis on particular skills or qualities which we believe are essential to the proper practice of public health medicine. These are set out below.

Epidemiology (together with the associated disciplines of statistics and health economics)

8.10 In Chapter 3, we have described the key contribution of epidemiology to the achievement of improvements in public health. It is at the very heart of public health medicine and is vital to all of the tasks set out in paragraph 5.3, including the analysis of the principal health problems in the population which will form the basis of the annual report. (5.3.5) The “Green Book” acknowledges in the opening paragraph of its introduction that “epidemiology is the science fundamental to the study and practice of community medicine”. However, we have received evidence that this statement is not always reflected in the emphasis given to the subject in current training programmes. There are several reasons for this. First, epidemiology has sometimes been inadequately perceived as a key priority by practising public health doctors and trainers and by trainees. If those working in the field do not perceive a need for the skill — and the reason for this stems from the type of work they are undertaking — then it is very unlikely that those aspiring to join them will do so either. The problem has thus become self-perpetuating. Secondly, the focus of interest in epidemiology in academic departments has tended to be in the application of epidemiology to the identification of causes of particular diseases or conditions rather than analysis of health needs of the population and of the provision, organisation and evaluation of services which are so relevant to those working in health authorities.

8.11 We believe that our clarification of the responsibilities of health authorities and public health doctors will restore the place of epidemiology as a central skill for the

specialist in public health medicine. Public health doctors employed by health authorities will become increasingly aware of the need for a high level of expertise in this field in the exercise of their day to day responsibilities. This growing awareness will, in turn, be reflected in the work of academic departments which should review arrangements for teaching in the light of both practical and theoretical requirements. There should be greater collaboration between service and academic departments, the former providing the practical application complementary to the training provided by the latter. We believe that in this context it would be helpful if more service trainees, particularly in the senior registrar grade, spent some of the period of their training, say three – six months, working in academic departments. This would have the dual advantage of increasing mutual awareness of their relative contributions, and of preparing a future generation of trainers. In addition, we expect that the FCM will wish to ensure that particularly careful attention is paid in assessing candidates for Membership on the standard of expertise they have achieved in epidemiology.

Behavioural sciences

8.12 In view of the acknowledged fact that human attitudes and behaviour are relevant to the origins and prevention of so many of today's ills, the behavioural sciences are also a key element of the training of public health doctors. This is recognised in the Green Book but we would urge the FCM to encourage a higher profile for this aspect of the curriculum. It is obvious that developments in this field are of particular importance in health education and promotion.

Communicable disease and infection

8.13 We have received extensive evidence that current training in control of communicable disease and infection is woefully inadequate. This was noted in both the Stanley Royd and Stafford Inquiry reports.^{1,2} We understand that very few trainees have access to more than one week's teaching in the control of communicable disease and the opportunities for gaining experience at CDSC are inevitably limited. In view of our recommendations in Chapter 7 that there should be a stronger and more clearly defined role for health authorities in this field which, in turn, will require a higher level of expertise on the part of public health doctors, we feel it is essential that all trainees should have a firmer basic grounding in the control of communicable disease and infection. Only in this way will the future ranks of DCIOs be filled. We urge the FCM to place greater emphasis on the subject in Part I of the MFCM. We suggest that every trainee should be required to spend a substantial period (eg three months) working on attachment to a DCIO. We hope that our suggestion in paragraph 7.31 that the training role of CDSC should be extended will provide opportunities for more trainees to gain direct experience of outbreak control.

8.14 The number of major outbreaks which occur in this country is thankfully relatively small, when compared with the number of people who need to gain experience in their control. It is therefore important to ensure that those who do not have direct experience of outbreak control do at least have access to theoretical training exercises which permit the development of practical skills. We welcome the development in some regions of major training exercises in control of communicable disease and infection involving trainees in public health medicine, microbiology, environmental health, together with representatives of the PHLS, nursing and general management. Such exercises permit not only theoretical experience of control of outbreaks but also foster greater understanding of the relative contributions of the many professionals involved.

which will greatly assist the development of good communication and collaborative working relationships in the future (see also para 8.2 above).

8.15 In addition to providing for a firmer basic grounding in the control of communicable disease and infection for all trainees, our recommendations for the establishment of DCIO posts to cover every health authority and for regional specialist support posts suggests that some trainees, with a particular interest in this field, should be encouraged to undergo more extensive training than others. We urge the FCM to facilitate such sub-specialisation in the requirements for MFCM. We have also received evidence that there are some senior trainees (with, for example Membership of the RCP) in other specialities such as medicine, infectious diseases and microbiology, who have developed a special interest in epidemiology or the control of communicable disease and infection or both. Some of these would be eligible for appointment in due course to DCIO posts and willing to undertake further training in epidemiology and other aspects of public health but find it difficult to obtain recognition from the FCM without undertaking the full programme of training. We believe that such potential recruits, some of whom wish to continue with a parallel clinical career, are an important additional resource to public health medicine and in particular to control of communicable disease and infection. We urge the FCM, without in any way lowering standards, to adopt a flexible approach to personalised training and suggest that health authorities should encourage the establishment of appropriate appointments for such trainees with a combination of skills. The route into public health medicine and the need for special courses for DCIOs is discussed further in paras 8.19 and 8.20 below.

Additional requirements

8.16 We believe that the most significant changes which need to be made to basic post-graduate training in public health medicine are those relating to epidemiology, behavioural sciences and control of communicable disease and infection as described above. We have received evidence, however, of weaknesses in four other areas:

8.16.1 Organisational context of public health medicine

It appears that some public health doctors have difficulty in understanding the organisational and management systems within which they work and the legislative and bureaucratic framework within which those systems have been established. This is particularly true in the field of communicable disease and infection and the relationship of health and local authorities in the field. An adequate understanding of such organisational features is an essential requirement for a public health doctor, who is an important link between NHS management and clinicians and is very often required to interpret the one to the other and vice versa.

8.16.2 Interpersonal skills and teamworking

Because of their role in co-ordination of services and professional groups, particularly but not exclusively in the field of health promotion and prevention, public health doctors, more than members of any other specialty and in common with general managers, need to acquire skills and be given the opportunity for personal development in management, interpersonal relationships and team working. We have received evidence of problems in the past when such skills have not been present.

8.16.3 Media and presentational skills

A grounding in oral and written communication skills provided by trainers with specialist expertise is essential for all public health doctors, leading to the development of skills and the appreciation of weaknesses and shortcomings, and how these can be overcome. In addition, those occupying or aiming to occupy posts as DPH or specialising in health promotion will need special coaching in media techniques.

8.16.4 Initiation of change

Public health doctors need to operate in many different organisational contexts and relate to many people. They should frequently act as initiators and catalysts for change. When one investigation or initiative is complete, they must be prepared to detach themselves from that part of the organisation and move on to the next task. It is important, therefore, that their training pays more than usual attention to skills of time management, change management, priority setting and delegation.

We urge the FCM, the academic departments and RHAs to take note of these factors in the review recommended above. We hope that the Faculty, in particular, will pursue them through the accreditation process.

8.17 We were surprised to discover that for the most part there are no sources of independent advice or counselling available for trainees in public health medicine as there are, for example, for trainees in other specialities through the post-graduate clinical tutor system. To a certain extent, the Faculty advisers act in this capacity but their contribution is necessarily limited since they cover large numbers of trainees and this role is generally in addition to a full-time work commitment. We understand that one region has allocated two sessions of the time of an SCM at RHA HQ to perform this function. This is a welcome development. *We RECOMMEND, therefore, that all RHAs, in consultation with the FCM and the academic departments, should make arrangements for tutors to support and advise trainees on an individual basis.*

Specialisation

8.18 As we have already mentioned in paragraph 8.15 we have recommended the provision by RHAs of specialist support for communicable disease and infection. We have also noted in paragraph 5.23 that it is at regional level that there will need to be the greatest degree of specialisation generally within the speciality of public health medicine. Specialists may also be needed in some larger districts. It will be important to ensure that the number of available specialist posts is matched by the number of suitably qualified applicants. *We therefore RECOMMEND that there should be discussions between RHAs, the FCM and the academic departments to develop a training programme for those who wish to specialise in various aspects of public health medicine.*

Route into public health medicine

8.19 In paragraph 8.15 we have described the difficulties encountered by some senior trainees in specialities related to public health medicine in transferring to the speciality or obtaining appointments which permit them to combine skills in more than one speciality. We understand that a similar problem exists at more senior levels where consultants from other medical disciplines wish to move into public health medicine or

combine clinical work with public health duties. *We RECOMMEND that the FCM, without in any way lowering standards, should review the arrangements for personalised training in the speciality of public health medicine.* There is a need to ensure that opportunities exist for general physicians to develop and maintain an interest in communicable disease and infection. In addition, we believe that the combination of skills in more than one speciality can in appropriate cases be beneficial. *We RECOMMEND that health authorities should bear in mind the possibility of making consultant appointments which permit the exercise of combined skills.*

Continuing education

8.20 The fact that public health medicine is more affected than clinical specialities by changes to the organisation and management of the NHS, coupled with the fact that inevitably in an organisation as large as the NHS change is to some extent constant, highlights a great need for public health doctors to have access to relevant continuing education. The implementation of our report will in itself require a degree of reorientation for many practising public health consultants, particularly in the field of communicable disease and infection. There will, for example, need to be an intensive programme of training for DCIOs if all recommendations in Chapter 7 are accepted. Only if such continuing education is provided will public health doctors be able to fulfil the role which their health authorities have a right to expect of them. *We therefore RECOMMEND that RHAs, the FCM and the academic departments should organise a continuing education programme for all practising consultants in public health medicine and we urge health authorities to ensure that their public health doctors are encouraged to attend these courses.*

Role of academic departments

8.21 A circular on collaboration between academic and service departments of community medicine was issued in April 1975. The advice which it offers remains relevant today, 12 years later. Unfortunately it has not, in practice, been implemented. Evidence submitted to us has suggested that there is scope for greater collaboration between academic and service departments of public health medicine as we have already mentioned in 8.11. In some areas, there is lack of appreciation of what the other does and of the contribution which each can make to the work of the other. There is not such an immediate relevance and interdependency as in clinical services such as surgery. We hope that service and academic departments will forge closer working relationships, but a positive effort is essential. This might be encouraged by making more joint appointments, organising joint seminars/discussion groups, locating departments in the same building where possible, establishing links between academic departments and service departments in non-teaching districts, requiring senior registrars to spend some of their training period in academic departments (see 8.11 above). Crucially, there needs to be collaboration in the development and organisation of health services research. Such research needs to be firmly based on the practical requirements of health authorities and underpinned by the research skills of the academic departments. Too often, however, members of academic departments do not have direct experience of working in health authorities and are thus unfamiliar with the practical nature and time scale of their operational requirements. Similarly service public health doctors often have an imperfect knowledge of research methods and health authorities have been reluctant to invest resources in this activity. The result is that valuable research is not carried out because of the failure of one or other side to appreciate the problems and potential contribution of the other. The suggestions we have made above for the closer working relationships will, we hope, alleviate this problem.

8.22 As we pointed out in paragraph 2.5, the Hunter report¹¹ suggested bringing together the MOsH, the administrative medical officers of hospital boards and the medical staff of the academic departments of public health and social medicine. Although this produced profound changes for practitioners in health authorities, it led to relatively little change in academic departments. There are relatively few academic staff whose main concern has been to develop a theoretical research base related in general to the study of the preservation and promotion of health in populations, and in particular to the need for an evaluation of health services. For the reasons mentioned in paragraph 8.21, the quality of health service research applications has not been high and this, coupled with the scarcity of funds for medical research has severely restricted urgently needed health service research into the provision, organisation and evaluation of services for which health authorities are responsible. However, if public health medicine is to be placed on the sound footing that we believe is necessary then the context must be set in the undergraduate curriculum. *We RECOMMEND that the UGC and the universities review the staffing and arrangements for teaching public health medicine in the light of our broad definition of the subject.*

REPORT OF THE COMMITTEE OF INQUIRY INTO THE FUTURE DEVELOPMENT OF THE PUBLIC HEALTH FUNCTION AND COMMUNITY MEDICINE

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

Introduction

1. The Inquiry was established by the Secretary of State for Social Services on 21 January 1986, with the following terms of reference:

“To consider the future development of the public health function, including the control of communicable diseases and the specialty of community medicine, following the introduction of general management into the Hospital and Community Health Services, and recognising a continued need for improvements in effectiveness and efficiency; and to make recommendations as soon as possible, and no later than December 1986.”

In announcing the establishment of the Committee to Parliament, the Secretary of State said: “The Inquiry will be a broad and fundamental examination of the role of public health doctors including how such a role could best be fulfilled.” The Committee, which is England based, was set up in response to two major outbreaks of communicable disease — salmonella food poisoning at Stanley Royd Hospital in Wakefield in August 1984 and Legionnaires’ Disease at Stafford in April 1985, which had both resulted in public inquiries. These reports pointed to a decline in available medical expertise “in environmental health and in the investigation and control of communicable diseases” and recommended inter alia a review of the responsibilities and authority of Medical Officers of Environmental Health. In addition, there was continuing concern about the future role of the specialty of community medicine and the status and responsibilities of community physicians after the implementation of general management in the National Health Service. This is the first general review of the public health function since the Report of the Royal Sanitary Commission in 1871.

The scope of the Inquiry

2. We have adopted a broad definition of “public health”, namely “the science and art of preventing disease, prolonging life and promoting health through organised efforts of society,” and we have recognised that there are a multiplicity of influences which affect the health of the public. However, our terms of reference direct us specifically to look at “the future development of the public health *function*.” We have therefore concentrated on how the statutory agencies in respect of health, acting on behalf of the Secretary of State for Social Services, should be organised within the current institutional framework in order to do three things:

- to improve the surveillance of the health of the population centrally and locally;
- to encourage policies which promote and maintain health; and
- to ensure that the means are available to evaluate existing health services.

Although we have focussed as directed on two areas in particular as identified in our terms of reference we regard these, although important, as subordinate to the main task described in the previous sentence.

How we have approached our task

3. In general terms our approach has been to chart the past development of the public health function (Chapter 2); to describe the wide ranging nature of public health today referring not only to the functions of health authorities but also to those of local government, the voluntary and other agencies etc and including the contribution of a medically qualified specialist in public health medicine as one of the key public health practitioners (Chapter 3); to review the public health responsibilities of statutory agencies at the centre and at local level (Chapter 4); to examine the role of public health doctors in the organisation and management structure of the NHS (Chapter 5); to discuss the problems of the availability of public health doctors (Chapter 6); to clarify responsibilities for the control of communicable disease and infection (Chapter 7); and finally to consider the implications of our recommendations for the training of public health doctors and other practitioners working in the field (Chapter 8).

The evidence

4. In formulating our recommendations, we have had the benefit of a generous amount of evidence from a wide variety of agencies and individuals with an interest in public health. We have identified the following problems:

- a lack of co-ordinated information on which to base policy decisions about the health of the population at national and local levels. This has led to:
- a lack of emphasis on the promotion of health and healthy living and the prevention of disease.
- widespread confusion about the role and responsibilities of public health doctors – both within the NHS itself and among the public.
- confusion about responsibility for the control of communicable disease and poor communication between the agencies involved, in particular widespread dissatisfaction with the position of the Medical Officer of Environmental Health (MOEH).
- weakness in the capacity of health authorities to evaluate the outcome of their activities and therefore to make informed choices between competing priorities.

There has been overwhelming support for the need for a well-trained, medically qualified public health specialist as a key figure in the health service. Although we have received unequivocal evidence of past and present difficulties in the supply of such specialists and of doubts concerning the credibility of some, it is clear that, where authorities have had good experience of the specialty, they are unable to envisage an effective working arrangement in which such specialists do not figure. We hope that our recommendations will ensure that in future public health doctors are generally more able to make valuable contributions. We also recognise the important input of non-medically qualified practitioners in this field eg environmental health officers, health visitors and nurses, health promotion and health education officers, statisticians, health economists, experts in education, town and country planners, architects and engineers.

Some general principles

5. There are several themes and principles underpinning our recommendations:

- We believe that the greater emphasis on personal accountability and

responsibility for specified objectives which followed the introduction of general management has been a crucial and positive development. By defining the responsibilities for public health both of authorities and of named individuals appointed by those authorities we have tried to clarify and strengthen this important aspect of the work of the health service within the framework of general management, while at the same time, maintaining maximum flexibility for authorities to respond to local circumstances.

- At a time when the NHS is subject to great changes; when market forces are being brought to bear; when there is greater diversification of financing – all with the intention of increasing further the resources available for the improvement of the health of the public, it is more important than ever that health authorities should focus on their public health responsibilities including the prevention of illness and premature death and the promotion of health. In so doing we consider that they should identify a named individual to advise them on the execution of these responsibilities and the maintenance of adequate standards.
- Significant improvements have been made in recent years in refining planning and management processes within the NHS. Less progress has been made in defining targets and objectives in the light of an analysis of the major health problems facing a particular locality. We have made suggestions as to how target and objective setting could be improved.
- The World Health Organisation (WHO) has defined a range of targets to ensure “Health for All by the year 2000”. The UK Government has endorsed the WHO approach. Public health doctors can make a major contribution to setting and achieving such targets and to the evaluation of health services. In principle, their skills and knowledge should fit them to undertake analyses of health problems upon which investment decisions can be based and to evaluate outcomes. This is vital if improvements in effectiveness and efficiency are to continue in order to maximise benefit from available resources. Such work by public health doctors provides authorities with the means to make choices between competing priorities.
- Public health is not only a responsibility of the NHS. Central and local government, the voluntary sector, industry, the media, the private sector and the individual all have either responsibilities or a contribution to make. Collaboration is vital, particularly between the triumvirate of agencies at local level – health authorities, local authorities and family practitioner committees.
- Communicable disease and infection remain major and increasing problems both in this country and abroad. It is essential that responsibilities for their surveillance and prevention should be clarified, and that an effective system of control with a short reaction time should be in place.

The report

6. Our main conclusions and recommendations, chapter by chapter, are as follows:

Chapter 1: Introduction

This sets out reasons for establishment, terms of reference, membership, method of working etc. It defines “public health” and the scope of the Inquiry.

Chapter 2: Development of the public health function

Early attempts to take collective action in the interests of the health of the population grew into a more sophisticated system during the nineteenth century. In 1919, the Ministry of Health Act brought together all publicly funded preventive activities and health care under a single system of central and local government. In 1948 the NHS was set up as a tripartite structure and responsibilities for the public health ranged across the three structures: the local authority, with whom the Medical Officer of Health remained; the hospital boards, which developed their own corps of administrative medical officers; and the general practitioner services administered by executive councils. The 1974 reorganisation aimed at integration, and brought about the disappearance of the office of MOH and the emergence of the specialty of community medicine. Although the Hunter Report envisaged "a vital and continuing task for doctors working full time in health service administration" some community physicians failed to meet these expectations and contributed to a failure to establish the professional standing of the specialty. At the same time and perhaps partly as a result, health authorities in some cases failed to give sufficient emphasis to public health issues. In the restructuring of the NHS in 1982 Community Medicine was the only medical specialty affected. The implementation of general management in 1984 at a time when the nature of the public health functions of health authorities was not clearly defined, and when the credibility of the specialty of community medicine had in some places become compromised, tended unintentionally to confuse its image further and sometimes to weaken the position of community physicians. Evidence submitted to us suggests that if the current arrangements continued fewer able doctors might in future enter the specialty and some already committed might decide to leave it.

Chapter 3: Intersectoral nature of public health

Although we have concentrated on the contribution of the statutory agencies we strongly support the emphasis given by the World Health Organisation to the role of other sectors of society (eg the voluntary sector, industry, the media) and of individuals in preserving their own health. It is necessary for all elements of society to recognise that they have a contribution to make to health.

While the achievement of improvements to public health will require the efforts of people with many different skills, we believe that success depends upon an understanding of the health of the individuals who make up the population of the locality, and on the measurement of those environmental, social and behavioural factors which affect the balance between health and disease. The need for specialists who combine a medical education with an understanding of epidemiology and the social and behavioural origins of ill-health is as important today as it was in the 19th century.

We have had considerable evidence that the terms "community medicine" and "community physician" can and do cause considerable confusion. To avoid this confusion and to return to a term which we believe is more readily comprehensible to a wide range of people at home and abroad, we *RECOMMEND* that the specialty of community medicine should in future be referred to as the specialty of public health medicine and its qualified members as public health physicians. Those appointed to consultant career posts in the NHS should be known as consultants in public health medicine. [1] We invite the Royal Colleges of Physicians and the Faculty of Community Medicine to consider the name of the Faculty in the light of this recommendation.

Chapter 4: The health services, local government and public health

In our view, one of the problems facing the NHS in recent years has been the implicit nature of its objective to further health by the prevention of illness and promotion of healthy lifestyles and the fact that the organisation by which it is to be discharged remains ill-defined. This objective should be explicit and there needs to be a re-appraisal of these responsibilities both at DHSS and by the statutory bodies for which it is responsible.

We RECOMMEND that a small unit should be established within DHSS bringing together relevant disciplines and skills to monitor the health of the public. [2]

The establishment of such a unit within DHSS will strengthen the support provided to the Secretary of State in discharging his responsibility to Parliament. A major function would be to support the Chief Medical Officer. The unit would also need to be closely aligned with the NHS Management Board and in particular its planning directorate, with the health and personal social services policy group, and with the family practitioner services group. The analyses which it would provide would assist in the assessment on which strategy, management and policy decisions across a broad range of public health issues would be based, and in the evaluation of outcomes.

A more sharply focussed monitoring of health at the centre will assist in setting the agenda for the annual review process by defining specific targets for achieving improvements in health. It will also be helpful to the work of other Government departments.

There is no body in the field of non-communicable disease equivalent to the PHLS and CDSC with responsibility for long term surveillance. An early priority of the monitoring unit should be to explore ways whereby adequate national surveillance of non-communicable disease can be accomplished.

Information from OPCS will provide data on which the monitoring function in DHSS will be based. We welcome the proposed reconstitution of the Registrar General's Medical Advisory Committee and suggest that it should include representation from the NHS at Regional and possibly district level; from FPCs and also from PHLS/CDSC.

Evidence submitted to us demonstrates almost universal support for the PHLS and CDSC. Moreover there is a widespread view that CDSC is under-resourced. We make suggestions designed to strengthen PHLS in Chapter 7.

We urge that the closer integration of the Health Education Authority into the work of the NHS at all levels should be exploited to the full to ensure that more detailed attention and high priority is given in the future to the prevention of disease and the promotion of health. We urge early and close collaboration with RHAs and DHAs in nationally organised initiatives. In addition, it will need to continue to work in collaboration with other bodies such as local authorities, schools, industry and other organisations concerned with creating a healthy society, while at the same time maintaining a robust degree of independence. The HEA will also need to link closely with the DHSS monitoring unit.

The Secretary of State discharges his responsibilities under the NHS Act 1977 through RHAs, DHAs, SHAs and FPCs. These responsibilities include duties relating to public health, although they are rarely made explicit. *We RECOMMEND that the Secretary of State should consider issuing guidance clarifying and emphasising the public health responsibilities of health authorities. [3]*

We define the public health responsibilities of district health authorities as follows:

1. To review regularly the health of the population for which they are responsible and to identify problems. To define objectives and set targets to deal with the problems in the light of national and regional guidelines.
2. To relate the decisions which they take about the investment of resources to their impact on the health problems and objectives so identified.
3. To evaluate progress towards their stated objectives.
4. To make arrangements for the surveillance, prevention, treatment and control of communicable disease and infection.
5. To give advice to and seek co-operation with other agencies and organisations in their locality to promote health.

We consider that this should be the framework within which decisions on priorities and developments should be based and *we RECOMMEND that DHAs should be required to commission an annual report from their Director of Public Health (see recommendation 9) on the health of the population. In formulating their views about the report they should consult local authorities, FPCs, and other relevant bodies locally.* [4] The report should be presented to the health authority by the DPH and debated by them in public. The report will also form part of the accountability process through RHAs to Ministers and Parliament. It should form part of the information on which strategic plans and short-term programmes are drawn up and thus assist in the planning process.

We note that the material issued to people taking up office as HA members omits guidance on their responsibility for the health of the population in general and for the evaluation of the services provided. *We RECOMMEND that DHSS, RHAs and NAHA should revise the material they produce for the training and induction of members to emphasise their public health responsibilities.* [5]

The public health responsibilities of regional health authorities are summarised as follows:

1. To review regularly the health of the region's population. To identify the principal health problems of the region (including those relevant to regional specialist services and teaching). To define regional objectives and set regional targets in the light of national guidelines. To agree objectives and targets for the public health responsibilities of DHAs.
2. To relate the decisions which they take about the distribution of resources to DHAs and about investment of resources to their impact on those health problems and objectives.
3. To monitor DHA progress towards identified targets.
4. To make plans for dealing with major outbreaks of communicable disease and infection which span more than one district and ensure their implementation as appropriate.

We RECOMMEND that RHAs should be required to commission from their Regional Director of Public Health an annual report on the health of the population. [6]

It is vital that there should be close and continuing co-operation between FPCs and DHAs to ensure that the needs of the populations for which they are responsible are covered. We welcome the recent publication of a consultation document on access to the

FPC patient register by HA staff. We hope that our comments will be taken into account and we *RECOMMEND* that FPCs and health authorities should grant each other access to the registers they hold in the interests of patient care. [7]

There is a compelling need for greater collaboration between health authorities and local authorities, the two main statutory arms involved at local level in health policy, and for continuing close working relationships between trained professionals working in this field. It was envisaged in 1974 that the responsibility for medical advice to local authorities, particularly on environmental health issues, would be assumed by the MOEH. The post of MOEH has been associated with a degree of difficulty and uncertainty since its inception and has all too often proved to be unsatisfactory from the standpoint of the local authorities it was intended to serve and unrewarding to the postholder. We make recommendations about advice on communicable disease and infection in chapter 7, but as far as other medical advice to local authorities is concerned, we believe that the focal point in a health authority and the person responsible for ensuring effective collaboration with the local authority should be the DPH. We *RECOMMEND* that the DPH and Chief Environmental Health Officer should meet on a regular basis and that they should establish channels of communication which encourage collaboration between their organisations. [8].

We underline the importance of health authorities, local authorities and FPCs developing links with CHCs, voluntary organisations, consumer groups, the local media and local industry, trade unions etc. These all have a vital contribution to make to the achievement of better health for the public.

Chapter 5: The role of public health doctors in the organisation and management structure of the NHS

We consider that the public health responsibilities of DHAs are so important that they require the identification of a single person to be responsible and accountable for the function on behalf of the DHA and the DGM. We *RECOMMEND* that DHAs should appoint a named leader of the public health function in their district who should be known as the Director of Public Health (DPH). [9] The DPH will be managerially accountable to the DGM. In view of the considerable turmoil resulting from reorganisations in 1974, 1982 and 1984, when community physicians in many cases had to submit to formal appointments exercises, where a DMO is currently in post, our expectation is that he/she should normally be appointed as DPH. We believe that subject to questions of availability, this person should be a medical practitioner with special training in epidemiology and those environmental, social and behavioural factors which affect the balance between health and disease, in other words a consultant in public health medicine.

The central tasks the DPH and his/her colleagues will be required to undertake are:

1. to provide epidemiological advice to the DGM and the DHA on the setting of priorities, planning of services and evaluation of outcomes;
2. to develop and evaluate policy on prevention, health promotion and health education involving all those working in this field. To undertake surveillance of non-communicable disease;
3. to co-ordinate control of communicable disease;
4. generally to act as chief medical adviser to the authority;

5. to prepare an annual report on the health of the population; (or to quote the former MOH duty "To inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the [district] and be prepared to advise the [health authority] on any such matter").
6. to act as spokesperson for the DHA on appropriate public health matters, and
7. to provide public health medical advice to and link with the local authorities, FPCs and other sectors in public health activities.

We have received evidence that there are still places where public health consultants at district level undertake essentially clinical tasks for local authorities. *We RECOMMEND that public health consultants should no longer be required to carry out this work.* [10]

We RECOMMEND that the DPH will generally be the chief source of medical advice to the health authority. [11] The DPH should also act as a source of public health medical advice to the relevant local authorities and FPC.

We believe that DsPH should continue to be managerially accountable to DGMs but entitled to give professional advice directly to the DHA. In view of the central importance of the health authority's public health responsibilities *we RECOMMEND that the DPH as the named officer responsible for discharge of the function should be part of the key decision making machinery in the district.* [12]

In exceptional circumstances, where DHAs are unable to recruit suitably qualified consultants in public health medicine for the DPH post, the DGM will need to consider alternative interim arrangements which should be agreed with the RHA.

All the evidence we have received has suggested that as in the case of other consultants it is very difficult for DsPH working single-handed to provide a professionally competent service. *We RECOMMEND that every DHA should assess the number of public health doctors needed and should make arrangements for access to the advice of a team of at least 2 consultants.* [13] This does not necessarily imply the establishment of such a team in every district. Small districts may wish to pool resources. Moreover, it is possible, following recent changes in London, that there will be further rationalisation of the current pattern of districts over the next 10 years or so. We urge authorities to consider engaging the services of non-medically qualified staff (eg health economists, statisticians, planners) to support and work under the direction of the DPH.

We reject the view expressed in some evidence submitted to us that public health doctors, as public servants, have a duty or a right to advocate or pursue policies which they judge to be in the public interest independently of any line of accountability. The advisory function should be exercised by direct presentation of the issues to the health authority in writing and/or by oral presentation.

As far as appointments are concerned, we are of the view that there is a significant difference between the role of clinical consultants and public health consultants. In view of the fact that the DPH will be managerially accountable to the DGM, *we RECOMMEND that district general managers should be full members of committees which appoint Directors of Public Health.* [14]

We RECOMMEND that the named leader of the public health function in regional health authorities should be known as the Regional Director of Public Health [15]

Chapter 6: Availability of public health doctors

The most comprehensive analysis of the availability of public health doctors is that published by the Faculty of Community Medicine in June 1987. It shows that the vacancy rate among community physician ranks is extremely high (21.5 per cent). The age profile of those community physicians in post in England on 1.12.86 shows that only 30 per cent will still be in post in 2001. If recruitment of trainees in England continued at current levels, and there was no expansion in demand for consultants in public health, the shortfall of available consultants would peak before 1990 (at round 140) and decrease thereafter until the national establishment was filled in 1998. However, the increase in demand resulting from our manpower recommendations is in the region of 109 posts. *We RECOMMEND that each RHA with its DHAs should urgently review its manpower requirements in the light of our recommendations and amend current policies for training public health doctors. [16]. We further RECOMMEND that each RHA should aim to train sufficient public health doctors to meet its own manpower requirements with the aim of reaching a national rate of 15.8 consultants in public health medicine per million population by around the year 1998. [17].*

There are a number of actions which could be adopted now to ease the situation and ensure that full establishment is reached as soon as possible. In reviewing their manpower requirements RHAs should also consider the possibility of introducing such measures.

Chapter 7: Control of communicable disease and infection

Communicable disease and infection control is governed by a set of measures which have evolved over time and which, taken together, have created a system which is complicated and at times unclear.

There are no simple solutions to the problems we have identified. The microbes which give rise to communicable disease and infection do not work within statutory limits and responsibilities. They can wreak havoc across a range of authorities and agencies very quickly. It is crucial first, to recognise the need for continuing co-operation and collaboration between the two main statutory agencies. Secondly, those responsible must be able to react quickly and decisively to problems as soon as they are identified. Thirdly, there needs to be a clear recognition of the responsibilities of health authorities for the treatment, prevention and control of most communicable disease and infection. Finally, we acknowledge the continuing role of local authorities in the prevention and control of notifiable diseases, particularly those which are food and water borne.

We believe that the office of Medical Officer of Environmental Health (MOEH) straddles uncomfortably between health and local authorities, has proved unsatisfactory in practice and should be abolished. In line with the general thrust of arrangements since the implementation of general management in the NHS, for clarifying responsibilities and holding named individuals responsible for their discharge, our recommendation focusses on the need for a more tightly defined and accountable role in control of communicable disease and infection. In order clearly to reflect health authorities' responsibilities, *we RECOMMEND that DHAs should assign executive responsibility for necessary action on communicable disease and infection control to a named medical practitioner who will be called the district control of infection officer (DCIO). [18]* This does not necessarily imply the creation of a post in every district.

This person would be medically qualified and have expertise in communicable disease and infection. He/she would be a member of the district's Department of Public Health

and would be a consultant in public health medicine or another relevant specialty such as microbiology, infectious disease medicine etc. The DCIO would be responsible for linking the vital work undertaken by microbiologists and control of infection teams within hospitals with cases of infection occurring outside. The DCIO would normally be accountable managerially to the DPH. The DCIO would act as a source of public information on issues relating to control of communicable disease and infection.

The DCIO will be working at a higher level than and within a different framework from many current MOsEH. We do not believe, therefore, that it will be possible in all cases to continue with the type of current arrangement which combines DMO and MOEH posts or some current postholders (some of whom are not working at the required level). The DCIO posts will in practical terms constitute a new role and should be recognised as such.

We do not underestimate the difficulty of appointing a cadre of DCIOs to cover the communicable disease and infection function in all authorities. We would expect some current MOsEH to be appointed as DCIOs. We would not expect every district to appoint a full time DCIO dedicated exclusively to that district. Providing geographical boundaries and accountability are clearly defined we would support arrangements, particularly in smaller or less densely populated districts, or in conurbations which involved joint appointments or appointments which combined DCIO responsibilities with other closely related duties. In order to ensure a smooth transition, and proper consideration of personnel issues etc, *we RECOMMEND that RHAs should draw up plans for handling the transition from the current arrangements in consultation with their districts.* [19]

Perhaps the greatest challenge to public health in recent years is that presented by AIDS and HIV infection. The DPH and his/her staff (generally the DCIO) should have a key role in co-ordinating the activities of the many agencies and organisations involved in the surveillance and prevention of the spread of HIV infection.

We RECOMMEND that in order to assist the DCIO discharge his/her responsibilities for control of communicable disease and infection, an advisory District Control of Infection Committee should be established. [20]

We also RECOMMEND that the DHA should require its DCIO to contribute a section on control of communicable disease and infection to the annual report (see recommendation [4]). [21]

We RECOMMEND that the guidance recommended in [3] should make it clear that the RHA's duty to monitor District performance extends to ensuring that adequate management arrangements exist for dealing with communicable disease and infection both in hospital and in the general population. [22]

We RECOMMEND that it should be the responsibility of each RHA to ensure the provision of specialist support services, in consultation with DHAs, LAs, PHLS and the relevant academic departments adopting the approach best suited to its needs. [23]

We would like to see the PHLS strengthened in a number of ways, for instance by more effective exchange of information between CDSC and its sources of data, by expanding the ability of CDSC to provide a service of field epidemiology in communicable disease and infection on request to health and local authorities, and by an expansion of the practical training role of CDSC.

We RECOMMEND that DHSS should consider means by which a reserve power could be created, whereby the CMO could authorise CDSC to assist in immediate investigation of an outbreak. [24]

We RECOMMEND that the CMO should make arrangements to delegate to CDSC in the majority of cases the requirement to be notified under Regulation 6(2) of the Public Health (Infectious Diseases) Regulations 1968. [25] There will need to be an agreement as to which circumstances require that CDSC inform CMO of serious outbreaks.

We believe that the legal responsibility to report a case of notifiable disease rests clearly upon the clinician who first sees the patient and suspects the diagnosis. We RECOMMEND that as a matter of urgency DHSS should produce and circulate to all doctors a brief explanatory guide to the notification procedure and its purpose. [26] It is important that doctors are aware of the reasons for requiring each disease to be notified.

We RECOMMEND that the notification system should be reviewed in the context of the general revision of public health legislation recommended in [29]. [27] We also RECOMMEND that there should be regular reviews of the list of diseases classified as notifiable. [28]

Some of the provisions of public health legislation now seem a little dated. We RECOMMEND that DHSS should revise the Public Health (Control of Disease) Act 1984 with a view to producing a more up to date and relevant legislative backing to control of communicable disease and infection. [29]

The revision will also need to include a close look at the powers currently ascribed to "proper officers", to establish whether these are needed at all, and if so whether they should be the responsibility of health or local authorities and which officers of these authorities should be nominated to execute them.

Chapter 8: Education and training

In the evidence we have received, attention has repeatedly been drawn to the fact that there is a lack of appreciation on the part of public health doctors of the work of other practitioners concerned with public health such as environmental health officers and vice versa. We believe that multi-disciplinary training should be more widely available. We RECOMMEND that DHSS, the GMC, the NHSTA, RHAs, the medical schools, the UKCC and other training bodies/institutes should review their education and training programmes in the light of our recommendations and the need for renewed emphasis on public health issues. [30]

Widespread appreciation of public health issues demonstrates a need for a strong national resource centre or centres, providing post-graduate education of the highest quality such as exist in Europe and the USA as Schools of Public Health. We invite the Working Party which, under the Chairmanship of Sir John Reid, is currently considering the long term objectives of the London School of Hygiene and Tropical Medicine, to consider our recommendations with a view to strengthening the School. More generally, we RECOMMEND that the relevant training institutions and professional bodies should discuss how best to achieve multi-disciplinary awareness and collaboration in the training of public health practitioners, including the possibility of establishing a school or schools of public health. [31] In addition, there may also be merit at regional level in considering the school of public health concept in other locations bringing together existing departments.

It has become evident to us in the course of our discussions that there is often a lack of

clarity about the shared responsibility for basic post-graduate training in public health medicine, such that in some places no one body is identified as being in the lead and there is lack of impetus for critical review of training needs and provision. *We therefore RECOMMEND that RHAs, who are responsible for the employment of the majority of trainees, should assume lead responsibility for the co-ordination of the post-graduate training of public health doctors.* [32]

We believe there is a need for thorough re-examination of the training requirements for public health doctors. *We RECOMMEND that representatives of the RHAs, the Faculty of Community Medicine (FCM) and the academic departments should undertake an urgent review of the requirements in the light of the general principles outlined.* [33]

We RECOMMEND that all RHAs, in consultation with the FCM and the academic departments, should make arrangements for tutors to support and advise trainees on an individual basis. [34]

We RECOMMEND that there should be discussions between RHAs, the FCM and the academic departments to develop a training programme for those who wish to specialise in various aspects of public health medicine. [35]

We RECOMMEND that the FCM, without in any way lowering standards, should review the arrangements for personalised training in the specialty of public health medicine. [36] *In addition, we RECOMMEND that health authorities should bear in mind the possibility of making consultant appointments which permit the exercise of combined skills (in public health medicine and a clinical specialty).* [37]

We RECOMMEND that RHAs, the FCM and the academic departments should organise a continuing education programme for all practising consultants in public health medicine and we urge health authorities to ensure that their public health doctors are encouraged to attend these courses. [38]

We RECOMMEND that the UGC and the universities review the staffing and arrangements for teaching public health medicine in the light of our broad definition of the subject. [39]

Implications of our recommendations

Timing

7. We have made 39 recommendations. Thirty-one can be implemented with no delay, 29 of them at very low or minimal cost.

Recommendations 27 and 29, involve revision of legislation which will mean securing Parliamentary time. Recommendations 13, 16, 17, 18 and 19 and 23 involve the appointment of additional consultants in public health who will not be immediately available due to the supply problems described in Chapter 6.

Cost

8. In framing our recommendations, we have been mindful of the need to keep costs to a minimum. Many of our suggestions involve the clarification of roles and responsibilities and not the creation of additional posts. Twenty-nine of the recommendations can be implemented at nil or minimum cost. Recommendations 4, 6, 13, 16, 17, 18, 19, 23, 31 and 38 will be more likely to carry direct resource implications. We believe that additional expenditure in these areas is necessary first, to secure effective

control of communicable disease to prevent outbreaks such as those which occurred at Stanley Royd and Stafford and secondly, to enable health authorities effectively to discharge their public health responsibilities to give greater emphasis to the prevention of illness and the promotion of healthy lifestyles and to evaluate services. However, much of this expenditure is, in effect, little more than a re-allocation of NHS resources and will in any case build up gradually over a long time period – the next 10-12 years – since it is dependent on the preparation of manpower plans, and on the availability of trained manpower. We do not expect that our recommendations will affect overall plans for the total number of doctors within the NHS, but rather their disposition between specialties. This applies equally to trainees; we do not expect that overall numbers will increase, but that junior doctors will choose to enter the new specialty of public health medicine rather than some other specialty. Where there are additional costs, these can be offset by using existing funds from unfilled vacancies. It should also be remembered that there will be considerable unquantifiable benefits. In evaluating services, public health doctors will facilitate improved efficiency and effectiveness and help health authorities make better choices within existing resources.

Conclusion

9. We believe that, taken together, our recommendations represent a significant package of proposals which will clarify and strengthen the discharge of the public health function. We hope that 1988, the year which marks the 40th anniversary of both the NHS and WHO, will see our recommendations implemented and that in the ensuing decades they will facilitate the improvement of health in England.

MEMBERS OF THE COMMITTEE OF INQUIRY INTO THE FUTURE DEVELOPMENT OF THE PUBLIC HEALTH FUNCTION AND COMMUNITY MEDICINE

Membership was as follows:

Sir Donald Acheson KBE DM DSc FRCP FFCM FFOM (Chairman)	Chief Medical Officer Department of Health and Social Security
Mrs Juliet M Baxter	Vice-Chairman of West Berkshire Health Authority A Vice-President of the Pre-School Playgroups Association
Sir Michael Carlisle BEng CEng FIMechE FIMarE FBIM	Chairman, Trent Regional Health Authority
Mr Michael Eastwood MSc MIEH FRSH MBIM (from September 1986)	Director of Environmental Health and Consumer Protection, City of Manchester
Professor Alasdair M Geddes MB ChB Ed FRCP FRCP Ed	Honorary Professor of Infectious Diseases, University of Birmingham; Senior Physician in infectious diseases, West Midlands Regional Health Authority, and Consultant Physician at East Birmingham Hospitals
Mr Peter A Griffiths AHSM MBIM	District General Manager, Lewisham and North Southwark Health Authority
Dr Roderic K Griffiths BSc MB ChB FFCM	Director of Health Care Policy Central Birmingham Health Authority
Miss Sue Mowat OBE RGN RHV (from September 1986)	General Manager, Primary Care Services Unit, Hillingdon Health Authority
Dr Michael O'Brien MB ChB FFCM DPH	Regional Medical Director East Anglian Regional Health Authority
Dr Joseph W G Smith MD FRCP FRCPath FFCM FIBiol DipBact	Director, The Public Health Laboratory Service
Professor Ian M Stanley MB ChB MRCS MRCP FRCGP (from September 1986)	Professor of General Practice, University of Liverpool
Mr Alfred Stocks CBE MA	Formerly Chief Executive, Liverpool City Council
Secretariat:	
Mr Paul Curd (from May 1987)	
Ms Kathy Doran (from June 1987)	
Dr Bryan Hunt	
Ms Elizabeth Mothersill (until June 1987)	
Mr Louis Rieunier (from April 1987)	

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE LONDON SE1 6BY
TELEPHONE 01-407 5522 EXT 7310
GTN (2915)

ROOM A710
COMMITTEE OF INQUIRY INTO THE FUTURE
DEVELOPMENT OF THE PUBLIC HEALTH FUNCTION
AND COMMUNITY MEDICINE.

Dear

1. The Secretary of State for Social Services has established an Inquiry into the future development of the public health function and community medicine in England. The Chairman of the Inquiry is the Chief Medical Officer, Dr Donald Acheson, and the terms of reference of the Inquiry are:

To consider the future development of the public health function including the control of communicable diseases and the specialty of community medicine, following the introduction of general management into the Hospital and Community Health Services, and recognising a continued need for improvements in effectiveness and efficiency; and to make recommendations as soon as possible, and no later than December 1986.

A note on the membership of the Inquiry is enclosed.

2. As the first stage in its task, the Committee is inviting organisations and others with an interest in the matters covered by its remit to submit written evidence to it. At the Committee's request, therefore, I am writing to invite your organisation to provide a written statement of its views on those matters. I am writing similarly to the other organisations shown on the list enclosed. In addition to these, the Committee will welcome written evidence from any other organisations or persons who are interested in the issues raised. The Committee is considering how this can be made known as widely as possible and will welcome any publicity which can be given to the content of this letter.

3. In preparing its evidence, your organisation may wish to have in mind the following points.

3.1 The task of the Inquiry, as described by the Secretary of State when he announced its establishment on 21 January, is to undertake "a broad and fundamental examination of the role of public health doctors, including how such a role could best be fulfilled".

3.2 As a working list of the areas in which the specialist in community medicine has responsibilities, the Committee has taken the following:

3.2.1 determining the health needs of whole populations;

3.2.2 contributing to planning of appropriate health services, and evaluating the outcome of such services;

3.2.3 ensuring that health authorities are provided with medical advice of appropriate quality as and when necessary;

3.2.4 control of communicable disease (including "proper officer" functions);

3.2.5 medical advice and support to local authorities in connection with their other environmental health functions and their social services and housing functions;

3.2.6 health surveillance of pre-school and school-age children and advice and support to local education authorities in connection with various statutory functions;

3.2.7 prevention, health promotion and health education;

3.2.8 provision, co-ordination and evaluation of programmes which require co-ordination of the work of doctors both within and outside hospitals (eg immunisation, screening programmes).

3.3 The Committee's work will include an examination of recruitment and training in community medicine.

4. The Committee would find it very helpful if written evidence submitted to it could be structured to cover the following particular points:

4.1 comments on the Committee's working list of areas of responsibility of community medicine specialists (3.2 above);

4.2 taking the eight areas of responsibility in 3.2 individually, comments on:

4.2.1 how effectively the responsibilities in that area are discharged at present;

4.2.2 what problems are perceived (if any): and, where appropriate;

4.2.3 what solutions, within the Committee's remit, can be identified.

5. Organisations and others are asked to send their written evidence to me at the above address, to arrive by Friday 11 July 1986.

6. The conduct of the Inquiry in regard to such matters as invitations to organisations and persons to provide oral evidence is a matter for the Chairman and Committee. The Committee's Report will be published.

Yours sincerely

Secretary to the Inquiry

WRITTEN EVIDENCE

Details of those submitting Written Evidence

National Organisations

Association of Clinical Cytogeneticists
 Association of District Medical Officers
 British Association of Community Physicians
 British Association of Otolaryngologists
 British Geriatrics Society
 British Medical Association
 Central Committee for Community Medicine and Community Health
 Central Committee for Hospital Medical Services
 Community Medicine Consultative Committee
 General Medical Services Committee
 Joint Consultants Committee
 British Paediatric Association
 Conference of Medical Royal Colleges and Their Faculties in the UK
 Council for Postgraduate Medical Education in England and Wales
 Faculty of Community Medicine
 Faculty of Occupational Medicine
 National Association of Family Planning Doctors
 Royal College of General Practitioners
 Royal College of Obstetricians and Gynaecologists
 Royal College of Pathologists
 Royal College of Physicians of London
 Joint Committee on Higher Medical Training
 Royal College of Physicians of Edinburgh
 Royal College of Psychiatrists
 Society of Community Medicine

Academic Departments of Community Medicine

Academic Departments of Community Medicine – Heads of Departments Group
 Dr C Burns, Charing Cross and Westminster Medical School
 Dr F Eskin, Centre for Professional Development, University of Manchester
 Prof P J S Hamilton, London School of Hygiene and Tropical Medicine
 Prof W W Holland, United Medical and Dental Schools of Guys and St Thomas' Hospitals
 Prof G Knox, University of Birmingham
 Prof I Leck, University of Manchester
 Dr K McPhee and Colleagues (Medical Statisticians), University of Oxford
 Prof M P Vessey, University of Oxford
 Dr D R R Williams, University of Cambridge

Committees and Sub-Committees of the Community Medicine Specialty and Health Authority Departments

Leicestershire Health Authority – Division of Community Medicine
 Manchester Joint Consultative Committee (Health)

Northern Regional Health Authority – Committee for Community Medicine and Community Health
North West Thames Regional Health Authority –
Community Medicine Working Party
Department of Community Medicine
Oxford Regional Health Authority – Community Physicians Group
Oxford University – Specialty Sub-Committee for Community Medicine
Port and City of London – Community Medicine Environmental Health Group of the FCM
Sheffield Health Authority – Division of Community Medicine and Community Health
South East Thames Regional Health Authority – Community Medicine Specialty Sub-Committee
Trent Regional Health Authority –
Advisory Sub-Committee in Community Medicine
Committee for Community Medicine and Community Health
Warwickshire Health Authorities – Division of Community Medicine

Other Academic Departments

Dr J Ashton, Department of Community Health, University of Liverpool
Prof M Baker, Clinical Epidemiology Unit, University of Bradford
Prof D Hull, Department of Child Health, University of Nottingham
Prof K McCarthy, Prof of Medical Microbiology, University of Liverpool
Dr T W Meade, MRC Epidemiology and Medical Care Unit, Northwick Park Hospital
Prof G Rose, London School of Hygiene and Tropical Medicine, and Colleagues (from Academic Departments in London)
Prof N Wald, Department of Environmental and Preventive Medicine, Medical College of St Bartholomew's Hospital, University of London
Dr C Webster, Wellcome Unit for the History of Medicine, University of Oxford.

Other Medical Organisations and Groups

ASTMS Medical Practitioners Union, East Lancashire MPU Group
British Postgraduate Medical Federation Child and Family Health Unit: SCMOS, West Lambeth Health Authority
Community Medicine Child Health Group, North Western Region
Community Physicians in North East Thames Regional Health Authority (Dr J M Crown, Chairman, NETRHA DMOs Group)
Community Physicians in South West Thames Regional Health Authority (Dr M Spencely, DMO, Merton and Sutton HA)
Community Physicians in the Yorkshire Region
64 Community Physicians (Dr D J Josephs, South Bedfordshire Health Authority)
Health Services Study Group
Joint Medical Advisory Committee, University of London
Medical Officers of Schools Association
Mersey Regional Health Authority
Postgraduate Dean, Council for Postgraduate Medical Education and Others, (E Ramsay, Regional SCM)
Mersey Regional Medical Committee (Dr J Baines, DMO, Warrington Health Authority)

Midlands and South Western Inter-Regional Training Scheme in Community
Medicine
Regional Health Authority Medical Officers (Dr W McKee, Chairman)
Regional Specialists in Capital Planning (Dr T Sussman, Chairman)
Registrars and Senior Registrars in the Specialty of Community Medicine in the
Midland and South Western Consortium
Tameside Local Medical Committee
Trainees in Community Medicine, North West Thames Regional Health Authority
Working Party of Community Physicians in Northern Region

Regional and District Medical Officers (or equivalent)

Dr J K Anand (DMO Peterborough HA)
Dr A R Buchan (DMO, Leicestershire HA)
Dr W G Charlesworth (DMO, Dartford and Gravesham HA)
Dr D Cullen (DMO, Plymouth HA)
Dr L J Donaldson (RMO, Northern RHA)
Dr H P Ferrer (DMO, Worcester and District HA)
Dr L P Grime (DMO, Burnley, Pendle and Rossendale HA)
Dr M Harrison (DMO, Sandwell HA)
Dr J Stuart Horner (DMO, Croydon HA)
Dr A L Kirkland (DMO, Mid Essex HA)
Dr P W Lang (DMO, Chorley and South Ribble HA)
Dr W J McQuillan (DMO, Northampton HA)
Dr W McKee (RMO, Wessex RHA)
Dr A M Nelson (DMO, Kingston and Esher HA)
Dr M O'Brien (RMO, E Anglia RHA)
Dr D L Olsen (DMO, Hampstead HA)
Dr J Phillips (DMO, Liverpool HA)
Dr M Reynolds (Chief Medical Adviser [RMO], SWRHA, on behalf of CPs in
SWRHA)
Dr J S Rodgers (DMO, Kettering HA)
Prof H Schmieden (Acting DMO, Stockport HA)
Dr F Seymour (Director of Clinical and Scientific Services, North West Thames
RHA)

Other Doctors

Dr S Atkinson (SCM, Bristol and Western HA)
Dr D Bainton (Holmfirth, Huddersfield)
Dr G I Barrow (Medical Consultant in Environmental Microbiology and Hygiene)
Dr J W Bland (GP, Coventry)
Dr J P Walsworth-Bell (Regional SCM, NWRHA)
Dr P E Brooks (Director of Service Development, Herefordshire HA)
Dr C St J Buxton (SCM, Brent HA)
Dr G E Camm (Blanefield, Glasgow)
Dr B Cooke (Bloomsbury HA)
Dr D W Denning and 3 colleagues (Community and Immunisation Advisory Clinics,
Northwick Park and Tottenham)
Dr P Draper (Emeritus Consultant in Community Medicine to Guy's Hospital)
Dr G Hatton-Ellis (Torbay HA)
Dr D W Gau (GP, Beaconsfield, Buckinghamshire)
Dr D St George (Registrar in CM, Merton and Sutton HA) with Dr P Littlejohns

Dr M S Gilbody (Trafford HA)
Sir George Godber (Cambridge)
Dr A P Haines (MRC Epidemiology and Medical Care Unit, Northwick Park Hospital)
Dr J C Hannah (Central Manchester HA)
Dr A Hargreaves (SCM, West Cumbria HA)
Dr P J Heath (SCM, West Midlands RHA)
Dr V K Hochuli and 11 Senior Registrars in South East Thames RHA
Dr E J Hunt (Senior SCM, St Helens and Knowsley HA)
Dr P Lambert (Basingstoke and North Hampshire HA)
Dr B McCloskey (SCM, Worcester and District HA)
Dr R S Morton (Sheffield)
Dr S R Palmer (PHLS, Regional Epidemiologist for Wales)
Dr W S Parker (Former MOH, County Borough of Brighton)
Dr D G H Patey (Colchester, Essex)
Dr J M Read (Clinical Medical Officer — Adult Health, Basingstoke, Hants)
Prof P Rhodes (Regional Postgraduate Dean, Faculty of Medicine, University of Southampton)
Dr M V Rivlin (SCM — Planning, Mersey Regional Health Authority)
Prof G Rose (London School of Hygiene and Tropical Medicine)
Dr P M Fox-Russell (SMO, South West Surrey HA)
Dr R L Salmon (Herefordshire HA)
Dr A Scott-Samuel (CP, Liverpool)
Prof A Semple (University of Liverpool)
Dr G Davey-Smith (London School of Hygiene)
Dr R Stanwell-Smith (Bristol and Western HA)
Dr G H Stewart (SCM, St Mary's Hospital, Newport, Isle of Wight)
Dr E P Wright (Consultant microbiologist, Hastings HA)

Doctors in Scotland, Wales and Northern Ireland

Prof J Catford, Director, Heartbeat Wales
Prof P Harper, University of Wales College of Medicine
Dr A Macpherson on behalf of Division of Community Medicine, Argyll and Clyde Health Board
Dr H Russell (retired), Edinburgh
Dr J Skone, 'The Health Services in South Glamorgan During 1985' — Report of the CAMO
Dr C J Weir, paper representing the consensus views of practicing Community Physicians in Northern Ireland

Doctors from Abroad

Dr P Gully, Saskatoon Community Health Unit, Saskatchewan, Canada
"Centers for Disease Control: Organisation, Mission and Functions", CDC, Atlanta, Georgia, USA

Nursing Organisations

Royal College of Midwives
Royal College of Nursing

Health Visitor Organisations

Health Visitors' Association

Standing Conference of Representatives of Health Visitor Education and Training Centres

Standing Conference of Representatives of Health Visitor Training Centres, South West Region

Joint Nursing/Midwifery/Health Visiting Organisations

United Kingdom Central Council for Nursing, Midwifery and Health Visiting

English National Board for Nursing, Midwifery and Health Visiting

Health Service Management — Professional Organisations

Institute of Health Services Management

Other Hospital, Health Authority and Community Health Service Management

J Ackers, Chairman, West Midlands RHA

Mrs S Alexander, Chairman, Trafford HA

Dr I Baker, DMO, on behalf of Bristol and Western HA

P Benton, Chairman, Enfield HA

D Berriman, on behalf of RHA Chairmen

Ms B Borrett, Chairman, Southern Derbyshire HA

Dr J Carpenter, on behalf of East Birmingham HA

M Chapman, Chairman, West Essex HA

Mrs J Cumberlege, Chairman, Brighton HA

D Dawson, Director of Personnel and Organisational Development, Bloomsbury HA

S Dickens, DGM, South Birmingham HA

B Edwards, on behalf of RHA General Managers

Mrs H Filby, Assistant Secretary, Nottingham HA

N Gerrard, Community Services Manager, Oldham HA

A Gick, General Manager, Tameside and Glossop HA

G Hague, Chairman, Wigan HA

J Hague, RGM, Northern RHA

Miss C Hawkins, RGM, South Western RHA

P Hewitson, DGM, Northallerton HA

Prof J Howell, Chairman, Southampton and South West Hampshire HA

A Kember, RGM, South West Thames RHA

D Kenny, RGM, North West Thames RHA

M King, Chief Executive, East Anglian RHA

D Marland, Chairman, South Warwickshire HA

B Mathers, Chairman, Wolverhampton HA

P May, Head of Administration, Frenchay HA

B Meade, DGM, Kingston and Esher HA

Mrs C Miles, Chairman, Oxfordshire HA

Mrs L Milligan, Associate Director of Clinical Services and Service Planning, Hospitals for Sick Children SHA

Prof J Moore, Chairman, North Manchester HA

Miss Y Mouncer, Deputy Director, on behalf of National Association of Health Authorities

G Nichol, DGM, Darlington HA
G Nichols, DGM, East Yorkshire HA
V Peel, DGM, Bolton HA
A Randall, DGM, Worthing HA
T Rogers, Chairman, Salisbury HA
D Ryan, DGM, South West Durham HA
Sir Jack Smart, Chairman, Wakefield HA
J Spence, Chairman, Medway HA
R Spencer, DGM, Bromsgrove and Redditch HA
A Taylor, Chairman, Newcastle HA
A Thomson, Chairman, Lancaster HA
Mrs M Todd, Chairman, Durham HA
R Trainer, Secretary, Mid Staffordshire HA
Dr E Vincent, DGM, Wandsworth HA
A Wall, DGM, Bath HA
R Widdowson, Chairman, Pontefract HA
D Wild, Director of Professional Services, South West Thames RHA
East Birmingham Health Authority
East Surrey Health Authority

Family Practitioner Services Management including Individual FPCs

Society of Administrators of Family Practitioners Services
Society of Family Practitioner Committees
Barnet FPC
Berkshire FPC
Cumbria FPC
Lincolnshire FPC
Northumberland FPC
Nottinghamshire FPC
Surrey FPC

Scientific and Technical – Organisations

Association of Medical Microbiologists
Institute of Medical Laboratory Sciences

Scientific and Technical – Individuals

Prof P C G Isaac, Chartered Civil Engineer

Information

R B Tabor, Wessex Regional Librarian

Prevention and Health Promotion – Organisations and Individuals

DHEO/HPO Members of the NHS/HEC/DHEO/DHPO National Consultative
Committee
Health Promotion Department, Winchester HA

Organisations of Local Authorities

Association of County Councils
Association of District Councils
Association of Metropolitan Authorities
Association of Sea and Airport Authorities

Environmental Health – Organisations

All Wales Chief Environmental Health Officers Panel
Chief Environmental Health Officers Group (Hampshire and Isle of Wight)
Institute of Housing
Institution of Environmental Health Officers

Environmental Health – Departments

Borough of Great Yarmouth Department of Technical Services
City of Birmingham Environmental Health Department
City of Bradford Metropolitan Council (Directorate of Housing and Environmental Health Services)
Leeds City Council Department of Environmental Health, Cleansing and Transport
Oxford City Council Health and Environmental Central Committee

Environmental Health – Individuals

B C R Dickens (EHO)
R G Fidoe (EHO)
M Jacob (EHO, DHSS)
N H Parkinson (CEHO, Selby District Council)

Social Services – Organisations

Association of Directors of Social Services

Education – Organisations

Society of Education Officers

Education Authorities

Walsall Metropolitan Borough Education Department

Education – Individuals

Lt Col G W Chew, Administrator, Lingfield Hospital School
Jane Lewis, Lecturer, Department of Social Science and Administration, London School of Economics and Political Science (Articles in "Public Health" and Bulletin of the Society for the Social History of Medicine)

Individual Local Authorities

City of Nottingham
Lewes District Council
Liverpool Council
London Borough of Barnet

Middlesbrough Borough Council
Mid-Sussex District Council

Local Authority Chief Executives

Society of Local Authority Chief Executives

Local Authority Legal Officers

Association of District Secretaries

Other Statutory Bodies

Communicable Disease Surveillance Centre
Economic and Social Research Council
Health and Safety Commission
Joint Committee on Vaccination and Immunisation
Medical Research Council
NHS Health Advisory Service
NHS Training Authority
Office of Population Censuses and Surveys
Public Health Laboratory Services
University Grants Committee

Government Departments

Department of Health and Social Security
Department of Health and Social Services (Northern Ireland)
Ministry of Agriculture, Fisheries and Food – State Veterinary Service
Ministry of Defence – Defence Medical Services Directorate
Scottish Home and Health Department – Communicable Diseases (Scotland) Unit

Voluntary Sector and Patients' Organisations

Age Concern England
Alcohol Concern
Association for Research in Infant and Child Development
Child Accident Prevention Trust
Child Growth Foundation
Disabled Living Foundation
Muscular Dystrophy Group of Great Britain and Northern Ireland
National Association for Maternal and Child Welfare
National Childbirth Trust
National Consumer Council
National Council of Voluntary Child Care Organisations
National Council for Voluntary Organisations
Patients Association
Pre-School Playgroups Association
Royal Society for the Prevention of Accidents
Save the Children Fund
Shelter
Standing Conference of Ethnic Minority Senior Citizens (London)

Voluntary Organisations Liaison Committee for the Under-Fives
Voluntary Organisations Personal Society Services Group

Community Health Councils

Association of Community Health Councils for England and Wales
Darlington CHC
Durham CHC
East Hertfordshire CHC
Lancaster CHC
Portsmouth and SE Hampshire CHC
Sandwell CHC
South Gwent CHC
South Tees CHC
South Warwickshire CHC
South West Durham CHC
West Berkshire CHC
Weston CHC

Other Organisations

British Society for the Study of Infection
Family Planning Association
Health Services Management Centre, University of Birmingham
Health Education Council
Hospital Infection Society
Institute for Complementary Medicine
King Edward's Hospital Fund for London
London School of Hygiene and Tropical Medicine -- School of Public Health
Nuffield Foundation
Nuffield Provisional Hospitals Trust
Office of Health Economics
Royal Institute of Public Administration
Royal Institute of Public Health and Hygiene
Royal Society of Health
Royal Society of Medicine
Society for Social Medicine
Society of Health Education Officers
World Health Organisation

ORAL EVIDENCE

Details of those attending oral evidence sessions:

Association of District Councils

Lady Elizabeth Anson
Mr M Ashley
Mr B Etheridge
Mr A Kirkman

Association of District Medical Officers

Dr P W Briggs
Dr D Cullen
Dr T Trace

Association of Metropolitan Authorities

Councillor T Harris
Councillor M Lightfoot
Mr D Wells
Mr P Westland

Central Committee for Community Medicine and Community Health of the BMA

Dr K Dalzell
Dr S Horsley
Dr D P B Miles
Dr H G Pledger
Dr E A Wain

Mr J Hopkins
Ms D Warner

District General Managers

Mr D Jackson
Mr B Nicholls
Dr E Vincent

District Health Authority Chairmen

Mrs J Cumberlege
Mr J Royston Moore
Dr A Taylor

Miss Y Mouncer

Faculty of Community Medicine

Dr R Rue

Health Education Council

Sir Brian Bailey
Dr A M Davis
Dr D Player

Health and Safety Commission

Dr E J Cullen

Health and Safety Executive

Dr J T Carter

Health Visitors Association

Ms R Lowe
Ms S Goodwin

Institute of Health Services Management

Dr M Dixon

Institution of Environmental Health Officers

Mr D J Barnett
Mr A M T Johnson
Mr A M Tanner

London School of Hygiene and Tropical Medicine

Professor D Bradley
Professor P Hamilton
Professor G Rose
Dr C E Gordon Smith

Dr B Cooke
Dr B McCloskey
Dr G Davey-Smith

National Council for Voluntary Organisations

Mrs J Begg
Ms S Blennerhassett
Ms S Stace
Ms M Taylor

Office of Population Censuses and Surveys

Mrs G T Banks

Qualitative Research Unit, Social and Community Planning Research

Ms J Ritchie
Ms P McLeman

Regional General Managers

Mr A Kember

Mr D Kenny

Mr D Blythe

Regional Health Authority Chairmen

Mr D Berriman

Professor B Tomlinson

Regional Medical Officers

Dr R A Haward

Dr A McGregor

Dr W J E McKee

Dr F Seymour

Royal College of General Practitioners

Dr J Hasler

Society of Health Education Officers

Ms C Burnett

Ms K Birch-Kennedy

World Health Organisation

Dr J E Asvall

Individuals

Dr J Ashton, Senior Lecturer, Department of Community Health, University of Liverpool and Director, WHO Healthy Cities Co-Ordinating Centre.

Professor J C Catford, Professor of Health Education and Health Promotion, University of Wales College of Wales, and Director of the Welsh Heart Programme (Heartbeat Wales)

A NOTE ON THE 'INDEPENDENCE' OF THE FORMER MEDICAL OFFICER OF HEALTH

1. Between 1922 and the abolition of the office in 1974 the MOH could not be dismissed without Ministerial consent. The protection which this afforded showed that Parliament recognised:

1.1 that public health issues were of major — even of overriding — significance in a locality.

1.2 that in discharging duties which carried such a significance the MOH might well fall foul of local vested interests from time to time.

1.3 that those very interests might well be represented — indeed entrenched — in the Council, and that as a consequence the MOH without statutory protection might be unable to protect the public interest.

2. While there was clearly a wide variety of ways in which such clashes might arise, examples which illustrate the possibilities would be disputes arising:

2.1 over the priority to be given, in terms of funding, to activities, campaigns or other items which the MOH deemed vital to the health of the local population.

2.2 over the enforcement of standards of public health and hygiene in premises of various kinds and in relation to food preparation and handling. Here the MOH ran the gauntlet of the business community. In setting in motion slum clearance programmes, for example, he not only threatened slum landlords' income, by designating a house as "unfit for human habitation" he destroyed its capital value too! As regards food hygiene, if the inspection of premises was followed by prosecution, ridicule for the proprietor and a serious setback to the business could follow.

3. While the MOH's statutory protection would clearly cover the situation where dismissal was threatened unless he/she trimmed his/her activities, there were clearly limits beyond which it could not be pushed. The important thing to remember is that it was only intended to cover the MOH's activities when acting in the *capacity of MOH in the town or county concerned*. It did not confer some 'divine right' to ruffle political feathers by commenting with impunity on the public or political issues of the day — and much less if he did so in the name of his employing authority.

ADVISING A HEALTH AUTHORITY

One aspect of advising the public has caused problems and following discussion at the Board Executive, the President has offered the following note:—

Community Physicians are responsible for providing comprehensive medical advice to their Health Authorities with the aim of protecting and promoting the public health.

This requires them competently to:

- ★ identify significant health problems.
- ★ review the strategies available to prevent, treat and alleviate these problems.
- ★ propose the most appropriate action in the context of the other needs which confront the Health Authority and its overall resource position.

In some cases this will be relatively straightforward, eg the management of an outbreak of diphtheria. In other cases the medical advice must recognise the social, political and ethical dimensions of the issue, eg health education for school children about HIV infection. In all cases the community physician should educate and advise, rather than antagonise.

The community physician has to advise his or her Health Authority of the health implications of its decision-making. Difficulties have arisen where either the opportunity to offer advice was frustrated or advice having been offered and rejected, the community physician involved did not pursue the professional point of view appropriately. It may be useful to outline how the advisory function should be undertaken.

The community physician concerned should ensure that advice on the issue is put to the Health Authority in public. This would usually be put directly by the Community Physician (often the District Medical Officer) in writing and by oral presentation, with the opportunity for the Health Authority members to put questions. The quality of the presentation must be high.

In addition, the medical advisory machinery has a statutory right to act as a vehicle for advice and the Health Authority is required to receive such advice. This may therefore be an additional or reinforcing route through which complementary advice is offered to the Health Authority on Community Medicine matters.

Should the Health Authority take a public decision to defer or reject the community physician's advice any further attempts to present his point of view, eg at a public meeting or through the press, should be made only after discussion with the Health Authority chairman and general manager and on the understanding that as an officer of the Health Authority the community physician would have to work within the framework of the Health Authority's decision.

The community physician should report the position to the Regional Medical Officer. The subject may also be one that would be appropriately pursued through the professional journals.

Rarely, the matter could become a resignation issue for the community physician concerned. In practice, controversial issues relating to medical advice tend to resolve over time in the light of additional information, experience and re-examination. During such a period the community physician must strive, within the parameters of Health Authority policy, to protect the community from any adverse effects of the controversy and to monitor the position as it affects the health of the community. The regional Medical Officer may be able to facilitate a resolution and the Chairman of the Health Authority will be concerned to reach a position from which policy can be taken forward.

Rosemary Rue (PFCM)

— extract from "The Community Physician" Newsletter of the Faculty of Community Medicine Issue No 11 July 1987)

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TERMS OF REFERENCE AND MEMBERSHIP OF SUB-COMMITTEE ON CONTROL OF COMMUNICABLE DISEASE AND INFECTION

1. This Sub-Committee was established by the Committee of Inquiry to undertake detailed examination of the various issues raised by evidence in the areas of surveillance, prevention and control of communicable diseases.

2. The terms of reference of the Sub-Committee were:

“To consider the surveillance, prevention and control of communicable disease”.

3. Membership was as follows:

Professor Geddes — Chairman
Mrs Baxter
Mr Eastwood
Dr Griffiths
Miss Mowat
Dr O'Brien
Dr Smith
Mr Stocks

Co-opted members:

Dr M R Alderson MD LRCP MFOM DPH FRCR FFCM then Chief Medical Statistician, OPCS

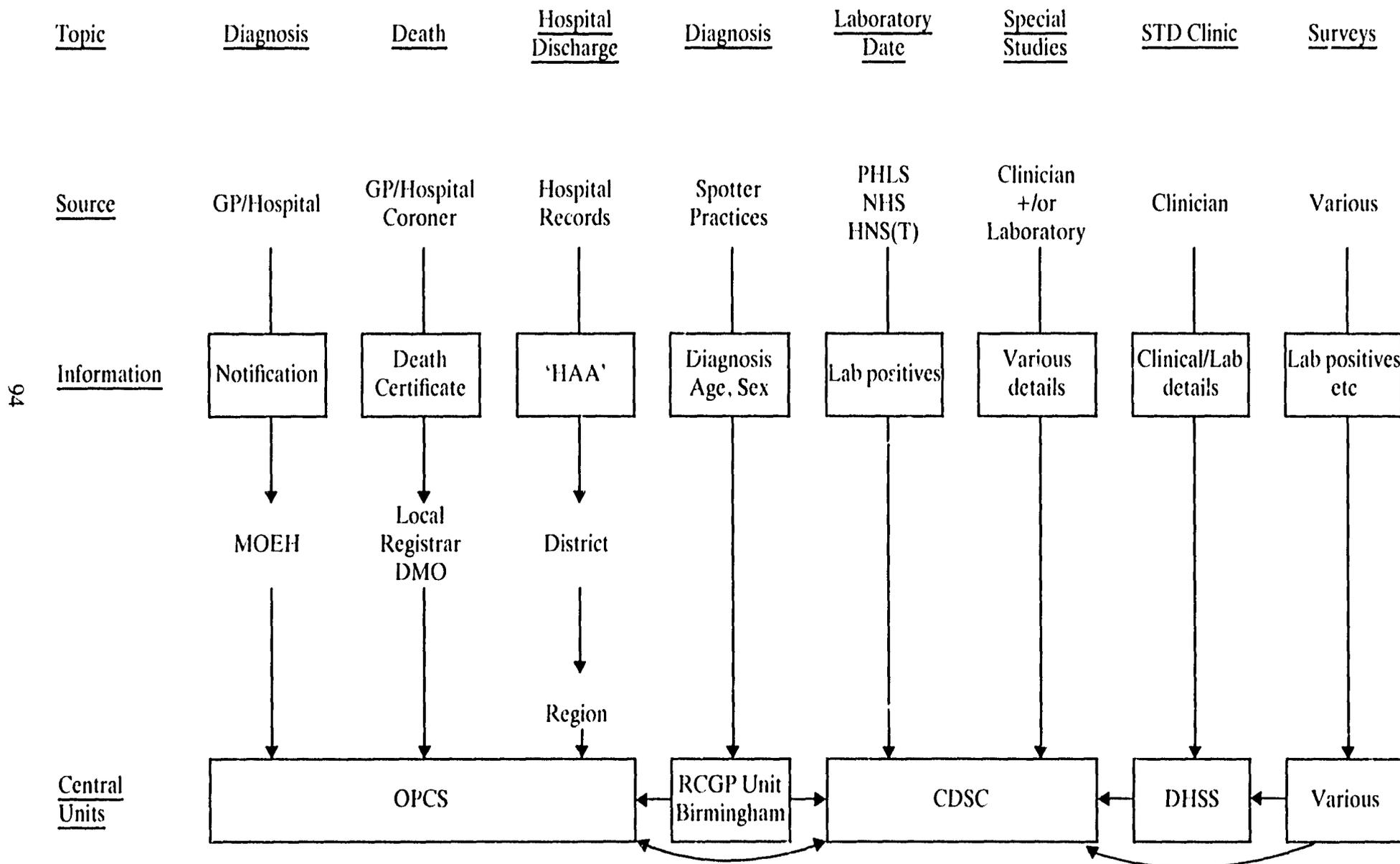
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4. The Sub-Committee held its first meeting on 9 December 1986 and met seven times.

FIG 1: TRANSFER OF INFORMATION ON COMMUNICABLE DISEASE



NOTIFIABLE DISEASES

The following diseases in England and Wales are at present subject to statutory provision requiring notification.

Acute encephalitis	Measles
Acute meningitis	Ophthalmia neonatorum
Acute poliomyelitis	Paratyphoid fever
Anthrax	Plague (1)
Cholera (1)	Rabies
Diphtheria	Relapsing Fever (1)
Dysentery (amoebic and bacillary)	Scarlet fever
Food poisoning (1)	Smallpox
Infective jaundice	Tetanus
Leprosy	Tuberculosis
Leptospirosis	Typhoid fever
Lassa fever	Typhus (1)
Malaria	Viral haemorrhagic fever
Marburg disease	Whooping Cough
	Yellow fever

There are separate statutory provisions and regulations applying to Scotland and Northern Ireland.

(1) Notifiable under Sections 10 and 11 of the Public Health (Control of Disease) Act 1984.

The other diseases listed are required to be notified by virtue of the provisions of the Public Health (Infection Diseases) Regulations 1968 as amended.

**Table 3: Activity analysis, Environmental Health Departments
Distribution of Staff Time (Technical and Professional only)
(Average for all LAs in England and Wales, 1985/86)**

Function/Activity	Proportion of total staff time %
Housing Standards	23.56
Air Pollution Control	4.48
Noise Control	5.88
Occupational Health, Safety and Welfare, and Shops Act	10.23
Meat Inspection	8.77
Food Hygiene, inspection of Food stuffs, sampling	14.27
Port Health	0.97
Infectious Disease Control	2.83
Health Education including home safety	2.28
Animal Health and Welfare	2.16
Public Entertainment, Licensing	2.11
Control of Other Public Health Risks (Includes drainage, pest control, statutory nuisance, offensive accumulations).	22.46
TOTAL TIME	100.00

Source: Environmental Health Statistics: CIPFA Statistical Information Service,
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SUGGESTED CONSTITUTIONAL ARRANGEMENTS FOR A DISTRICT CONTROL OF INFECTION COMMITTEE

1. As indicated in paragraph 7.25, constitutional arrangements will vary according to local circumstances. It is suggested that, in addition to the DCIO, membership might include a health authority member, an EHO, a GP nominated by the FPC or LMC, a microbiologist, a control of infection nurse, a representative of the local PHLS laboratory, a senior infectious disease clinician and an STD doctor. Unit Control of Infection Officers might serve *ex officio* on the district COI committee. In certain circumstances, eg when planning for or dealing with an outbreak of rabies, a MAFF representative would need to be included. The principal task of the Committee would be to advise the DCIO on the formulation and circulation of a written policy which should be regularly updated. It would co-ordinate and supplement the work of hospital COI committees.

2. Small districts might choose to link with adjacent larger ones and establish joint committees and in conurbations it might be expedient for consortia to be formed including three or four health districts in order to match the boundaries of the appropriate local authority. Special arrangements would be needed for London.

3. It is envisaged that the district COI Committee would have an advisory role. It would assist the DCIO to exercise an overview of the work of hospital COI Committees and provide such support as may be required. It would ensure links with the PHLS and with general practitioners in the district in order to achieve the most effective surveillance system. Similarly, it would help in the oversight of the immunisation performance of component districts although in the case of a consortium, executive responsibility for immunisation would remain with the individual districts. The district COI Committee would, with the DCIO, draw up a policy statement setting out how monitoring and surveillance was to be carried on in the district and the steps to be taken in the case of outbreaks and by whom. In particular it would help to define the collaboration arrangements that would be necessary in various circumstances and the channels of liaison through which they should be implemented. The district COI Committee would support and advise the DCIO with regard to obtaining specialised epidemiological support, in defined circumstances, whether from NHS resources, academic departments, PHLS, CDSC or elsewhere.

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The Committee are grateful to the following, who assisted them in formulating their proposals on education and training:

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