The magazine of the
UK Faculty of Public Health
www.fph.org.uk

March 2015

In this issue

Public Health Today

Redressing the balance

The inequalities edition

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Contents

Welcome

I AM writing this from Kolkata where David Allen and I have been representing the UK Faculty of Public Health (FPH) at the 14th World Congress on Public Health organised by the World Federation of Public Health Associations (WFPHA). Since the winding up/incorporation of the UK Public Health Association, FPH has held a seat on the WFPHA and Gabriel Scally has ably represented our interests there. Gabriel stepped down at this year's conference, and his place has been taken by an Italian representative. I would like to thank Gabriel for carrying the torch for us at this important forum.

Having said that, I have been moved this week to consider again the value of conferences. To Francis Bacon "Reading maketh a Full man, Conference a Ready man & Writing an Exact man". It is surely time to review the nature of conferences in the Internet age, especially as large numbers of people travel across the world to get to them. For JK Galbraith "conferences... are to proclaim shared purposes, to reveal to the participants that they are not alone and thus reinforce confidence. Or they are to stimulate action where action is impossible. By acting, they persuade the participants, and often others, that something is happening when nothing is happening or can happen."

At international health conferences, that sense of action is conveyed by the adoption of the inevitable 'declaration', and this Kolkata meeting was no exception. These would mostly be better called 'suggestions', as the likelihood of any action following is usually slim. So my conclusion is not that meetings like this are a waste of time but that they need rethinking to have real clarity of purpose. And, yes, we did have some good discussions and exchanges of ideas. Perhaps most promising was the meeting with the Permanent Secretary for Health for West Bengal. Sushma Acquilla, who was also present at the conference, has been responsible for a great deal of groundwork leading to this meeting aimed at developing a Special Interest Group for the Indian sub-continent. Sushma will be following up our discussions, especially with regard to supporting educational capacity-building with the soon-to-be-opened West Bengal Institute of Public Health and other opportunities for collaboration in the State of Odisha (formerly Orissa).

On the subject of Special Interest Groups and the implementation of our strategy for global health, this will now fall to the renamed Global Health

Committee under its new chairman Neil Squires, a former Head of Profession for Health at the Department for International Development. I am delighted to hand over the chair to Neil whose extensive experience of global health means that we are now well placed to punch above our weight in this area. We had a very strong field of applicants for the chair, and I hope that we can make full use of the expertise of the unsuccessful candidates as we move forward into full engagement with members and fellows.

Meanwhile, a number of our members and fellows have been heavily engaged in the Ebola emergency, not least Brian McCloskey who has been supporting David Nabarro with the United Nations and Nick Gent and Paul Cosford of Public Health England. Our ability to field people of their quality says much about the strength of UK public health. This was also on show at the recent conference at the Royal Society of Medicine (RSM) on Ebola which was jointly organised by the RSM's Epidemiology and Public Health Section and Catastrophes and Conflict Forum in association with FPH. A selection of the very strong set of talks is available on the RSM website.

And finally, our vice president for policy, John Middleton, has been working with FPH fellow Debbie Abrahams MP, well supported by Senior Policy Officer Mark Weiss, in establishing an All Party Parliamentary Group on Health in All Policies. Well done everybody.

John Ashton

PS: While in Kolkata I attended a superb *Times of India*-sponsored debate on the proposition that "Freedom of speech is an absolute right". It was a mature, stimulating and humorous event. It was conducted without acrimony in an atmosphere of safety. On my way home, I heard of the terrible murders at a similar event in Copenhagen. Public health must be concerned with these matters.

Free trade deal threatens UK health services

A PROPOSED trade deal between Europe and the US poses a profound threat to the UK's health, the Faculty of Public Health (FPH) has warned.

In a major report entitled *Trading Health?*, FPH and the European Public Health Association, representing 71 organisations across 41 countries in Europe, have called on the government to reject the Transatlantic Trade and Investment Partnership (TTIP).

FPH believes that TTIP threatens states' right to regulate for the public benefit and would open up the NHS to further competition and private-sector provision.

Little evidence has been presented of the benefits TTIP offers for improving heath or inequalities and no health impact assessment has been undertaken of the agreement. However, by prioritising gross domestic product and the profit of private companies above the right to health, TTIP threatens to exacerbate inequalities in health for generations and compromise efforts to address preventable non-communicable disease and climate change, the report says.

Without urgent revision, TTIP may increase tobacco-related harms, particularly among young people; it may increase alcohol related disorders; and it may restrict governments' ability to reduce consumption of unhealthy foods. TTIP may also increase the cost of vital medicines, such as cancer drugs.

> **TTIP threatens states' right to regulate for the public benefit and would open the NHS up to further competition and private-sector provision**

You can read the executive summary of *Trading Health?* at http://bit.ly/1Fi08Ad

Mark Weiss
Senior Policy Officer
Faculty of Public Health

Packaging vote 'decisive' blow against tobacco

THE tobacco industry suffered a "decisive" defeat on 16 March 2015 when the House of Lords joined the House of Commons in voting for the standardised packaging of cigarettes and other tobacco products. The regulations, under the Children and Families Act, were passed without a division. The UK now joins Australia and the Republic of Ireland in making the move.

The requirements will be introduced on packaging and labelling on 20 May 2016. Standardised packaging, which is designed to exclude all attractive promotional elements, will help protect the next generation from smoking.

John Middleton, FPH Vice President for Policy, said: "All those peers who voted in favour are to be congratulated for introducing a measure that will help make it less likely that hundreds of children will start smoking every day. The public and healthcare professionals support this move."

Deborah Arnott, Chief Executive of Action on Smoking and Health, said: "This is a decisive moment in the long and patient struggle to reduce, and then end, the horrors that the tobacco industry has brought to our country and to the rest of the world."

Mark Weiss

News in brief

Flu vaccine 'barely effective'
This year's seasonal flu vaccine was barely able to protect people from the main strain of flu being spread in the UK, health officials said. Evidence showed that the vaccine was stopping only three out of every 100 vaccinated people from developing symptoms.

E-cig ban from hospital grounds
Patients and visitors will be banned from using electronic cigarettes in hospital grounds across Scotland. A survey by the BBC revealed that all but one health board would completely ban the devices by April. The Scottish government has said it is up to individual health boards whether they prohibit the use of e-cigarettes.

Plumbers 'should report cold homes'
Plumbers and heating engineers should join with GPs and care staff in tackling problems caused by cold homes, health experts say. The National Institute for Health and Care Excellence said each council area should establish teams to help people access grants and advice. Professionals who carry out home visits could then refer those at risk.

Cut music to 'an hour a day'
People should listen to music for no more than one hour a day to protect their hearing, the World Health Organization said. More than one billion teenagers and young adults are at risk of permanently damaging their hearing by listening to "too much, too loudly", according to the WHO, with audio players, concerts and bars posing a "serious threat".

Under-10s obesity 'levelling off'
The rise in childhood obesity may be beginning to level off in the under-10s, a study suggests. It found a steady rise in the proportion of overweight children in England in 1994-2003, but in the past decade it has remained at about 30%. The King's College London researchers add that obesity rates among 11-15 year-olds were still rising, however.

'Gerbils caused Black Death'
Black rats may not have been to blame for numerous outbreaks of the bubonic plague across Europe, a study suggests. Scientists believe repeat epidemics of the Black Death, which arrived in Europe in the mid-14th century, instead trace back to gerbils from Asia. Prof Nils Christian Stenseth, from the University of Oslo, said: "If we're right, we'll have to rewrite that part of history."

INTERVIEW

Alastair McLellan is editor of the *Health Service Journal* and is also group editor of the *Local Government Chronicle* and *Nursing Times*. He was development director during the launch phase of the government's patient information portal NHS Choices. Here he tells *Public Health Today* why he believes public health is better off in local government

'The NHS is seen as a monolith'

Let's improve the debate, says McLellan

What are the common misconceptions people have about the NHS?
All the polling has always shown the closer you get to the service, the more satisfied you tend to be with it. People love their local general practitioner [GP] and have pretty high regard for their local hospital but see the NHS itself as a sort of bureaucratic monolith which is unresponsive to patient need. If you're going to have a nationally state-run service, you're going to have all the good things like the consistency of national standards, and you have to put up with the bad things, such as people seeing it as a monolithic organisation run from Whitehall. 'Twas ever thus, and it will be ever thus, because the NHS is the most efficient way to organise healthcare in this country and therefore will continue, so far as I am concerned, for many decades into the future.

It's very interesting seeing how the Manchester deal was done, and how quickly that could move from devolution… to stories… about town hall and health service bureaucrats making a decision about a local hospital. I don't think [Manchester] is a game-changer, but it is very important. At the moment we've got a process to develop a plan. As ever, we should absolutely not be cynical but we absolutely should be sceptical.

What do you think the public health community can do to up its game with health and social care colleagues?
Our coverage has largely moved to *LGC* [*Local Government Chronicle*] to reflect the fact that public health has moved to local authorities, and so I'm not as close to it as I used to be. I think public health is in the right place, and belongs to local authorities. From what I can tell, public health is happier in local government than it was in the NHS. The way public health people think about the world is closer to the way local government people do than health people. They are trying to improve people's wellbeing rather than mitigate their unhappiness which is what people in health care are doing.

The concerns around the dangers about money being diverted into other areas have broadly not been founded, though I'm sure there are cases where it has been. Where the money has gone to traditional non-public health areas it's been used in interesting areas such as housing, which public health people are happy about. They understand the importance of good housing or employment to public health. It's a much richer and more interesting discussion than the slightly reductive disease prevention conversation that usually happened around public health in the NHS. My friends in the sexual health community suggest that what was already a Cinderella service hasn't improved its status by moving commissioning into local authorities, and in many cases has declined. That is a particular area of concern.

Given that the big public health challenges in this country are not things like Ebola, the role of prevention is the most significant aspect of public health. That's where I think the public health community should focus its energy and not worry too much how they are seen alongside GPs and surgeons. I understand why it happens but I think it's the wrong comparison. The home in local government, and the ability to have highly skilled and trained people make contributions to debates about housing, transport and employment is a much better place to be.

How can public health up its game with the health media?
I would give the same advice that I would give to anyone. It's easy to play to the gallery in healthcare. Playing to your constituents will win you pats on the back and a nice warm fuzzy feeling inside. It probably won't win you much influence. If you want to make a difference, ask: are we doing what we should be? Are we aligned to priorities that the country has and playing our full part? Are we challenging ourselves and acting accordingly? That's the way you have influence in public life. The heart surgeons challenged themselves about data. That was a very challenging and important piece of work. It's a good example and I wish there were more like it. Spend as much time challenging yourself as you do others: that's when people see you as someone who is thinking broadly and with something fresh to say. The public health community is perfectly placed to do that.

> **Public health people are trying to improve people's wellbeing rather than mitigate their unhappiness which is what people in health care are doing**

How would you describe the cultural differences between the NHS and local authorities?
I love writing about healthcare and wouldn't want to do anything else. There is no difference in the quality of people in healthcare and local government. However, I think people who work in local government tend to have broader interests, whereas people who work in healthcare are only interested in healthcare.

Looking at the NHS and social care across the UK, what do you think is working well?
HSJ [*Health Service Journal*] is an England-only publication, and so I don't know a lot about how the situation is in Scotland, Wales and Northern Ireland. We've had combined health and social care in Northern Ireland for some time now. While there is plenty of good practice, it is not a highly performing health and social care economy. It isn't simply a case of combining the two: as ever, execution is the key issue.

What do you think needs to change for us to offer better care?
That is an enormously long answer, but luckily Simon Stevens has already given it in the Five Year Forward View!

What do you find the most rewarding aspects of your job?
The immense privilege of being so close to so many important decisions, and those making the decisions about what is probably the most defining characteristic of this country. That gives me and my colleagues enormous satisfaction. If you look at how people define Britain, it's the NHS that comes out on top in most cases.

And the most challenging?
To see the paucity of the debate around healthcare in much of general media coverage and political debate. So much of it is pointlessly polarised and produces more heat than light. When you do know how complex and interesting it is, it's frustrating. That's when I end up throwing things at the television.

How do you relax?
I'm terrible at switching off, because as a journalist I never go off duty. There are a lot of interesting things happening on my doorstep in Stoke Newington in central London. I am months away from two important events in my life: my 51st birthday and the birth of my first child. I think that will probably keep me busy!

Interview by Liz Skinner

It's inequity, stupid

Forget the economy, employment, the NHS, education. The burden of inequity is the most important issue facing voters and candidates, says Alan Maryon-Davis

IT SHOULD be right up there at the very top of the election agenda. Even higher than the economy, taxation, jobs, the NHS, housing, education, defence or immigration. It should be the key question we ask every candidate for every seat. What would your party do to tackle society's deeply damaging inequalities?

After 7 May, every new minister sitting around the cabinet table will have the power to make a real difference to inequalities, for better or worse. And national policy plays out so profoundly at local level that whatever new government we get will shape the challenges we each face in our own patch. Every election is important. But, with the increasing polarity of UK politics and ever-widening inequalities, this election could be more pivotal than most.

With exquisite timeliness, the debate in this edition of *Public Health Today* is the fundamental question of whether state intervention is the solution to inequalities. On the Yes side Clare Bambra and Ted Schrecker argue that history tells us it is so; whilst in the No corner Brendan O'Neill calls for trust in the individual and faith in trickle-down prosperity.

Elsewhere, Danny Dorling asks if we can realistically imagine a day when, to be decently housed, people no longer have to rely on charities. Stewart Lansley and Joanna Mack talk about 'breadline Britain' and the rise of mass poverty, while Tim Thornton, Bishop of Truro, tells us how they're harnessing community assets to tackle food poverty in Cornwall.

> **This goes beyond public health. It's a matter of social justice. And it's what fires us up**

Another huge issue is the number of working poor in the UK. Barrie Brown provides a useful analysis of zero-hours contracts. Colin Crooks describes his social enterprise which helps workless people to skill up and start their own businesses.

Ingrid Wolfe reminds us of the UK's shocking inequalities in child mortality. George Hosking talks about a key Parliamentary report on children's first 1,001 days. And Clare Offer revels in Bradford's plans for spending £50 million of Big Lottery funding over 10 years on their Better Start programme.

Andy Gregg wonders why there's an under-representation of BAME groups in free schools; whilst Hannah Graff tells us about a new suite of practical tools for tackling fuel poverty at local level.

Finally, there's the scandal of the unused talents of one fifth of our population, according to Liz Sayce of Disability Rights UK. And Jenna Pudelek of Scope describes how it feels for those disabled people who repeatedly find themselves being spurned by prospective employers.

For most of us in public health, the real issue behind inequalities is unfairness – the burden of inequity. This goes beyond public health. It's a matter of social justice. And it's what fires us up.

It's also what we should be grilling our politicians about, especially now at election time. I wonder how much it will feature over the next few weeks. Don't hold your breath.

Alan Maryon-Davis
Editor in Chief

Success stories: how nurturing enterprise enables social mobility

IN MY work as a social entrepreneur, I have observed that many people who traditionally are regarded as difficult to employ actually have a frustrated aspiration to run their own business. Lack of confidence and knowledge of business are crucial barriers. So in May 2013, I started to create a grassroots enterprise network in Lambeth, south London.

Tree Shepherd combines extensive practical experience of running businesses with a patient, supportive and non-judgmental approach to deliver a hands-on enterprise training and coaching programme aimed at workless people who want to do their own thing. The response in our corner of London has been incredible. With funding from Lambeth Adult Learning and other agencies we've trained more than 300 people, and we have a growing waiting list for our courses. Of our trainees, more than 20% have experienced significant disability or illness ranging from cancer and depression to alcoholism. None of them wanted their illness to define them – they wanted to be self-employed to create a new and more satisfying identity for themselves.

Almost without exception we have seen these people grow in confidence and capability: 87% tell us that they feel significantly more confident since joining the programme. Ursula came to our business coaching surgery in late 2013. She explained how she "was in recovery from depression and anxiety as a result of an abandonment schema", and she wanted to set up what became Project Dare, a burlesque body appreciation programme mainly targeted at women. However, she felt inhibited by her lack of business experience. By coaching her steadily through the main issues she faced we watched Ursula grow in confidence and get her business started. So much did she learn that in October last year she gripped an audience of 40 start-ups with her down-to-earth presentation on how to market your business and find customers.

Jane Roberts joined our programme in 2014. Jane suffers from a form of cerebral palsy, which causes her general and fine movements to be quite laborious and her speech to be slow and sometimes hesitant. Early last year she realised that she was holding herself back and joined our enterprise programme. Jane says: "Establishing Characteristics of Childhood as a business delivering bespoke training to the childcare workforce has accelerated my recovery process, as I am no longer shackled with self-doubt. I discovered Tree Shepherd's course at just the right time, which gave me the knowledge, skills and self-confidence to transform [my experience] into a social enterprise."

All this experience suggests to me that we need to change our approach to worklessness and illness. Research shows that employment radically improves a person's sense of self-worth. What we are now seeing is that self-employment allows people with considerable health challenges to express themselves and find new energy and confidence by doing something that they are passionate about. By trusting people and supporting them to achieve their dreams we can harness self-worth to the cause of personal health improvement. A more empathetic, supportive approach not only yields better outcomes but is also more cost-effective. We calculate that the cost of our initial entrepreneurial intervention is less than a £1,000 per person.

Colin Crooks
Chief Executive Officer
Tree Shepherd

Giving children a good start in life's journey

INCREASINGLY, we understand how a child's experiences in the earliest years, and even before birth, can shape future health and life chances. Intervention in those critical years from conception to age three can have a huge impact on inequalities throughout life.

Particularly key to a child's life chances is the care they receive in the first two years, and the opportunity to form secure attachments with the adults around them.

The city of Bradford has one of the youngest populations in the UK and also experiences some of the highest levels of deprivation and inequality. In June 2014, a partnership led by local community development organisation Bradford Trident successfully bid for £50m of Big Lottery funding to invest in three of the most deprived wards in the city to improve outcomes for 0-3 year-olds. About 1,430 babies are born every year in the wards of Little Horton, Bowling & Barkerend and Bradford Moor. The Better Start project will engage with more than 20,000 of them and their families over a 10-year period.

The 22 projects delivered with this funding will focus on social and emotional development, parenting and family support, nutrition and speech and language development. They include the expansion of the Family Nurse Partnership, a home-based language development programme, outdoor play and exercise activities, nutrition programmes, peer-support programmes and language development activities. Other projects will promote parenting skills, early attachment and provide support for mothers at risk of postnatal depression.

The Born in Bradford Innovation Hub will develop evidence-based innovations and ensure ongoing robust evaluation to allow us to create a programme that can be adjusted according to what works. This will maximise the delivery of effective activities, confident outcomes and invaluable, nationally significant learning.

We also have the opportunity to share learning with the four other Better Start projects in Nottingham, Southend, Blackpool and Lambeth. Within the lifetime of the Better Start projects, we hope to gather evidence of what works to improve children's life chances and to roll these out locally and nationally.

Clare Offer
Public Health Specialty Registrar
Better Start Bradford

DEBATE: Is state intervention the solution to inequalities? History shows it is the only way, say Clare Bambra and Ted Schrecker, while Brendan O'Neill puts faith in economic growth

When the safety net is shredded, the gap widens

HEALTH inequalities have been increasing in the UK and elsewhere over the past few decades. In Stockton-on-Tees the gap in male life expectancy between the most and least deprived areas is 16 years. These inequalities result from the vastly different 'epidemiological worlds' in which rich and poor live, work and play – the social determinants of health. In our unequal market economy, people with more resources, or who are sorted by housing markets into more affluent areas, have better educational opportunities, work environments, healthcare services, transport, security, employment chances, housing and so forth.

This rise in health inequalities accompanies other significant changes in our politics and society. Since the 1980s, the UK has experienced a neoliberal political project, launched by Thatcherism but continued to varying extents by all subsequent governments, and intensified by post-crisis (selective) austerity. This project has shrunk the public sphere, restricted the role of the state and increased the role of the market. Evidence from the UK, New Zealand and the USA shows the connection to social and health inequalities. When public services and social provision are expanded, as during

YES

the US 'war on poverty' in the 1960s, the health gap narrows; when the welfare safety net is shredded, the gap widens. The causal pathways are multiple and complex, but the overall weight of evidence is formidable.

The World Health Organization Commission on Social Determinants of Health identified "tackling the inequitable distribution of power, money and resources" as one of its three overarching recommendations. The editor of the monthly newspaper *Le Monde diplomatique* recently wrote that: "The inequality machine is reshaping the planet." The work of economist Thomas Piketty and many others shows that only state action, local and national, can tame the inequality machine. Nor can we rely on 'nudges' or on the benevolence and paternalism of employers and businesses whose interests are often in conflict with what good health requires.

Public health history shows this. The great sanitation reforms of the 19th century, the Clean Air Acts of the 1950s and the ban on smoking in public places were all the result of state intervention. In contrast, neoliberal individualism, austerity and the 'free hand of the market' will only serve to widen our social and health divides.

Clare Bambra
Professor of Public Health Geography
Ted Schrecker
Professor of Global Health Policy
Durham University

We need to trust the individual

EVERY time a problem arises, someone calls in the state to fix it. Too much public smoking? Get the state to ban it. Children are chubbier than ever? Ask teachers to rifle through their lunchboxes in search of contraband like Mars bars. People aren't exercising enough? Get the state to spend millions on public-information campaigns designed to get us off our lardy behinds.

Such intervention is justified as addressing inequalities, especially health inequalities. The argument is that some sections of society, especially the poor, do not enjoy the same access to information as the better-off, and thus need a nudge from the state to put them on the road to a more enlightened, slimmer existence.

There are many problems with inviting the state to shake up people's lifestyles. One is that it's patronising, fuelled by the idea that there's an enlightened caste – the kale-eating public-health lobby – which must save the corpulent and cigarette-smoking little people from a lifetime of ill health.

This isn't new. In *The Road to Wigan Pier*, George Orwell wrote of the "society dames" who would "teach the unemployed about food values". These dames were always shocked by the

NO

poor's lifestyles, not realising that "the less money you have, the less inclined you feel to spend it on wholesome food". When you are "underfed, harassed, bored and miserable, you don't want to eat dull wholesome food. You want something a little bit tasty", said Orwell.

He recognised something today's public-health agitators miss: we need economic growth and a wealthier society if we want people to have more fruitful lives, not the harassment of individuals for failing to be healthy. Too often, we micromanage individuals' lives rather than think about how to transform the structure and fortunes of society itself. Lecturing the unhealthy takes the place of reimagining the future.

Another problem with state intervention is that it undermines people's ability to take responsibility for their destinies. Surrounding people with the scaffolding of 'expert advice' ends up infantilising them. In the words of the 19th-century liberal thinker John Stuart Mill: "The mental and moral, like the muscular, powers are improved only by being used." In short, it's possible to 'care' too much, and in the process to end up harming the targets of your largesse.

We need less state intervention and more trust in individuals to do what is right for them.

Brendan O'Neill
Editor
Spiked magazine

Home truths

Housing is as essential as health or education – and should be freed from profiteering, argues Danny Dorling

UNLIKE those with the worst health, adults in the worst housing in Britain have to turn to charity, including homeless hostels. It is not impossible to imagine a day when, to be well housed, we no longer rely on the actions of charities. Currently that day seems rather a long way off, given the prevailing UK policy direction and the continued reliance of our economy on an overheated housing market.

It need not be like this. We no longer depend on charities to provide healthcare. People no longer go to the charity hospital, almost all of which were nationalised in 1948. The recent increase in private provision within the NHS is a step backwards. In housing, for most people in Britain (who do not rely on social housing) we never took the step forward that was needed in the first place. Implicit in that step is the idea that all should be well housed and no one should profit greatly out of housing. If you think that aspiration fanciful, the most obvious correlate is how not relying on profit-making provision has largely transformed education in Britain. Schools that claim charity status today are mostly charities for the rich. The rich are very wary of handing their children over to a school that makes an actual profit. Hardly any private firm currently profits much from delivering education, although sadly more and more are trying to turn that sector into a money-spinner.

Housing, health and education are all essentials, but hardly any of us can become experts in their consumption. Our personal involvement is largely through one-off events, with choice greatly limited by circumstance. We need a diversity of provision, but we also need protection from those who would profit by having some inside knowledge, vested interests and fewer scruples than most.

> **"All should be well housed and no one should profit greatly out of housing"**

Currently in the UK, progress in education and health seems to be in reverse gear, moving gradually away from non-profit provision. When we were last as economically unequal as we are today, enough people acted so that hardly anyone in the population had to rely on charity. The steps taken were many, and often each alone appeared insignificant; they ranged from striking to improve pay to voting out corrupt MPs.

Less obvious political actions can be important. There was a growing general distaste of greed from the 1930s through to the 1970s. People commented more and more openly on unfairness and campaigned for greater equality: between men and women; landlord and tenant; and rich and poor. In 1921, when so much of the provision of housing was not an entitlement, it was possible for the academic Richard Tawney to write: "No one has forgotten the opposition offered in the name of the rights of property to factory legislation, to housing reform... Even to this day... an English urban landlord can cramp or distort the development of a whole city by withholding land except at fancy prices, English municipalities are without adequate powers of compulsory purchase."

It is time we saw housing as being as important as health.

Danny Dorling
Halford Mackinder Professor of Geography
School of Geography and the Environment
University of Oxford

This is an edited extract from 'All That is Solid: How the great housing disaster defines our times and what we can do about it', published in paperback on 26 February 2015 (Allen Lane)

Too many are too poor to eat healthily

THE *Feeding Britain* report which we published in December 2014, as a result of our All-Party Parliamentary Group inquiry, showed that many people living in this country were going hungry.

I see clear inequality here in Devon and Cornwall, where significant numbers of people are living in deprived circumstances. We have well over 20 foodbanks and satellites throughout the county delivering food every week to those who would otherwise go hungry. As we went around the country and heard from a wide range of people, including public health professionals, the story was the same wherever we went: large amounts of money are being spent on such food-related matters as malnutrition, obesity and diabetes. All this shows how inequality leads to problems which can so easily and quickly lead to health issues. There is a premium on poverty which means that it is more expensive to feed at all, and especially to feed well, if you have little or no money. Lack of access to basic equipment and to resources also means that the likelihood is that less nutritious and more processed food is eaten. The possibility of obesity and problems with low energy and inability to care properly for oneself becomes even more real. I was encouraged to hear in various places, not least here in Devon and Cornwall, about the good work being done by public health and local authorities to try and tackle the underlying problems within the food system.

Education is crucial in challenging issues of inequality. Pressure on resources and the need for the right kind of resources, at the right time and in the right way, is a constant struggle. These matters should not be left to the voluntary sector, as wonderful as it is, nor to professionals under increasing pressure to hit short-term targets. But apart from all the many important matters I heard as part of this inquiry, the underlying concern I go on worrying away at is that so many of the relationships and natural means of keeping society together have either been destroyed completely or have almost totally disappeared.

> **So many of the natural means of keeping society together have been destroyed completely**

Matters of inequality are always in danger of getting worse if we do not understand ourselves to be all part of a society. That is why I come away from the inquiry concerned that the glue has gone from our society and am committed to go on working to do what I can to find ways of restoring the sense of all being part of one country – and all being interdependent.

Rt Rev Tim Thornton
Bishop of Truro
Chair
All-Party Parliamentary Inquiry into Hunger in the UK

Poverty 2015: cold, hunger and anxiety

POVERTY in the UK is at a 30-year high. Our research, charting poverty over time using a minimum living standard defined by the public as its baseline, finds that today nearly one in three people fall below this standard – double the level found in 1983. Based on public opinion, this is the nearest we have to a democratically-defined poverty line. It paints a bleak picture of the state of living conditions for a growing minority of the population.

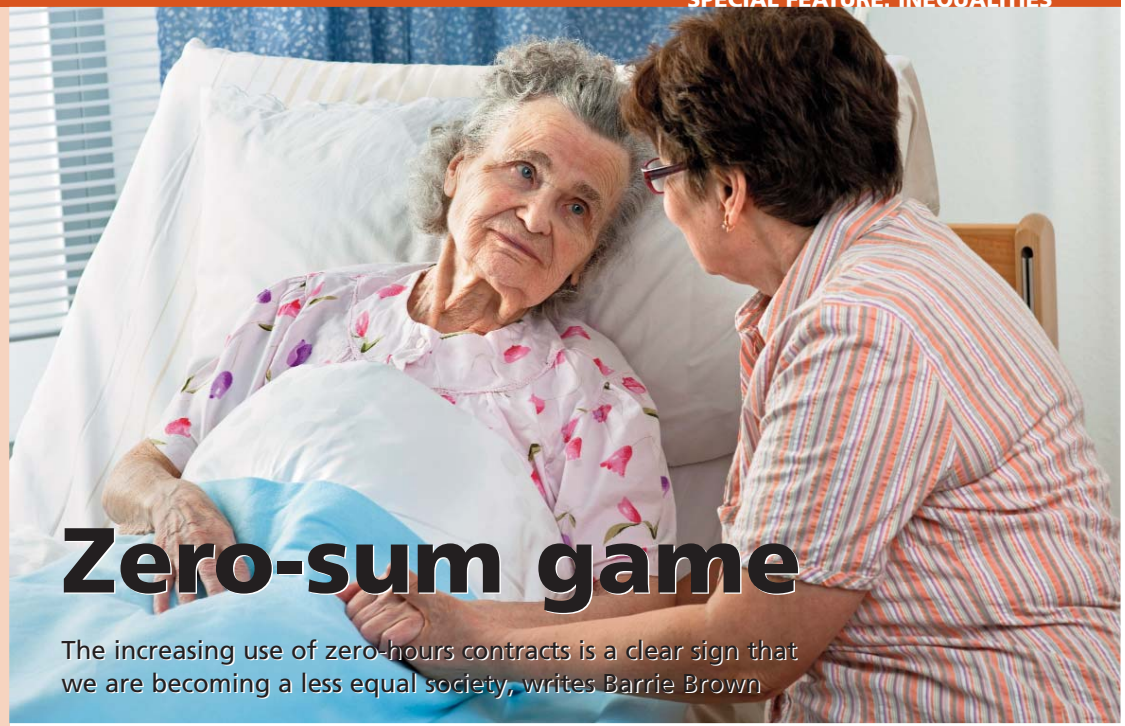
More people lack some of the most basic of these publicly-defined necessities than in 1983. One in 10 households live in a damp home, up from just 2% in the 1990s. The number who cannot afford to heat their home adequately has trebled since the 1990s. One in five children live in a home that is cold or damp; one in 10 miss out on an essential clothing item such as a warm coat or a second pair of shoes. An estimated 600,000 children cannot afford to go on school trips each term.

Being poor is not confined to having the barest of material standards. The 2012 survey found that three out of four of those who lacked three or more publicly-defined necessities have at least one financial problem and three-quarters feel poor. Three out of five have problems with their health. Those who cannot afford meat, fish or its vegetarian equivalent every other day are seven times more likely to be in poor health than those who can, and those who cannot afford to heat their homes are six times more likely. Half of those who lack three or more necessities suffer four or more of the standard 12 indicators of stress, anxiety and depression – a cut-off widely used as an indicator of poor mental health.

With high levels of poverty built into the UK economy, the issue ought to be one of the hottest of the election campaign. Instead there is virtual silence. The poor are once again being written out of the political script.

Stewart Lansley
Visiting fellow at the Townsend Centre for International Poverty Research University of Bristol
Joanna Mack
Senior Producer
Open University

The writers are authors of Breadline Britain: The Rise of Mass Poverty (Oneworld), based on ESRC-funded Poverty and Social Exclusion research



Zero-sum game

The increasing use of zero-hours contracts is a clear sign that we are becoming a less equal society, writes Barrie Brown

MUCH has been written and said about zero-hours contracts since they came to prominence in the wake of the financial crash seven years ago.

For the vast majority of the estimated 1.5 million workers in Britain on zero hours, their contracts are simply not a sustainable means of employment. In 2014, the Chartered Institute of Personnel and Development found that voluntary and public sector employers were among the most likely to deploy zero-hours contracts, with 35% of education and 27% of healthcare employers doing so.

For people on such a contract, day-to-day life will almost certainly carry a large amount of insecurity. They don't know, from one day to the next, how much work, and therefore income, they will have each month. This raises anxieties about housekeeping, paying rent or the mortgage. There's also a real impact on work/life balance: people live with the constant expectation that they must respond to work offers at very short notice and fear saying 'no' in case they don't get called in future. As a result, living standards are severely hit, with ever more people working harder but getting poorer.

> **Day-to-day life will almost certainly carry a large amount of insecurity**

A recent survey of home care workers found that 41% were on zero-hours contracts, which was in line with the government's recent acknowledgment that 307,000 care-sector workers in England had these terms of employment. The contracts have a knock-on effect when it comes to the quality of service being offered, with many care workers not being paid for their travelling time and expected to carry out home visits within just 15 minutes.

In addition, as a Resolution Foundation report has explained, the high turnover of staff as a result of zero-hours contracts means that many carers are left to do their jobs without sufficient experience or training. One day-services support worker from Kendal, who is mentioned in the report, starkly summed things up by saying that being on a zero-hours contract "definitely has an impact on the care we provide. We look after lots of patients with dementia, and we're supposed to be 'up' and positive for them each day. But now everyone is worried and looking for other jobs and that rubs off on patients."

Clearly this is neither acceptable nor tolerable. Zero-hours contracts are fundamentally exploitative in nature,

> **Many carers are left to do their jobs without sufficient experience or training**

and their proliferation carries warnings about the kind of society we are fast becoming. Unite wants an outright ban on zero-hours contracts. Thankfully the vast majority of our members in the health sector are directly employed by the NHS and therefore on decent terms and conditions. Nevertheless, together with other trade unions, we will continue to fight against zero-hours contracts, which do nothing but increase insecurity and inequality in the workplace.

Barrie Brown
National officer for health
Unite

The wasted fifth

The nation is missing out on the passions and skills of disabled people because of a poorly designed and administered system, say Jenna Pudelek and Liz Sayce

WHEN Emily Birkinshaw started having non-epileptic seizures at work, her employers did not renew her contract and she was faced with the prospect of not being able to support herself.

Emily, 28, has fought for her independence – and to get the support needed to pursue her career. She now works on Scope's First Impressions, First Experiences programme, which helps young disabled people in London find ways into work. Emily, who also receives in-work support for mental health problems, uses her own experiences to help and inspire the young people she works with.

"You've got so much stacked against you, if you're a disabled person looking for a job," she says. "Your confidence is just knocked over and over again." A lot of the young people on the programme haven't done work experience, and some have attended the type of special educational needs school where it was expected they would go into a day service. Emily says: "There's a need for more opportunities that aren't tokenistic for young disabled people – opportunities that work with their passions and skills and encourage them to develop careers they love."

Disabled people want the same opportunities to work as everyone else. Nine in 10 disabled people work or have worked, but only half are in employment now. There are more disabled people in the labour market than ever before. However, disabled people are finding that their aspirations to work and the requirements of the benefits system are not being matched by effective support to find work.

Jenna Pudelek
Press Officer
Scope

> **There's a need for more opportunities that aren't tokenistic for young disabled people**

SO WHAT'S in the way? At present, disabled people are put through a tough regime of 'work capability assessment' (WCA) – part of a system meant to offer work for those who can, support for those who cannot. Instead, it is a fit-to-work test that doesn't function properly, because it is badly designed and poorly carried out. Many find the WCA punitive, humiliating and distressing.

There are also significant problems with the government's Work Programme which is designed to help people on certain benefits to find and keep work. The latest figures show that more than 85% of (mainly disabled) people on the Work Programme have not moved into employment.

Disabled people deserve better. It's time to put the power and resources for support to get work in the hands of disabled people and employers. This will have an impact on health outcomes. People in work tend to have better mental health and are less likely to make demands on health services.

We need to look more broadly at the role disabled people play in their communities. Here, full and meaningful participation by disabled people is vital. Health and wellbeing boards, with their remit to improve the health of the whole community, have a pivotal role to play. Alongside disabled people's organisations, public health professionals are in a good position to promote social networks and harness the power of community and peer support. This helps overcome isolation, enable disabled people to achieve better health and opportunities, and influence local health provision.

We're missing out on the talents of a fifth of our population. By working together, we can reap positive benefits for all.

Liz Sayce
Chief Executive
Disability Rights UK

Free schools selecting out ethnic minorities

THERE is ample evidence that inequalities throughout the education system can be particularly damaging to Black, Asian and Minority Ethnic (BAME) students and young people. Many of these inequalities may affect a young person's health and mental health outcomes throughout their lives. Barriers to achievement and discrimination occur at almost every stage of the education process, some of which have been exacerbated by an increase in schools falling outside the control of local authorities. Problems with admissions, especially to free schools, levels of exclusions, stereotyping by some teachers and failure to invest in careers guidance and other support for BAME young people all need to be addressed to mitigate these inequalities.

In 2014, Race on the Agenda (ROTA) published a report which found that many free schools prioritised the children of staff, founders or specific feeder schools, and carried out interviews, auditions or testing by ability or aptitude. Such selection tests can disadvantage applicants without access to specialist preparation or coaching, which has a disproportionate affect on BAME students.

The Equality Act 2010 requires all schools to fulfil the public sector equality duty (PSED) which supports schools in tackling unlawful discrimination, meeting diverse needs, identifying and addressing the reasons for different educational outcomes for different groups, and creating school environments where all pupils feel valued and safe from all kinds of bullying and harassment. By 6 April 2012, all schools should have published information to demonstrate their compliance with the duty and published one or more specific and measurable equality objectives.

ROTA's report, based on a survey undertaken in October 2013 of the 78 free schools that opened in 2011 and 2012, found that most free schools appeared to be unaware of the Equality Act and the PSED, with less than a quarter (23.1%) making reference to it in key policies and documents. Only two schools were fully meeting the requirement to publish equality information and measurable equality objectives. Two-fifths (39.7%) were failing to identify prejudice-related bullying and/or derogatory language in their anti-bullying or behaviour policies.

The impact of bullying on young people, particularly young people from BAME communities, can be devastating for their future life chances. It can also have an impact on their mental health and behaviour. Research carried out by ROTA with 500 BAME young Londoners found that many parents were extremely concerned about the frequency with which their children were diagnosed with attention deficit hyperactivity disorder. Parents report that this diagnosis can become a means of labelling behaviour to contain it, rather than addressing the reasons behind it.

Meeting the equality duty can deliver important public health benefits for all schools. It helps schools to address the needs of vulnerable and disadvantaged groups and contributes to outstanding achievement for all. The duty supports schools to become places where all pupils feel valued and safe. It is in the interests of all schools to ensure their admission policies and pastoral care support all pupils' mental wellbeing, regardless of their ethnicity.

Andy Gregg
Chief Executive
Race on the Agenda

All tooled up to fight fuel poverty

THE basic entitlement to live in a warm, dry and healthy home is out of reach for millions of people across the UK. They cannot afford the energy required to heat their homes adequately and, consequently, suffer in cold, damp conditions which affect their health and wellbeing and significantly diminish their quality of life. The impact on wellbeing and wider determinants of health such as income, housing and employment are well established and the link between fuel poverty and health inequalities is clear.

The UK Health Forum has developed a toolkit in partnership with the Department of Energy and Climate Change, Public Health England, Friends of the Earth, the Royal College of General Practitioners and the Faculty of Public Health. It has resources for tackling fuel poverty and its associated health risks such as poor mental health and excess winter deaths. The toolkit includes a downloadable guide, *Fuel poverty: Improving health and wellbeing through action on affordable warmth*, a supplement guide for primary care practitioners, case studies and an active list of links and resources. The toolkit describes how public health professionals can help to tackle the problem of fuel poverty, cold homes and health inequalities by working in partnership with housing, environmental and energy services, the voluntary and community sector and local residents.

The toolkit, which was updated in January 2015, is located on the UK Health Forum's free online resource, Healthy Places, with supporting documents. To access the toolkit visit: http://bit.ly/1xYB5Az

Hannah Graff
Senior Policy Researcher
UK Health Forum

Here's the other, darker meaning of 'five a day'

WHAT does 'five a day' mean to you? A catchy health promotion message, to be sure. But there's a darker alternative meaning. If the UK had the same mortality rate as Sweden for children from birth to 14 years old, there would be five fewer child deaths each day.

A child born in the UK is more likely to survive than ever before. But it is clear we could do much better; other similar countries have done so. Over the past 40 years, the UK has not matched the progress in child survival that many other European countries have achieved. For infant and child mortality, we've gone from average or better, to among the worst performing countries. By 2010, the UK had among the highest infant and child mortality rates of wealthy European countries.

There are more than 5,000 deaths each year in the UK among children under 19 years. The majority of deaths happen in infancy, most in the first month of life. Pre-term and low birthweight are major risk factors. Adolescence has the next highest mortality rate after infancy. Although external factors, such as transport injuries and violence, are the commonest causes of death in adolescence, the death rate from non-communicable diseases is higher in the UK than other wealthy European countries.

The major causes of childhood deaths are made more or less likely by macroeconomic and social policies that

> **There are more than 5,000 deaths each year in the UK among children under 19 years**

mitigate poverty, inequalities and social determinants of health. Public health policies and child health services can help prevent more deaths.

Examining the differences in child mortality trends and policy between similar countries reminds us that we could do better and helps us to define goals. The variations between countries highlight an important fact: the chances for children to survive and thrive are greatly influenced by political choices.

Poverty and social inequalities shape child survival. Children who live in poverty are at greater risk of death than their wealthier peers. When the rich are much richer than the poor, children are at greater risk of death than when wealth is more fairly shared.

The UK disproportionately disadvantages children and young people. Poverty and social disadvantage affect the young more than other age groups in the UK. This is in contrast to many other European countries, where these problems are more equitably shared between ages. In Britain, recent social spending cuts disproportionately affect families with children.

What can be done to improve child survival?

- Redistribute wealth to reduce poverty and narrow the gap between rich and

poor. Macroeconomic policies matter to child survival: around a quarter of infant deaths could be prevented if all babies were born in circumstances as favourable as the most advantaged families.
- Strengthen social protection for families. Countries that spend more on families have lower child mortality rates.
- Invest in public health and health systems. Child health systems that promote survival combine strong child-centred primary care services with a focus on public health.

There are plentiful research papers and policy reports describing what needs to be done to improve UK child survival. Evidence must be translated into adequately funded and sustained national and local policy. Finally, an accountability mechanism to monitor and make recommendations to a minister who can take action is vital.

Ingrid Wolfe
Clinical Senior Lecturer
King's College London
Co-Chair
British Association for Child and Adolescent Public Health

First 1001 days: foundation for the future

IN JANUARY, the All-Party Parliamentary Group for Conception to Age Two – the First 1001 Days completed an intensive inquiry into optimum policies for the development of children. Its report, *Building Great Britons*, concluded that society prospers according to the nature of its citizens.

The more our citizens are physically and mentally healthy, well educated, empathetic, prosocial, hardworking and contributing to the costs of society, the better society will flourish. As the proportion of citizens who are damaged, physically or mentally ill, poor at relationships, antisocial, violent or criminal rises, so the quality of society worsens.

The groundwork for good citizenship occurs in the first 1,001 days of a child's life. A society that delivers this creates a strong foundation for almost every aspect of its future. A society that fails to deliver it generates enormous problems for the future in terms of social disruption, inequality, mental and physical ill health, and cost.

The report recommends that achieving the very best experience for children in their first 1,001 days should be a mainstream undertaking by all political parties and a key priority for NHS England. It also recommends that local authorities, clinical commissioning groups and health and wellbeing boards should prioritise all factors leading to the development of socially and emotionally capable children at age two. This could be achieved by adopting and implementing '1001-days strategies' based on primary preventive principles, with particular emphasis on fostering mental/emotional wellbeing and secure attachment, and preventing child maltreatment.

George Hosking OBE
Chief Executive
WAVE Trust

Crunching the numbers on the data explosion

I WAS very keen to get my hands on this book as I was hoping that it would tell me just what the 'big data' revolution that is sweeping through public health was all about. I was also hoping for hints on whether I should be scared, indifferent or rejoicing as we enter an age of limitless information. The preface provided a sobering fact: at the time the book was published the world was producing the same amount of data every two days as had been produced between the dawn of civil action and 2003.

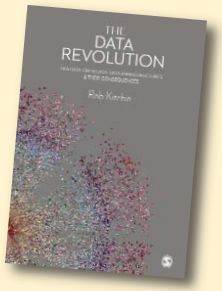
The book aims to update readers on all aspects of the data revolution and gives attention, not just to improvements in the amount of data we can now collect, but also to developments in how it is analysed, stored and used. And it looks at ethical, political and legal issues.

The book is not targeted at those working within health, and this led to a disappointing lack of examples relevant to public health. However, the chapter on the implications of the data revolution to scientific research gave a good overview of how typical research methods employed within public health will be affected. It discusses a world in which sampling, models and hypothesis-testing are obsolete.

The implications of the data revolution for public health research are massive, particularly when exhaustive data resources, open to use by anyone, are accompanied by advanced, analytical software that can (as proponents claim) find within the dataset answers to questions that researchers didn't even think to ask.

Despite the grand claims made by the author and other figures in the revolution, I was pleased to find that the hype surrounding the new data environment was subjected to a thorough critique. The book takes some of the most attractive ideas about the data revolution and asks whether the blind faith in these proposed benefits is warranted. Even data that captures detailed, linked information on entire populations can still be biased, misused and subject to random correlations that have no real benefit in the real world.

Despite my brain melting a bit with all the talk of 'petabytes' and 'yodabytes' (sorry, 'yottabytes'), I definitely came away with better understanding of the



data revolution.

Whether the data revolution currently has a complete understanding of itself, is another matter.

Stella Botchway

The Data Revolution: Big Data, Open Data, Data Infrastructures and Their Consequences
Rob Kitchin

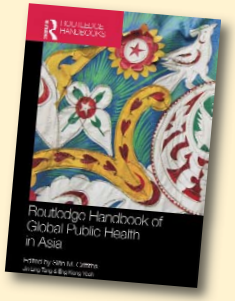
Published by Sage
ISBN 9781446287484
RRP: £22.99

What Bill and Angelina really need to know

I BUMPED into Bill Gates in Asda last week, and he casually asked what might be my funding priorities for public health in Asia. Thanks to this book, I quickly reeled off gaps in mortality research in Laos, a lack of evidence on what could persuade Indian politicians to prioritise maternal health, the need to make tobacco control policy in the Philippines more effective, to understand health behaviour in rural Thai villages... He went to the checkout looking thoughtful.

And just the week before at a dinner party, Angelina Jolie had listened spellbound as I regaled guests with summaries of essential HIV epidemiology in India and China, the challenges of the diseases of poverty in Cambodia, and how to engage China's tuberculosis service providers in coordinated action.

But this book isn't merely essential for impressing one's karaoke chums with facts about diabetes prevention in huge low-income populations. It covers a massive array of the key public health challenges in the world's biggest populations and also works as a 'how-to' guide using case studies of public health responses, such as the chapter on the response to the 2011 Thailand flooding and the one on influencing climate-change impact. There is data on major health determinants, urbanisation impacts, on the organisation of screening and health services. There's a detailed description of China's primary care system, a summary of human health



resources in the Philippines, the proportions of clean water availability in Indonesia, diabetes prevention strategy in the lowest-income countries, the relative effectiveness of child-health systems, and the enormous challenges of emerging infections and occupational hazards facing Asian populations. Ideally the editors will produce a companion book on influencing Asian governments' and multinational industries' economic decisions impacting on health inequalities. But for those intent on working in public health policy and practice in Asia, this is essential reference.

Andy Beckingham

Routledge Handbook of Global Public Health in Asia
Edited by Siân M Griffiths, Jin Ling Tang and Eng Kiong Yeoh

Published by Routledge
ISBN 9780415643825
RRP: £140.00

Book brief

Putting Wrong Things Right (£19.99) has been published by the Chartered Institute of Environmental Health to highlight the work of environmental health practitioners since 1952. To mark the Queen's Diamond Jubilee in 2012, CIEH chief executive, Graham Jukes OBE, asked members to contribute recollections and photographs from the previous 60 years. Subjects include smog, slum landlords and typhoid outbreaks.

From the CEO

ONE of the key motivations for coming to work at the Faculty of Public Health (FPH) was my interest in health inequalities. At the Royal National Institute of Blind People, I realised that the inequalities faced by many blind and partially-sighted people were all too clear. The additional costs incurred for transport, equipment and personal assistance to engage in healthy behaviours are substantial. If you need to use a taxi to get around, adaptive computer technology to access the internet or an accompanying guide in unfamiliar environments, the costs and levels of inconvenience increase dramatically.

If you are sent small-print health appointment letters, you will miss appointments. If the patient information leaflets inside your prescription are inaccessible, you won't know what pills to take and when, or worse, which are which. For some disabled people, it's much easier to microwave a ready meal than buy and prepare fresh ingredients, so it's harder to eat healthily. And of course, there are considerable challenges in regular exercise if you are blind: will the gym argue about 'health and safety' when using equipment? Can you find a regular running guide? Are there enough like-minded people around to make up a club for blind footballers/golfers/goalball players?

On my recent visit to the American Public Health Association conference in New Orleans, I was struck by health inequalities in the US. Seven million people with mental health problems qualify for health coverage but aren't able to take it up; a third of adults and two thirds of children with mental illness get no care at all. It was also evident on the streets of New Orleans itself: Hurricane Katrina devastated the poorer districts most because they were built on land furthest below sea level.

In a land of enormous food portions, few healthy food choices and "three for one" advertising boards held aloft outside bars on Bourbon Street (with the laughable footnote: "Drink Responsibly") there was good news too: who would have expected the show at the House of Blues to list the campaign for smoke-free bars and casinos as its key sponsor? (This was subsequently passed by the City Council in January).

These examples might reasonably be seen as 'first-world problems', and, whilst we know that many developing countries are starting to experience similar issues, the starkness of health inequalities in some African and Asian countries is of a different order altogether. FPH members are continuing to engage with these, as we embark on our five-year strategy, and I welcome your support.

David Allen

FPH Annual Conference
The Politics of Healthy Change
23-24 June 2015

Sage, Gateshead

Watch out for speaker and programme announcements coming soon.

For opportunities to partner FPH on this event see http://tinyurl.com/nqxpo7t or contact conference2015@fph.org.uk

Further information on the conference and registration at http://www.fph.org.uk/fph_conference_2015

Elections

We are pleased to announce the results of the following elections:

- Vice President for Policy – Professor Simon Capewell
- Assistant Academic Registrar – Dr Brendan Mason (re-elected unopposed)
- Local Board Member, Scotland – Dr Julie Cavanagh (elected unopposed)
- Local Board Member, Northern Ireland – Dr Adrian Mairs (elected unopposed)
- Local Board Member, Wales – Dr Dyfed Huws (elected unopposed)
- Local Board Member, Yorkshire & the Humber – Dr Judith Hooper (elected unopposed)

All those elected will take up office immediately after the Faculty of Public Health (FPH) annual general meeting on Tuesday 23 June 2015. Full details of the election results can be found on the FPH online members' area (http://members.fph.org.uk/default.asp) or are available on request from Caroline Wren at carolinewren@fph.org.uk or tel. 020 3696 1464.

In memoriam

Stephen Hewitt Hon MFPH
1957 – 2014

STEPHEN Hewitt was very well known in the world of planning and public health. He qualified as a town planner in 1980 then worked in Manchester and Rochdale before moving to Bristol. Stephen had a unique insight and energy, an encyclopaedic and eclectic knowledge and a firm resolve to stand up for what he believed. His 2012 essay, runner up in the Royal Town Planning Institute (RTPI) annual competition, encouraged us not just to determine if plans were 'sound', but to campaign actively for towns and cities that were good places to grow up and grow old in.

Stephen achieved great things for local communities working through many avenues. He was head of the Hartcliffe and Withywood Community Partnership, Chair of Creating Excellence, a governor at City of Bristol College, founding director and President of the Bristol Credit Union, a policy expert for the RTPI, on the steering group for the UK Healthy Cities Network, and he worked closely with the Homes and Communities Agency, Public Health England and the Town and Country Planning Association.

For the last four years of his life he worked jointly across the public health team and the Planning Directorate of Bristol City Council, influencing Bristol's Core Strategy and Development Management policies. Stephen saw this post as a prototype for re-establishing the relationship between town planning and public health, in effect reaffirming their joint origins in the 19th century. He was awarded honorary membership of the Faculty of Public Health in 2013 and gained his MSc in public health in June last year. He was rather special and will be missed greatly.

Angela Raffle FFPH
Consultant in Public Health
Bristol City Council

Anthony McMichael FFPH
1942 – 2014

QUALIFYING in medicine in Adelaide, South Australia, Tony McMichael worked for a while in a leper colony in India, followed by a brief period in general practice, before gaining a PhD in epidemiology at Monash University, Melbourne in 1972. Thence to the University of North Carolina, where he studied patterns of ill-health linked to hazards at work.

Back again in Australia, Tony worked in the division of human nutrition at the Commonwealth Scientific and Industrial Research Organisation and in 1986 became the first holder of the foundation chair of occupational and environmental health at the University of Adelaide. Among his many groundbreaking pieces of work was a study providing definitive evidence of the dangers of lead exposure for children, widely cited in the campaign for lead-free petrol. Another classic study, on passive smoking, was key evidence supporting a ban on smoking in public places.

But it was as a pioneer in the emerging field of global ecosystems and human health that Tony gained even greater international recognition in the late 1980s and early 1990s. By studying changes in the seasonal variation of deaths among older people in temperate climates, and changes in the distribution of insect vectors of diseases, he was able to develop models and methods to quantify the health impacts of climate change long before most of the scientific world were even aware of global warming as an issue.

Tony was appointed chair of the committee assessing health risks for the United Nations Intergovernmental Panel on Climate Change (1993-96) and took up a post as professor of epidemiology at the London School of Hygiene and Tropical Medicine in 1994. Returning to Australia in 2001 as head of the National Centre for Epidemiology and Population Health at Canberra, his research continued to add to our understanding of the complex interactions between climate and infectious disease. On his 'retirement' in 2007 he was appointed chair of the World Health Organization's research programme on climatic, environmental, agricultural and nutritional influences on the emergence of infectious diseases.

With more than 300 peer-reviewed articles to his name, Tony received many awards, including Officer of the Order of Australia. He was a tireless advocate for action on climate and health and, just before his untimely death in September, was a lead author of an open letter to the Australian prime minister urging him to put climate change and health firmly on the G20 agenda.

John Lee FFPH
1935 – 2014

DR JOHN Lee was born in South Africa and graduated MBBCh from the University of Witwatersrand in 1960. He then gained clinical experience in South Africa city hospitals. An interest in epidemiology took him to the London School of Hygiene and Tropical Medicine where he gained a diploma in public health in 1966. From 1967 to 1974 he worked for the Public Health Laboratories, publishing articles on salmonella food poisoning connected with animal foodstuffs. This was the topic of his MD thesis which was recognised by Wits University in 1973. Work with the Medical Research Council followed until 1976 when he took posts as a community medical consultant with Kingston and Richmond and then Hereford health authorities. In Hereford he made a major contribution to the first annual report required following the Acheson recommendations. As well as community

medicine work, he pursued new research interests in heart disease and the sympathetic nervous system. This interest continued after retirement when he published articles and contributed at community medicine conferences. In retirement he enjoyed tennis, bridge, walking his golden retriever, travel and visiting family in South Africa. He is survived by his wife, Valerie.

Deceased members

The following members have also passed away:

Peggy Beynon MFPH
Lindsay Davidson FFPH
Peter Gentle FFPH
Anthony Hedley FFPH
Lennox Pike FFPH
Brian Southgate FFPH
Michael Warren FFPH

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to the Faculty of Public Health between November 2014 and January 2015

Fellows
Sarah Andrews
Siu Mui Tina Chan
Felix Greaves
Marko Kerac
Merav Kliner
Mary Lyons
Paul Madill
Suzanne Meredith
Rachael Musgrave
Oyinlola Oyebode
John Ryan
Rebecca Taylor
Justin Wong
Siyan Zhan

Members
Campbell Todd
Louise Woolway

Diplomate members
Eleanor Houlston
Greta Chun-Huen Tam

Specialty Registrar members
Jessica Ayeh-Kumi
David Bagguley
Bethan Bowden
Christopher Cartwright
Katherine Comer
Andrew Dalton
Ruth Du Plessis
Hayley Durnall
Michelle Everitt
Daniel Flecknoe
Simon Hailstone
Zara Hammond
Jill Harland
Megan Harris
Rhosyn Harris
Rory Honney
Mohammed Jawad
David Johns
Gillian Kelly
Jane Kenyon
Sarah Lane
Louise Lester
Laura Maclachlan
Christine McBrien
Bethan McDonald
Philip Mchale
Chloe Montague
James Moore
James Morris
Will Morton
Partho Roy
Neah Shah
Lorna Smith
Paul Southworth
Catherine Stafford
Kuiama Thompson
Caroline Vass
Jenny Wares

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Samantha Bennett
Helen Gollins
Katharine Harvey
Elizabeth Lingard
Paul Madill
Louise Marshall
Joseph McDonnell
Rachael Musgrave
Oyinlola Oyebode
Jason Strelitz

Defined specialist portfolio route
Sara Atkin
Lisa Dodd
Susan Green
Derys Pragnell
Daniel Thomas

GENERAL MEDICAL COUNCIL REGISTER

Helen Barratt
Graham Brown
Mariana Dyakova
Aileen Kitching
Soo Fon Lim
Emily Youngman

Annual General Meeting

THE 43rd Annual General Meeting (AGM) of the Faculty of Public Health (FPH) will be held on Tuesday 23 June 2015 at 4.30pm at Sage Gateshead, St Mary's Square, Gateshead Quays, Gateshead, NE8 2JR, during the FPH annual conference. The AGM will note the admittance of new members and fellows to distinction grades of membership, prize and award winners, election results and the composition of the FPH Board for 2015-16. It will receive the FPH annual report and accounts for 2014 and reports from officers on the first half of 2015.

Proposals for topics for debate at the AGM are invited for consideration by the AGM Organising Committee. These should be sent to Caroline Wren at carolinewren@fph.org.uk by 1 May 2015. Each topic should be proposed and seconded by an FPH member in good standing and must follow the following format:

- synopsis of any proposed discussion item must be provided by 1 May
- proposer will take the floor at the AGM for a maximum of three minutes
- chair will allow brief comment by members present
- vote will be taken by a show of hands and chair will determine outcome either by estimation of result or by count if they so decide.

The number and range of topics taken to the AGM will be determined by the AGM Organising Committee. Some time will be allocated for free questions or comments to the officers of the Board.

Discussion will be reported to the full Board, which has responsibility for the strategic direction and policies of FPH. The Board will recognise these views but is not bound to accept specific proposals.

The AGM agenda papers will be available on the FPH online members' area or from carolinewren@fph.org.uk / 020 3696 1464, by Monday 1 June 2015.

Change to your annual CPD return

YOUR continuing professional development (CPD) annual return for 2014-15 is due to reach FPH by 30 April 2015. This is the return which states how many CPD credits you will be claiming for the previous year. The change brings forward the audit process so that those selected for audit will not be submitting during the main holiday season and will receive their results earlier.

Wilfrid Harding was the inspiration and driving force behind the establishment of our faculty. Here, on the centenary of Harding's birth, former FPH president **Alwyn Smith** celebrates his contribution

WILFRID Harding, who died in March 2010, was a figure of great importance to public health as a profession and to the Faculty of Public Health (FPH).

Born in Berlin as Wilfrid Hoffmann, one hundred years ago this year, he came to this country in 1933, originally to study at a Quaker school in Birmingham. In spite of having no science background, he then enrolled at University College Medical School, qualifying during the Second World War, his studies having been delayed by two periods of internment. After brief posts in hospitals, he saw service in Normandy and elsewhere in north-west Europe.

After demobilisation, he chose a career in public health and trained at the London School of Hygiene and Tropical Medicine (LSHTM). He was appointed Medical Officer of Health for the London Borough of Camden in 1965, a post he held until its abolition in 1974. He then became Area Medical Officer for Camden where he remained until his retirement.

There are three main reasons why Wilfrid is remembered as a particularly distinguished Fellow of FPH. First, he was an outstanding public health doctor. He collaborated with the LSHTM in the postgraduate training for the then Diploma in Public Health. I personally benefited from the practical experience he offered to those pursuing that course.

Second, he was pre-eminent in creating the Faculty of Community Medicine, as it originally was, in 1972. At that time our profession was threatened with imminent transfer from local government to the NHS, and it became important for public health doctors to have an organisation

Wilfrid Harding

comparable to those in clinical disciplines. Wilfrid's imagination, energy and a personal friendship with Max Rosenheim, then President of the Royal College of Physicians, led to the proposal to create a faculty of the three colleges of physicians (London, Edinburgh and Glasgow). That this immense undertaking became a reality was due greatly to Wilfrid's drive and reputation, not only within public health but within the medical profession as a whole. It is sad that he was not to become the first president of the faculty, but the second. The choice of Archie Cochrane as first president was probably influenced by the perceived need to have someone with an international reputation.

Wilfrid's third great service to the faculty was in organising the raising of the funds needed to acquire 4 St Andrew's Place. Wilfrid believed that the faculty's membership could be persuaded to raise the sum required, and, although serious doubts remained about whether this was feasible, he undertook an astonishingly successful campaign. It is not too much to attribute the possession of our headquarters to his heroic efforts. "Si monumentum requiris circumspice" can be loosely translated "Wilfrid got us this place".

The profession of public health has undergone more gratuitously inflicted disturbance than perhaps any other branch of the health professions in this country, much of it during Wilfrid's lifetime. The challenges he faced were met with courage, ingenuity and energetic zeal. Now, once again, we are threatened. I believe his spirit should inspire us.

Information

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