

4 The changing public health workforce

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A decent home, clean water, good nutrition, a proper education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship – these are the fundamentals for improving public health and well-being and reducing inequalities. And there's no question that most of the key levers are with council services.

Public health specialists know this full well. They are especially skilled at looking at the 'bigger picture' and acting as catalysts to promote healthy lifestyles and environments, prevent disease, protect and improve general health, as well as improving healthcare services. Much of their work is focused 'upstream' – the much-quoted analogy of helping to prevent people from being thrown into the river in the first place, rather than the more traditional healthcare role of fishing them out downstream, coughing and spluttering. In other words, they are usually more concerned with tackling the causes than the consequences of ill-health – especially the social determinants, the causes of the causes

Specialist public health professionals, directors of public health (DsPH) and their teams, who since the great schism of 1974 have been mostly based in the local NHS health authority (latterly the PCT), know full well that they can never hope to achieve lasting reductions in health inequalities without effective partnership with local government. In recent years, the breadth of the public health role has been recognised in that accreditation as a specialist is open to applicants from a wide range of backgrounds, medical and non-medical, who wish to become a consultant in public health, a director of public health (DPH) or other consultant-level public health professional. We are now beginning to see a number of directors of public health (DsPH) being appointed with a background largely in local government, bringing different experience and skills to the mix.

Even within the clinical health professions, there is an increasing understanding of the social determinants of health and the need to work 'upstream'. For example, a nurse who trained within a traditional medical model of health 20 years ago, working on hospital wards, may now be part of a supportive public health team, working to reduce health inequalities through a community

empowerment approach – carrying out health needs assessments for maternity or alcohol services, evaluating a domestic abuse project, talking to community pharmacists about sexual health services for young people or piloting work on community health trainers. And all this will involve close relationships with colleagues in local government or, increasingly, employment by a local authority itself.

Now, thanks to recent central policy, over 80 per cent of DsPH are joint appointments between the NHS and local authorities, acting as shared expert, catalyst and critical friend. The joint DPH should be well placed to enhance well-being and tackle inequalities through joint health promotion initiatives, community projects and programmes, joint strategic needs assessments, the local strategic plan and local area agreement. The DPH is also a key resource for the council's overview and scrutiny function. And a raft of targets and performance indicators shared jointly between the NHS and local authority should mean that effective integration of public health professionals and council officers is an absolute must-have. We're all in this together.

But how well is this fusion working? Are we seeing a true marriage of hearts and minds?

My impression is that, although it's sometimes less than optimal, there's a wealth of vibrant joint working between public health and council services, and in many places really well integrated joint teams. This publication gives lots of examples of good practice, and many more can be found on your council's and local PCT's websites. The great majority of such initiatives are steered by integrated joint NHS/local authority teams, usually with voluntary sector and commercial partners, and often driven by the DPH.

What do public health professionals bring to the party? Demographic and epidemiological data to map, focus and evaluate various interventions. Advice on the evidence base: what works? what's value for money? Shaping a social marketing campaign or health fair. Acting as the public face or media spokesperson. Providing leadership to drive the whole initiative.

Public health specialists are trained in all these skills and many others. They are drawn from a wide range of disciplines and professional backgrounds – health and

non-health. As well as driving health improvement, they are also experts in health protection (working closely with environmental health practitioners and emergency planners) and service quality (working alongside commissioners and providers in local government as well as healthcare).

So your local DPH, with his or her team, is an incredibly versatile resource which I hope is being put to best use in your area as leader, advisor, catalyst and, at times, critical friend. Sadly, for various reasons, this is not so everywhere. I have come across quite a few councils where the links with their local DPH are minimal and the potential gains unrealised.

Why is this? A common reason is a lack of awareness among council officers and elected members regarding the skills and expertise public health professionals have, or a lack of understanding as to how these attributes can help the council deliver its strategies and services. These can be remedied by a more assertive 'selling job' by the DPH – but also by a more positive and welcoming attitude on the part of the council.

On the local authority side, the DPH should be afforded sufficient status in the management structure, at chief officer level, reporting directly to the chief executive – and where appropriate given responsibility for key services such as the information hub, special housing or environmental health. The NHS side too should fully recognise the potential benefits and, together with the local authority, provide the DPH with a properly resourced, well-trained team with enough capacity to take on the extra work arising from a much wider span of responsibility.

There will be a need for public health specialists for as long as there is a need to promote and protect the health of the people, prevent avoidable health problems and reduce health inequalities. The nature of practice has changed to adapt to new public health challenges. Where once the main threats were from infectious diseases and malnutrition, our agenda is now dominated by long-term conditions and obesity. But the pendulum swings back and forth. The bugs are biting back – with pandemic flu, E coli 157, multiple-drug-resistant TB, MRSA, C diff and many more. And sustainability and carbon-reduction are increasingly becoming major public health issues.

This means that we need all the allies and support we can get within local government. Many of the larger local authorities, such as Birmingham and Manchester, now employ their own health teams who work closely with the joint Director of Public Health and the public health specialists in the PCT. There are also some interesting secondments and appointments of public health specialists to various local authority departments, such as planning

and transport, to help these departments see their core services through a 'health lens'. My own team in the London Borough of Southwark comprised a vibrant mix of local authority and PCT staff, and gained much energy from those relationships. I would like to see this trend continuing and being built upon.

We need to develop an approach that recognises that more or less the whole of the public sector workforce are potential contributors to public health. Chapter 5 contains an account of a course run by the London Borough of Greenwich called 'Health: Everyone's Business' which has been attended by a wide range of council staff from directors to those on the 'frontline'. When I gave a talk to the course members a while ago I was most impressed by the sheer variety of 'non-health' people attending – almost every council service was represented. This is the message we need to send to the whole of local government – health is everyone's business – although I would expect them to embrace this idea much more readily than many of my healthcare colleagues, still locked in the 'medical model' of health.

Every local authority chief executive and every director of a council department should regard themselves as having as much responsibility for the health of the population they serve as they do for their own named service area, be it transport, environmental services, education, urban or rural planning or sports and cultural services.

I know that there are many in local government who already have this understanding and that it is beginning to inform policy-making and operational planning across the public sector. For example, within the crime and disorder partnerships that now exist in each area, you are just as likely to find a public health specialist as a borough police commander or a town centre manager from the local authority, all of whom are beginning to see that reducing drug- and alcohol-related crime, preventing the injuries and ill-health caused by problem drinking, and town planning, are inextricably linked.

And it should be no surprise if a head of planning initiates health impact assessments before all major planning decisions, since planning decisions are also, ultimately, health decisions. We have largely gone beyond the days when planning for new towns assumed that car use would be the norm. But we have not reached the achievements of some of the northern European countries which have incentivised cycling and walking, through sophisticated planning, to an admirable degree. If we are to change what the Foresight Report on obesity calls our obesogenic environment, this is the kind of thinking we need. To achieve it, we have to foster the increasing mutual

understanding of the public health and local government roles.

I would also like to see local authorities making much greater use of the specialist skills of public health colleagues. For example, epidemiology is the cornerstone of public health practice. It is the study of health and disease in populations, including the causes or determinants, taking account of underlying social and demographic factors. Public health specialists analyse and interpret this information, and use it to help match services to need, and improve effectiveness, efficiency and equity. So it's about understanding what impacts on people's health and well-being, and profiling those who need services, those who use them, and, importantly, those who miss out. Epidemiological approaches can also tell us what works and what doesn't.

All of these skills are incredibly useful in helping local authorities understand the health impact of their services and, indeed, in helping communities understand the main influences on their health and well-being. I think it is fair to say that drawing on this kind of intelligence to help shape effective interventions has not been one of the strengths of local government. On the other hand, it is also probably fair to say that, until recently, engagement with communities on their own terrain and in their own terms has been more of a focus of development for local government than for the NHS. What huge 'added value' there could be in tackling health inequalities if we married the two great strengths of evidence-based practice and community engagement.

Joint working with public health has been most successful where there are real enthusiasts at senior level, high-profile champions and some quick wins. An attention-grabbing campaign, an award-winning initiative, an empowered community, better targeted services, achieved performance, improved health outcomes – these are the triumphs that win hearts and minds.

References and further reading

Foresight (2007), *Tackling Obesities: Future Choices*, www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/KeyInfo/Index.asp

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