Association of Directors of Public Health (UK)

Shaping Public Health for 150 Years

Wednesday 29th November 2006

New Connaught Rooms, 61-65 Great Queen Street, Covent Garden, London

Introduction

A brief introduction was given by Tim Crayford (Chair), President of ADsPH. This covered the history of the Association as well as current issues in Public Health. He referred to the large number of national Public Health groups at the moment and suggested that we should consider tighter and inclusive collaboration in order to create a stronger voice for Public Health. He finished with a reminder of the wide role of the DPH covering all three PH domains.

Then and now: the changing roles and vision for the UK's Directors of Public Health

Public Health in Scotland - Harry Burns CMO, Scotland

Public Health started in Scotland with Sir Henry Littlejohn and Sir William Gairdner in 1852. In 1861 Sir William looked at health inequalities comparing the prosperous area of Glasgow and its low infant mortality rates to higher infant mortality rates in the poorer areas. Research outcomes drove public health in Glasgow from that date.

Public health in Scotland is dominated by social inequality but there should be more rigour in the thinking around this. The reasons that more people living in poor housing die because of smoking, having poor diet etc are very complex. People die of disease and not poverty and we should be looking at medical epidemiology to provide the solution and not rely on purely social interventions that are not proven to work.

Changing needs in Scotland

- 1900 – 1950 Infectious Diseases
- 1950 – 2000 Episodic Care
- 2000 – 2050 Chronic Care?

We should be setting more aggressive targets for health improvement; current ones are not stretching enough. Epidemiology and rational application of evidence will help to achieve much better outcomes.

Public Health in Northern Ireland - Michael McBride CMO, Northern Ireland

Northern Ireland in the 19th century was extremely poor and its population very unhealthy. The potato famine and the fever epidemic in 1847 exacerbated the situation pushing many people into the towns. The 1881 census shows a Belfast population of 208,122 rising to 329,960 by 1981. The rapid expansion led to poor housing and squalid living conditions.

Dr Samuel Browne had a passion for municipal issues and in his Annual Report in 1888 he stated: "This unhealthy condition arises from three existing factors, viz, very variable atmosphere, excessively damp subsoil, and the employments and habits of the people". The Public Health Act

of 1878 was passed to improve sewage, housing etc. and the tracking of determinants of health started.

The 'Troubles' which started in the 1960s have put strains on public health services. However, since the turn of the 20th Century: life expectancy has improved; premature death has declined; but the rich - poor gap remains.

The current public health challenges show clear links to deprivation

- Out of work and unemployment
- Smoking (which is a top public health priority)
- Overweight/obesity (currently rising and a priority)
- Inequalities in health – dental decay in Belfast. Fluoridation has not been implemented
- Suicides have shown a dramatic increase

Last weeks in tray included: Herceptin; Alcohol and mixed sex wards.

We are committed to equity and evidence based healthcare.

History of Public Health in Wales - Tony Jewell CMO, Wales

Tony Jewell referred to the historic contributions of Lloyd George, Nye Bevan, Archie Cochrane and Julian Tudor-Hart.

Today's challenges are not unique. Deaths from CHD, cancer and long term limiting illness are higher than elsewhere. There is evidence showing strong links between educational attainment; male life expectancy; circulatory disease and socio-economics.

In 1999 The National Assembly in Wales set up Local Health Boards (LHBs) co-terminus with local authorities to provide effective services to local communities. Wales now has a national health service locally driven.

Tony Jewell had recently reviewed public health in Wales. In 2007 the new Government of Wales Act 2006 will be implemented allowing more decisions to be made in Wales for Wales. This has created real opportunities now.

Current priorities are:

- Improving health and reducing inequalities (by measuring health)
- Preventing the preventable (by screening)
- Work with the NHS and Social Care
- Build teaching and research capacity

Future vision

There is a vision for a unified all Wales organisation based on the three units: The Health Observatory; The Institute of Public Health; National Public Health Service. Information Sources will be at the core. The new public health strategy will be linked to determinants and partnership working will be key.

History of Public Health in England - Sir Liam Donaldson CMO, England

- William Duncan (1805 – 1863) was the 1st UK Medical Officer and is remembered for his improvement of the sewers and for drainage for the Borough of Liverpool. This was the era of cholera and epidemics.
- Sir John Simon became 1st Medical Officer for London in 1848 and was credited for immunisation and the era of child health.
- 1948 - 1973 became the era of state healthcare in the form of the National Health Service.
- 1974 – 1990 became the era of planning – (community medicine – Donald Acheson's report). People in public health were helping with planning etc. Plans were made but nothing was contributed towards the public health.
- 1991-1999 became the era of corporate management.
- 2000 – 2006 is the era of primary care and embedding public health in primary care.

Public Health practice has had to stand buffeting from the '7 Forces of Turbulence':

- searching for the soul of what we are about (what is public health?);
- numerous re-organisations;
- credibility in delivery (what has been done – what has changed?);
- weak evidence base;
- diversity in job content;
- the population health / individual healthcare tension;
- weakened budgets and infrastructure.

PH professionals need to be 'on top of' the 10 Key Public Health Activities: analysis; knowledge management; influencing; advocacy; change management; policy making; planning; evaluation; communications; empowerment and development.

Key message

Directors of Public Health have to be well known in their locality and associated with being good for public health. It is necessary to be a good actor and to project yourself.

Panel Questions and Answers

There was an interesting Q & A session that covered the following issues.

Inequalities and medical interventions – using GMS contracts / practice interventions

HB said that in **Scotland** some PCT teams have been empowered to refocus on this. Biological evidence can be monitored and is a lot easier to show. DsPH need a medical degree.

LD said he felt that if the biological pathways could be shown for health inequalities, more people would be convinced.

From floor: What was the correlation between GP Practice and QOF and wider determinants? Was there something more that could be done regarding life expectancy?

TJ said: Evidence is not out there, which was a huge disappointment. Some more work is needed on QOF contribution. Referring back to ten year study done by Julian Tudor-Hart. He said know

your locality – for example if a patient did not turn up for his blood pressure check then someone very local would remind the patient.

MM said: This was about leaders implementing and delivering a programme. The challenge was how to ensure all systems that were in place were used.

HB said: Why can't we do things at practice level? Our strength is epidemiology that should underpin the process. Use the QOF data to understand and link it to population. This needs to be focussed.

Working across the UK

TJ said: CMOs meet on a regular basis – a December agenda item is "how they work and what are their priorities" eg a united voice on alcohol. Devolution needs to be worked on across the country and internationally.

LD said: Meetings are valuable and offer a forum for sharing ideas and best practice. Executive letters are also prepared and circulated. Underlying themes in public health over the four countries are different. The Welsh programme is more public health related. Scotland's priority is smoking. Not a lot of work was carried out collectively, but it was very powerful when dealing with Europe. Sir Liam attends meetings of European PH heads.

From floor: National targets eg GUM waiting targets were based on small numbers in some localities, but still had to be the highest priority.

TJ said: Annual reports should give details of public health priorities in the local community.

LD said: Priorities would be different for England. There were PH priorities and other priorities. National priorities should be looked at.

MM said: Here was a unique opportunity to see what had worked across UK eg; linking primary care and secondary care. Should ensure that all parts of the system were linked up and worked together.

Resources – Choosing Health money had disappeared, what could be done?

LD said: Fiona Adshead and he had spent some time talking to David Nicholson and ministers to get the message across the management chain. DsPH need to build some clout to get resources mobilised.

From floor: South Wales releases badged funding for inequalities which was very successful.

LD said close partnerships with Local Authorities was the best way

Rod Griffiths said: Where resources are concerned people have to be blunt. The Wanless report states that if you ignore PH advice healthcare becomes more expensive and more unaffordable. If all the CMOs were on board it should help matters.

LD was in agreement with this. Jamie Oliver had been successful in reaching out to the public on the subject of school meals and healthy eating. It was important to think about the future.

From floor: This was agreed, but the short-term risk had more power than the longer-term risk.

Challenges to securing good population health – Caroline Flint, Minister of State for Public Health, England

Caroline Flint saw her public health challenges to be: alcohol; obesity; smoking and low levels of activity. There was no magic wand for her to use but clearly there was a responsibility for government and herself. There is a combination of what is done in government and there are other opportunities – eg healthcare working with others. How do we create an environment in which the NHS sees prevention as important as treatment? This is where public health can influence the agenda. The last year has been difficult for public health due to CPLNHS but we need to get through this and to make it better. It was necessary to change people's mind-sets and to challenge why public health was considered not very important.

Having devolved funding how can public health get its fair share of resources? Use targets and Health Challenge England. Get other partners on our side. Fiona Adshead and others had worked to get DsPH jointly appointed between NHS and Local Authority, getting extra investment. LAs will now be asking how to get better health. DsPH annual reports will be helpful. Also some work on commissioning framework guidelines/best practice so that the finance teams understand. It was important to come up with a formula about spend on prevention. There is a need to challenge poor outcomes when there is **not** spending on health prevention.

Caroline Flint wants input from DsPH. She wants to strengthen their voice. How much more can we develop with DsPH and their perspective on prevention? Also with GPs – how can we value them as part of the journey? She had been greatly helped by Patricia Hewitt and Tony Blair who had raised these issues and thanked them for their continuing work. Prevention was as important as treatment in improving public health.

Questions from the floor with the Minister's responses

Q - It is not all about money, but could we have ring-fenced budgets for producing the step-change required for prevention?

A - People work in a certain way. It is not always about value for money and whether it works or not. When she worked at the Home Office drug money was ring fenced and she thought it was an appropriate way to deal with funding for that project.

Q - Climate change would beat all other problems. What will the government do about eg carbon emissions targets in the NHS?

A - The government work with sustainability organisations regarding carbon emissions. There is a corporate toolkit that can be used by the NHS. The NHS is one of the biggest procurers in terms of buildings. Let CF know of any ideas.

Q - Recent initiatives had created a structure for careers – now the real message was to act together. This meant reducing the size of committees and the number of organisations in public health.

A - Let's allow this idea to become reality. The DH will support moves for stronger collaboration. Think practically how this can go forward to make the DsPH a more powerful voice!

Summary and next steps – Tim Crayford

Advance notice was given for the **ADsPH Annual Conference 15th May 2007** at the same venue. It was hoped that a pre-conference event at the House of Commons could be arranged with the aim of strengthening political relationships.

He thanked the speakers and organisers (ALPHA) for a thoroughly successful conference.