

Part I

Back to the Future: Reflections on Multidisciplinary Public Health?

Introduction

Linda Jones and Sarah Earle

The chapters in Part I investigate key constituents of contemporary public health, noting its inheritance, growth and consolidation into the multidisciplinary public health of the early twenty-first century. This description of its development is chosen advisedly. 'Inheritance' reminds us that public health has always been conscious of the weight of expectations arising from earlier public health achievements. 'Growth' highlights the expansion of scope and ambition, especially with the rise of health promotion in the 1970s and the subsequent attempt to create a 'new' public health which was consciously rooted in the Victorian inheritance. 'Consolidation' describes the work of the last decade or so, in which multidisciplinary public health has gained gradual acceptance, within and outside the health sector, as an enterprise that spans professions, policies, sectors and countries and, indeed, the world!

Such a journey has not been without its landmarks and battles. Jenny Douglas initiates the debate in Chapter 1 by exploring some of the tensions implicit in multidisciplinary public health and considering what should be the proper balance between its various elements. While investigation of the social determinants of health has become a much higher priority for UK governments in recent years, the health sector inevitably focuses on actions relating to the individual service user: treatment, preventive interventions, advice giving about behaviour change. Is this focus on individual behaviour compatible with full acknowledgement of the environmental and sometime health-denying circumstances in which some people live their lives?

Stepping back from contemporary debates, Iqbal Sram and John Ashton highlight progress and challenges for public health over the last 160 years. They marked the 150th anniversary of the 1848 Public Health Act in Britain in 1998 by composing a memo to Sir Edwin Chadwick, the architect of the 1848 Act. In Chapter 2 this memo is reproduced together with an update of the last decade. Some key principles established by Chadwick, in particular the role of the state in securing the population against major environmental threats to health, are highlighted. In spite of health improvements, global threats to health from war, dwindling natural resources and epidemics are still evident; Sram and Ashton also highlight new concerns such as the growing effects of climate change. Even more poignantly, urban health hazards and social class gradients in health are still evident, despite renewed efforts to tackle inequalities and support people in making healthier choices.

The last decade has seen a major focus on investigating and tackling the social determinants of health; the ways in which health is understood and experienced by the public are highly relevant to this task. People are unlikely to respond to a call to public health action that seems completely at odds with their views of how health and illness are generated. This is what makes the review of lay accounts in Chapter 3 so important to understand. Mildred Blaxter highlights how people's views of health are influenced by various factors including their age, gender, occupation, cultural background and state of health. While for some people health is seen largely in terms of physical fitness, for others it is a broader, more complex psychosocial concept. The messages about health as function, as social connectivity, as a sense of wellbeing, as contingent on other resources resonate strongly with work on wider social determinants of health and health inequalities.

The next three chapters investigate these wider determinants of health. Moyra Sidell applies Aaron Antonovsky's salutogenic theories about 'sense of coherence' to investigate older people's health. Instead of focusing on what stops older people from getting sick, she asks what helps older people to be healthy despite disease? Her answer in Chapter 4 is that meaningfulness, comprehensibility and manageability in the daily lives of older people can assist in maintaining their health. This reflects comments in Chapter 3 that health is embedded in everyday life: 'seeing all the lovely trees', 'being able to stand and stare', 'to walk round better' and 'work and help other people'.

Chapters 5 and 6 focus on how health is constructed and patterned through complex interactions between individuals, groups and environments. Bradby and Chandola take as their starting point a ground-breaking review of inequalities in health in the UK, the 1998 Acheson report, in particular its chapter on ethnicity. Deploying evidence from a range of recent studies they note the widening health gap between the majority population and some minority populations, such as Pakistani men and women, Gypsies and Travellers. But the health inequalities within – as well as between – ethnic majority and minority groups indicate a need for sensitive public health action that does not just target specific minorities but focuses on particular, evidence-based interventions. In Chapter 6, Hilary Graham reviews global and UK trends in poverty, a key indicator for poor health. While there is an enduring association between national wealth and national health, Graham reminds us that the use made of national wealth is also important in creating health chances. Where governments invest in health supporting services, life

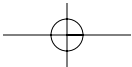
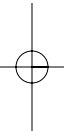
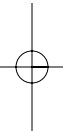
expectancy can be raised despite low GDP. This case has also been elaborated by Richard Wilkinson (2006) who has argued that, beyond the level of material sufficiency, social and economic stratification within countries is more significant in determining the distribution of health and illness than national wealth.

The final three chapters of Part I set out distinctive ways of responding to these trends in health and disease. Health protection has been a strong and enduring aspect of public health. In Chapter 7 Kate Ardern discusses how epidemiological issues, environmental impact and health risks can be identified using a health impact assessment tool. This situates health protection as one key element of a wider analysis of the health impact of policy development.

Next, Jane Wills assesses the contribution of health promotion and highlights its role in linking together the macro and micro agendas to create a focus on policy change, community development and work with organisations, groups and individuals. Integral to the development of health promotion has been a wider, transnational focus, reflected in the Ottawa Charter and now increasingly seen as core to public health work. Yet Chapter 8 highlights how health promotion values and the health promotion workforce are being sidelined in the UK, under pressure from the expansion of public health. Finally, Gerard Hastings and Laura McDermott reflect on the potential of social marketing to persuade people to modify behaviour in order to protect their health. Social marketing provokes fierce debate within public health and there are concerns that the UK government, in particular, may view it as a 'magic bullet' approach to persuading the public into healthier choices. However, Chapter 9 demonstrates that success in applying the techniques and approaches of marketing to health requires not just a sensible social marketing campaign but also systematic engagement with health practitioners to deliver support and relevant services.

Reference

Wilkinson, R.G. (2006) *The Impact of Inequality: How to Make Sick Societies Healthier*. Abingdon: Routledge.



Chapter 1

The Rise of Modern Multidisciplinary Public Health

Jenny Douglas

Introduction

This chapter charts the development of modern multidisciplinary public health and the radical shift away from the medical dominance of public health in the last two decades. The publication of UK public health strategies heralded a resurgence in public health, while changes in the Faculty of Public Health Medicine to become the Faculty of Public Health and the development of competencies for public health were important landmarks for multidisciplinary public health. The influence of other reports, such as the Wanless Reports, is explored and the relationship of health promotion to public health as part of multidisciplinary public health is examined. The conflicts and tensions that have emerged as a result of differences between policy and practice are interrogated as well as the role of politics in developing public health in primary care organisations, local authorities and voluntary organisations.

The origins of public health in the UK

Politics and public health are inextricably linked. It is worth noting that at the same time as the 'new public health' was emerging at an international level, spearheaded by developments in Canada and the World Health Organisation (for example, WHO, 1986), in the UK specialist public health was dominated by public health medicine. The health and local government reorganisation of the 1970s dismantled the local authority 'public health empire' under the Medical Officer of Health and replaced it with NHS consultant-based community medicine (Berridge, 2001). So while the ideology of the new public health embraced the need to look beyond biomedical understandings of health and to focus on the social, economic and environmental determinants of health, public health services in the

UK moved back into the narrow confines of the NHS, where having a medical qualification was a requirement for senior public health posts and where barriers existed for public health workers from other disciplines.

Modern multidisciplinary public health in the twenty-first century

The WHO's definition of public health was re-stated in 1988 by the Committee of Inquiry into the Future Development of the Public Health Function (The Acheson Committee Report, 1988). Initiated by a concern about the continual reorganisation of the NHS and the marginalisation of public health and health protection, the review of the public health function in England led to the change of terminology from 'community medicine' back to 'public health' and the re-stating of the broader role of public health to take action on the wider determinants of health. The Acheson report also called for the appointment of a Director of Public Health in each district and regional health authority and the production of an annual report on the state of public health of their population, although public health services remained in the NHS. Despite the perception of public health as a 'multidisciplinary endeavour', senior public health posts still required medical training and other public health workers were confined to support roles.

The first public health policy in England was *The Health of the Nation* published in 1991 (DoH, 1991). Although this policy set clear targets for reducing ill health, the report was heavily criticised for its focus on disease to the exclusion of an examination of inequalities in health and the lack of any reference to multidisciplinary public health (Evans and Knight, 2006).

The election of a new Labour government in 1997 placed public health policy and practice high up on the agenda of health and social care agencies. It placed an emphasis on reducing inequalities in health and social inclusion and each of the countries in the UK published a public health policy which reflected this. While the scope and purpose of public health appeared to be huge and expanding, the concept of what constitutes 'public health' was still open to debate and challenge.

In England, the Chief Medical Officer's project to strengthen the public health function (Department of Health, 2001), concluded that... 'the aim is a strong, effective, sustainable and multidisciplinary public health function which is in good shape to underpin the delivery of the NHS Plan and to improve health and reduce inequalities' (DoH, 2001: 43). Recognising that people from a range of backgrounds contribute to the public health workforce, the report identified three different levels of involvement in public health: public health specialists from a variety of professional backgrounds such as directors of public health and environmental health officers; public health practitioners including nurses and health promotion specialists; and professionals whose work includes elements of public health such as social workers, teachers and police officers. The multidisciplinary nature of public health was reinforced by guidance issued from the Department of Health to primary care trusts (DoH, 1999) advising that senior public health posts could be filled by non-medically qualified professionals. The English public health white paper – *Saving Lives: Our Healthier Nation* (DoH, 1999) – announced that there would be multidisciplinary

public health specialists in the workplace and that they could become Directors of Public Health. This heralded the breaking down of professional barriers and boundaries and enabled non-medically qualified public health specialists to break through the glass ceiling, develop their careers and to gain professional recognition.

Thus by the twenty-first century it was widely acknowledged that modern public health was multidisciplinary in nature and that an effective multidisciplinary public health workforce required that all public health workers were adequately trained. This gave rise to the question of competency to practise public health given that the public health workforce would be coming from diverse professional backgrounds. To this end a competency based framework for public health was developed in 2001 by Healthwork UK on behalf of a tripartite Steering Group comprised of the Faculty of Public Health Medicine, the Multidisciplinary Public Health Forum, and the Royal Institute of Public Health and Hygiene, supported by the health departments of the four UK countries (FPH, 2005). National Standards for Specialist Practice in Public Health were produced and a voluntary register for public health specialists was established. The voluntary register for generalist specialists opened in 2003 and by 2007, 160 generalist public health specialists were registered. Critics of the competency based framework argued that a voluntary register reinforced an artificial divide between specialists and practitioners and served to reinforce 'old' hierarchies – namely between medically trained public health specialists and other groups. Furthermore it is argued that individual public health specialists or public health practitioners could not be expected to meet the competencies in all ten key areas, and that if a truly multidisciplinary approach were to be adopted, the competencies should be measured across a multidisciplinary public health team. Nevertheless, it was acknowledged that some specialists had no interest in developing competence across all ten areas of public health practice but had advanced expertise in specific areas. Standards for defined specialists, for example health promotion and information specialists, were devised and the voluntary register for defined specialists opened in June 2006.

Recognising that the bulk of the public health workforce is made up of practitioners and not specialists, Skills for Health (2004) in conjunction with the Department of Health in England, the UK Skills Council and the Public Health Resource Unit, Oxford, developed a UK public health skills and career framework. This was published in spring 2008 and brought together public health competencies and underpinning knowledge, across nine different career levels in the public health workforce (Wright et al., 2008). This Framework divides the competences for public health practice between four core areas – surveillance and assessment, assessing the evidence, policy and strategy, and collaborative working – and five specific defined areas – health improvement, health protection, academic public health and health and social care quality. The Framework can be used across health and social care organisations and with a range of professional groups including chief executives of public sector organisations, teachers, nurses, health promotion specialists and care assistants.

There has been keen debate about the boundaries between public health and health promotion. Bunton and MacDonald (1998: 28) has stated that: 'the principles and content of modern health promotion ... are identical to those of the new public health'. The relationship of health promotion to public health is currently receiving considerable attention. However as public health has risen on the political agenda, critics have argued that health promotion and health promotion specialists seem to be disappearing (Scott-Samuel, 2003). Health promotion specialists are a group of health professionals who have received limited

attention in the academic literature on developing the public health workforce, although they make up the bulk of the multidisciplinary public health workforce (DoH, 2005) and bring a history of partnership working across professional and organisational boundaries. Despite the 20-year history of health promotion, new terms such as health improvement or health development are increasingly being used. For some health promotion is an integral part of the multidisciplinary public health function.

Despite the rhetoric espoused by successive UK government's public health strategies about the importance of a multidisciplinary public health workforce, differentials persist between the professional status and financial remuneration of different professional groups. While health promotion specialists make up the bulk of the multidisciplinary public health workforce in England and Wales, many health promotion practitioners argue that they do not receive the same remuneration or professional recognition as medically qualified public health practitioners.

Despite the reviews of public health in the four UK countries and the development of public health white papers, it was the Wanless Reports which placed public health high up on the government agenda. In 2002 Derek Wanless, a former banker produced a report for the Treasury that assessed resources that would be needed to provide high-quality health services (Wanless, 2002). This report examined future funding in the context of three possible directions: slow uptake, solid progress and a fully engaged scenario and set out an economic case for effective public health. A second report – *Securing Good Health for the Whole Population* – looked at the cost of a fully engaged scenario and assessed the actions that would need to be taken to achieve the relative reductions in future demand for health-care services and the improvements in the health of the population implied by the fully engaged scenario. The report concluded that one of the underlying reasons for the lack of progress on public health was a lack of political will and political importance attached to public health by successive governments (Wanless, 2004).

Continually changing organisational structures and positioning of public health has led to instability in the public health workforce. With the development of Primary Care Trusts (PCTs) in England in April 2001, each PCT was required to appoint a Director of Public Health. This marked a sea change as for the first time non-medically qualified Directors of Public Health were appointed although the majority of PCTs appointed medical directors. Despite this, this development led to recognition of the importance of public health and an expansion in the multidisciplinary public health workforce. The Faculty of Public Health (2004) reported that a much larger public health workforce was needed. However the newly configured PCTs were not economically viable and in 2006 PCTs and strategic health authorities were reconfigured. Many practitioners feared that this, accompanied with a refocusing of resources in the NHS would lead once more to the marginalisation of public health and health promotion and the gains that were made in the early part of the twenty-first century. There is the scope however for joint appointments of Directors of Public Health, with local authorities, particularly where newly formed PCTs are co-terminus with their local authority. Such a move could place Directors of Public Health in a position to influence local authority agendas and the health of the local population.

Since the reforms of 1974, when public health services in the main were taken out of local authorities, the influence of public health has been greatly reduced. Although environmental health departments had some statutory responsibilities for aspects of public health, limited resources meant that these responsibilities were discharged with a fairly narrow focus, with only a few environmental health departments developing a wider role in promoting public

health. In the 1980s some local authorities set up 'Health Units' e.g. Lambeth, which were part of the egalitarian thrust of welfare policy recognising that individuals' health experiences were shaped by wider structural factors and that local authorities were better placed to take action on the determinants of health. The 1980s saw the development of the Healthy Cities Movement and many towns, cities and boroughs set up Healthy City Units, for example, Sheffield, Liverpool, Camden. More recently, while some local authorities have used the Health Scrutiny Committee to call for action on inequalities in health, the role of local authorities on advocating public health has been greatly diminished in the last two decades.

Many voluntary organisations and community organisations have maintained a lobbying and campaigning role supporting public and lay activism around health issues. The widening social movement in health has been effective in challenging the UK governments on a range of public health policies. Such organisations as the UKPHA, National Heart Forum, Action for Smoking on Health, Diabetes UK, the Sickle Cell Society to name but a few, have been influential in changing the public health agenda and ensuring the continued involvement of the public. Arguably, it is groups such as the Multidisciplinary Public Health Forum, established in the mid-1990s, which championed the development of a trained and accredited multidisciplinary public health workforce in the UK.

Conclusion

One of the fundamental contentions of public health and health promotion is individual versus structuralist approaches. Individual approaches focus on encouraging people to change their behaviour and adopt healthy lifestyles. Structuralist approaches focus on changes in legislation, taxation, public policy, ecological or environmental measures. It can also be said that some health protection approaches like immunisation and screening lie between a lifestyle approach and a structuralist approach as they involve both changes in behaviour and changes in service provision. These are sometimes referred to as upstream and downstream approaches, where upstream approaches represent structuralist approaches.

One of the reasons that it is very difficult to define public health is because it represents a number of different understandings of 'health' and the causes of health and illness. Public health can be seen from two ends of a very broad spectrum. The one end of the polarity sees health as determined by biology or medicine. In the medical model the causes of ill health are seen to be due to disease or other medical concerns and the explanations of ill health are much more biological in nature. At the other end of the polarity poor health may be seen to be caused by a range of social, economic or political factors and hence the explanations of health and illness are much more sociological. Although the social model of health and the biomedical model of health are sometimes presented as oppositional perspectives, or two extremes of a binary divide, an understanding of both perspectives is essential to developing an understanding of health and health inequalities.

So how far have we got with promoting public health in the twenty-first century? What is modern multidisciplinary public health? The contention about definitions of public health in relation to addressing inequalities in health still continues as do the struggles surrounding its organisational positioning. Having experienced a renaissance in public health in the

latter part of the twentieth century and early part of the twenty-first century, practitioners fear that organisational changes to primary care trusts and strategic health authorities introduced in England in 2006 may once more relegate public health to the margins. It is feared that with the merging of PCTs and the reduction in numbers of Directors of Public Health, it is the non-medically qualified DPHs who will be lost. Still all regional directors of public health require medical training and the CMO and deputy CMO are by definition medically qualified. Many authors argue that although there are public health strategies in each country of the UK, the fact that public health services are still located in the NHS restricts the potential of public health to act in the interest of the health of people. Great strides have been made in the last 20 years in breaking down professional boundaries in multidisciplinary public health. More than ever there is a need to bring the politics back into public health as without political will and commitment the continuing widening inequalities in health in the twenty-first century will not be stemmed and public health will not be equipped to deal with the challenges of modern society and increasing globalisation.

References

- Berridge, V. (2001) Constructing women and smoking as a public health problem in Britain (1950–1990s), *Gender and History*, 13 (2): 328–48.
- Bunton, R. and Macdonald, G. (eds) (1998) *Health Promotion: Disciplines, Diversity, and Developments*. London: Routledge.
- Department of Health (1991) *The Health of the Nation*. London: The Stationery Office.
- Department of Health (1999) *Saving Lives: Our Healthier Nation*. London: The Stationery Office.
- Department of Health (2001) *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*. London: Department of Health.
- Department of Health (2005) *Shaping the Future of Public Health: Promoting Health in the NHS*. London: Department of Health.
- Evans, D. and Knight, T. (eds) (2006) 'There was no plan!' – the origins and development of multidisciplinary public health in the UK. Report of the witness seminar held at the University of the West of England on Monday, 7 November 2005. Bristol: University of the West of England.
- Faculty of Public Health (2004) *Public Health Capacity; the Challenges for Public Health*. London: FPH.
- Faculty of Public Health (2005) *The Ten Key Areas for Public Health Practice*, accessed at http://www.fphm.org.uk/about_faculty/what_public_health/10key_areas.asp.
- Scott-Samuel, A. (2003) Specialist health promotion—can we save it, *Public Health News*, 5 December.
- Skills for Health (2004) *National Occupational Standards for the Practice of Public Health Guide*. Bristol: Skills for Health.
- The Acheson Committee Report (1988) *Public Health in England: The Report of the Committee of Inquiry into the Future Development of the Public Health Function*, Cm 289. London: HMSO.
- Wanless, D. (2002) *Securing our Future Health: Taking A Long-Term View*. London: HM Treasury.
- Wanless, D. (2004) *Securing Good Health for the Whole Population: Final Report*. London: HM Treasury.
- WHO (World Health Organisation) (1986) *Ottawa Charter for Health Promotion*. WHO.
- Wright, J., Rao, M. and Walker, K. (2008) UK public health skills and career frameworks, *Public Health*, 122 (6): 541–4.