SDO Scoping Study of the Public Health System in England

1. Aim

1.1 To provide a baseline document as a resource for the research teams to be funded under two forthcoming public health calls for proposals from the NHS SDO programme for public health research.

2. Why a Scoping Study?

2.1 The boundaries of public health, and therefore of a public health system, are notoriously difficult to define. They are influenced by changing perceptions of the factors which influence health and shape health inequalities, of the methods considered to be effective in addressing public health issues, and of perceptions of the overlap between the public health system and broader social, environmental and economic activity.

2.2 The public health community in England has been subjected to a considerable degree of change and uncertainty from 1974 onwards, especially those sections of the workforce employed by, or working for, the NHS. At the same time, the policy context in which public health practitioners operate has changed in recent years from one where there was an expectation that government was responsible for leading collective responses to public health problems to one where the emphasis is much more on what individuals can do for themselves enabled by government and other sectors, notably business. All these developments have led to a public health community that is both unsure of its purpose and its fitness for whatever that purpose proves to be.

2.3 The complexities involved in addressing health inequalities and in improving the health of the population are reflected in local public health partnerships spanning health, local authorities, business and the third sector. In England these are underpinned by new and better aligned performance management arrangements. However, unresolved questions of remit, governance and accountability can undermine the effectiveness of partnerships which are nevertheless an essential dimension of the public health system.

2.4 Engagement is increasingly seen as key to a public health system. This refers not just to people engaging with their own health but to the ways in which a public health workforce, however defined, needs to engage with its public.

2.5 A scoping study of these changes and concerns affecting the public health function in England is therefore seen as essential to provide a baseline for the research programme. Having such a report will avoid any duplication and repetition which might otherwise occur.

3. The Changing Public Health Landscape

3.1 Since the present government entered office in 1997, there has been considerable policy and organisational reform which the scoping study will briefly review. A key milestone during this period was the Chief Medical Officer's (CMO) public health function review (Department of Health 2001). This identified three broad categories of people who contribute to the public health workforce:

- *Specialists*: consultants in public health medicine and specialists in public health who work at a strategic or senior management level or at a senior level of scientific expertise to influence the health of the whole population or of a selected community.
- *Public health practitioners*: those who spend a major part, or all, of their time in public health practice.
- *Wider public health*: most people, including managers, have a role in health improvement and reducing health inequalities although they may not recognize this, including: teachers, social workers, local business leaders, transport engineers, town planners, housing officers, regeneration managers and so on.

3.2 These three categories of public health worker are widely accepted as constituting the public health workforce. Alongside this work is the framework produced by the Faculty of Public Health to describe the public health function. Now widely accepted, the framework views public health as made up of three overlapping domains:

- health protection
- health improvement
- health service quality improvement.

Health protection
This domain embraces: infectious diseases, chemicals and poisons, radiation, emergency response, environmental health hazards.

Health improvement
This domain embraces: tackling health inequalities, education, housing, employment, family/community issues, lifestyles, surveillance and monitoring of specific diseases and risk factors, screening.

Health service quality improvement
This domain embraces: clinical governance, clinical effectiveness, efficiency, service planning, audit and evaluation.

3.3 The origins of the three domains 'lie in the historic importance of the control of communicable disease, health education and the role of hospital and community services over the past 150 years' (Griffiths, Jewell and Donnelly 2005: 910). Conceptualising the breadth of public health within the framework of three domains of practice is intended to make the management task more manageable. In respect of any public health problem,

the domains can help to frame both the actions needed and those who need to be engaged in constructing the public health response. They can also be employed to understand the skill mix needed by those delivering services.

3.4 The principal changes now affecting the sector began in earnest with Derek Wanless's second report looking at the state of public health (Wanless 2004). His report was critical of the poor implementation of government policy and also of the workforce's lack of 'fitness for purpose'. It was critical, too, of the state of the evidence base in respect of public health interventions and demonstrating what was cost-effective.

3.5 Wanless was especially concerned at the state of the wider public health workforce which he acknowledged was neither easy to define or enumerate. Nonetheless, he argued that the greatest contribution to public health is made by individuals in this category who often do not have 'public health' or even 'health' in their job titles. He called for a workforce development plan to consider and plan for the needs of the workforce in a more systematic and less ad hoc manner. Such a plan has not appeared.

3.6. While the public health system lacks a workforce development plan which reflects current public health challenges, it also lacks a plan for maximising the public health contribution from the 'wider public health workforce'.

4. The Changing Health Policy Context

4.1 Since 1997, there have been four reorganisations of the NHS with implications for public health and for those partners, notably local government, which are major stakeholders in public health improvement. In the latest changes still working their way through the system, the NHS is being subjected to arguably its most significant reform and it seems unlikely that anyone knows what the ultimate endpoint of these changes will be. However, a set of jigsaw policies which push and pull in different directions and do not form an integrated coherent set of initiatives are likely to have major consequences for public health and for the government's policy priorities both in this area and in long term conditions as set out in various policy statements but most recently in the white paper, *Our Health, Our Care, Our Say* (Secretary of State for Health 2006).

4.2 The true extent and impact of the changes underway in the NHS is unknown in other than anecdotal terms and the occasional modest research inquiry (for example, Hunter and Marks 2005). However, they are serious enough for the CMO for England in his annual report for 2005 to warn the government that its policy on public health – to transform the NHS from a predominantly 'healthcare' service to a true 'health' service – may not be achievable (Department of Health 2006). His major concerns are threefold: (a) financial deficits in acute care that leave public health budgets vulnerable to being raided; (b) repeated NHS management reorganisations which have left public health weakened and have 'ultimately eroded the focus and consistency of purpose of the public health function' (p. 40); and (c) although improvements in population health are effective and valuable, the benefits are by their nature both long term and not clearly related to individuals.

4.2 The CMO believes this situation, which is widely echoed by public health practitioners from across the board, is not the product of any person or group. Many factors have contributed to it. However, 'at its heart is a set of attitudes that emphasises short-term thinking, holds too dear the idea of the hospital bed and regards the prevention of premature death, disease and disability as an option not a duty' (p. 44).

4.3 The other aspect of changing policy is the role of the state versus role of individual in meeting the public health challenges. Over its nine years in government, there has been a shift from the viewing the state as steward to a concern that the state as nanny is not acceptable and that individual lifestyle choice has to be the main driver of change enabled by government wherever possible. However, as the prime minister argued in a recent major speech on healthy living, his own personal journey has made him something of a convert in terms of acknowledging the state as nanny and the positive role government can play in changing behaviour (Blair 2006).

5 The Public Health System

5.1 Taking the public health landscape and policy context as set out in sections 3 and 4 above, the scoping exercise will seek to explore how far these concerns remain valid and their implications for the future direction, organisation and development of the public health function. It will do this by building on the notion of the public health system. The US Institute of Medicine (IOM) uses the concept to describe a complex network of individuals and organizations that have the potential to play critical roles in creating the conditions for health (IOM 2003). They can act for health individually but when they work together toward a health goal they act as a system – a public health system.

5.2 The notion of a public health system provides a useful organising device to bring together all the various sectors that contribute to the public's health, including the health service.

6 Conducting the Scoping Study

6.1 The scoping study will be carried out by David Hunter, Professor of Health Policy and Management, and Linda Marks, Senior Research Fellow, both of the Centre for Public Policy and Health, School for Health, Wolfson Research Institute, Durham University. It will take around 7 months to complete, commencing in October 2006 and ending in April 2007. The study will comprise a literature review and consultations (face to face and/or group interviews) with selected 'movers and shakers' in public health as well as frontline practitioners. Those to be consulted and/or interviewed will be agreed in discussion with the SDO.

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Addendum

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