DIS-25.

Main identity

From: "MITRA" <info@mitra.org.in>
To: <sochara@vsnl.com>
Sent: Monday, December 29, 2003 11:26 AM
Subject: Happy New Year

Year 2003 has come to its end...and MITRA completed two years. Looking back at the year which has gone by, there were some high points for us and we thought we would like to share them with you!!

Under the brand building exercise undertaken pro-bono by TBWA-Anthem, India Calls, our volunteering program, has been renamed as 'iVolunteer'. In order to service the needs of volunteers and NGOs better, we have this year increased our presence to six cities in India-Delhi, Mumbai, Chennai, Banglore, Pune and Chandigarh. Since we believe that awareness amongst individuals in India about volunteering is very less, we organized a volunteer fair in Delhi in association with the students of the Department of Social Work, University of Delhi. The half-day fair where 20 NGOs set up their stalls, drew around 200 students. Our Chennai office also organized a half-day programme on creating awareness about different volunteering opportunities in Chennai amongst the professional crowd of Tidel Park, a software technology park in Chennai.

This year also saw us working with a few corporate bodies in the sphere of employee volunteering and with the American India Foundation (AIF) on placing their Service Corps Volunteers in the South of India.

Starting January 2004, MITRA has tied up with Voluntary Services Overseas (VSO) to recruit VSO volunteers from India to work in other developing countries in Asia, Africa and Eastern Europe. A typical VSO volunteering assignment last for 2 years and the volunteers are provided with Travel Assistance, Grants, Training support and a modest monthly allowance during the period of their placements. For the first batch of Volunteers who will depart in September 2004, we are looking for professionals in the skill areas of NGO Management, Microfinance, IT Training and Fundraising.

30/12

Bridging the Digital Divide

MITRA undertook an intensive study of four e-governance projects across India with the objective of having a better understanding of these projects in terms of their impact, cost and scalability for model building and charting out a roadmap for ongoing and future e-governance initiatives in India. Till date we have covered almost 4000 respondents in the three projects where primary data collection has been completed. The final project report will be ready by February 2004.

GKP Finalist

iVolunteer was one of the a finalist of 'The Inaugural Global Knowledge Partnership Youth Award 2003'. The Award aims to reward and bring international recognition to the outstanding work of young people who have used information communication technologies (ICT) for the promotion of development around the world. The Global Knowledge Partnership (GKP) is the world's first global multistakeholder partnership in ICT for

HRM/DS = Sub volunteer/ fellowship resource file
- pl. forward to Anand Bhan / Rakhal / Lalit / D-BS Manjunath / Dr Danny's.

30/12

Sent 30/12

12.30 '03

DIS-25.

Main Identity

From: "Girish N Rao" <girishnrao2002@yahoo.co.in>
To: "ComMedPGgroup" <commedpeople@yahoogroups.com>
Sent: Thursday, September 04, 2003 10:47 AM
Attach: two critical articles for good reading.doc
Subject: Two critical articles for good reading

9/4/03

Dear all

Please find attached a word document (20 pages). The one on obesity is from Community health list server - offering a lay mans perspective of the obesity crisis and down to earth too questions the professionalism and the second one I stumbled upon and that makes good reading especially if you have a public health background and is making it a career. Though it is UK centred it is more so applicable to the context of Karnataka. The moot question is whither public health?

I ask this question on the basis of a remark by a friend - please do let me know if I could forward articles which I think I could share: something which I have done now. I would not like to trouble if it is disturbing. So in this case I am blank marking the copy to individuals while addressing it to the comedpeople groups co-ordinated by Com Med PGs from Bangalore Medical College.

With thanks and regards.

Dr. Girish

lib Reserve file
Dr

This has 20 pgs attachments. Should I print it out? dot matrix print out pf
Dr 4/9

T.M
4/9

It's a Weighty Problem, But A Crisis? C'mon

By Fred Barbash

I am body mass challenged.

Okay. I'm chunky.

Okay, I'm obese. But I'm only obese technically speaking, based on my body mass index, the government's standard method for determining obesity. You'd never know it by looking at me.

But since I am technically obese, I find it heartening that there's rising concern about the "obesity epidemic." Perhaps it will encourage me to lose more weight. Perhaps a better understanding of the causes of obesity will help others with serious weight and weight-related problems. Perhaps Krupin's Deli will include on its menu a sandwich with just a couple of slices of corned beef as an alternative to the dozens of slices piled high.

Yet at the same time, the alarm over obesity causes me some alarm. I feel like a hunted man. I'm "wanted" for increasing the nation's economic costs by up to $117 billion a year. I'm reading about off the wall proposals to tax my next car as an incentive for me to walk, not drive, to Krupin's. I'm reading about nutty plans to tax my junk food and the TV set I watch when I eat junk food, as an incentive for me to get off the couch and eat an apple.

I'm not trying to make light of heavy. And no specific proposal is eating at me -- except that truly hideous suggestion that kids be sent home from school with body mass index report cards. I'm alarmed by the hysteria in the mass media, reflected in words such as "crisis" and "epidemic." There's been an epidemic of alarmist stories about obesity and its costs in the past year (about 2,000 according to my Internet search) that can only egg the politicians on to more foolishness and encourage insurance companies and perhaps employers to jettison another risk group.

I'm awed, as well, by the way in which a matter of personal responsibility has been transformed into a public crisis, whipped up by the uncritical news media, which swallow and regurgitate the crudest statistics about the most complicated of problems -- such as obesity.

This suits the agenda of an extraordinary variety of interest groups and academics, who, knowing of the media's new hunger for stories about the "crisis," duly produce studies demonstrating how their particular thing is actually the cause or it all. It's suburban sprawl forcing people to drive everywhere. It's health insurers who won't reimburse for Weight Watchers. It's video games. It's the lunches parents send to school. It's the lunches served by the schools.

The rise in obesity is not really new. Specialists have been worried about it for some time. The statistics indicating dramatic increases in obesity have been around for several years. It's a 20-year trend.

People who are overweight have certainly known it. That's why the number of those dieting (54 million) has risen parallel with the rise in

obesity, according to an April 9 study in the Journal of the American Medical Association.

It's the mass media that are just figuring it out.

Driving the story is a widely accepted and propagated statistic: Overweight and obesity cost society $90 billion to $117 billion a year. These numbers -- representing "economic cost" -- are critical for public policy. Economic cost, tallied by figuring direct medical expenses and indirect expenses such as lost productivity, has become the wedge by which government and allied institutions justify treating your business as everybody's business. Once, personal matters were personal matters. Now personal matters remain personal unless they have economic costs.

There are those who want the obese to pay for their obesity, so as not to burden the rest of society. Some proposals under consideration -- extra taxes on fattening foods, for example -- would shift the economic costs to me, in part to discourage the behavior which has supposedly led to my body mass index and in part, I suspect, to punish.

Allow me to respond personally to those behind these ideas.

Let's make a deal. If you would like me to pay for my body mass index, I will come back to you and find something you owe me.

Do you overwork, and suffer from workplace stress? That's $30 billion a year, says the International Labor Organization. Hand it over.

Do you bike long distances or run marathons or lift weights or do kakimo rolls in a kayak or go boating? Injuries from recreational activities cost $20 billion, says the American Academy of Orthopedic Surgeons. Pay up.

And don't get me started on occupational injuries, mental illness, bad driving, heavy drinking, body piercing and all the rest. All diseases and injuries -- and the behavior associated with them -- have economic costs.

Here's how it works practically. Most of us engage in risky behavior and are free to do so. When risky behavior becomes expensive behavior for society, our freedom shrinks. We get browbeaten. Or our behavior is made to seem antisocial through a campaign of negative publicity. Whatever makes our risky behavior possible -- say, fatty foods or fast cars or maybe someday skateboards -- gets taxed, possibly out of existence. It's not exactly Big Brother. Big Mother is more like it.

But how do we determine which costly behaviors are crises requiring institutional mobilization and intervention and which are not? Do we just start with the highest cost and work our way down?

At this point, the economic intervention model fails us and something pernicious takes over. The test becomes: Who can generate the most publicity? Whose costly behavior is also distasteful to a majority or perceived as immoral? We all remember the initial response to AIDS, a disease that is now viewed with appropriate compassion.

Fat people are already disfavored -- by employers, by insurance

companies, even by other fat people. In addition to having economic costs, obesity is considered unattractive and connotes, to many, slothfulness. The current cries of alarm may only make things worse.

I am not in favor of obesity. Who is? Even the Bush administration -- willing to overlook air and water pollution -- has joined the crusade against obesity. I accept that obesity is dangerously on the rise. I favor public health measures to alert us to its dangers and to help us slim down.

But assertions that we are in crisis tend to encourage crisis responses. Obesity is too complicated for that.

Consider, for example, the statistics showing a great rise in obesity among Americans. The definition of overweight and obesity is based on body mass index. Body mass index is a numeric scale based on a ratio of height to weight. Go to the Web site of the Centers for Disease Control (www.cdc.gov) and find their little body mass index calculator. I did.

A man 6 feet tall, according to the calculator, is obese if he weighs 280 pounds. That could make sense. He would still be obese if he lost 55 pounds and weighed in at 225. That makes less sense. He's "normal" at 180 pounds, which makes sense. But he's also normal at 137 pounds, which makes no sense at all.

By the body mass index, a man who is 5-foot-7 is "normal" at 120 pounds. Does that sound right? I am 5-foot-7 1/2. I once got down to 160 and looked drawn and emaciated. I hate to think how I'd look and feel at 120. Currently, I weigh 194 and am technically obese. But I play tennis with my 8 year old, go biking and kayaking, work out at a gym and feel pretty good. I have a stocky build, as did my father and both grandfathers.

I am, of course, taking the body mass index too literally. It's a range. The CDC says that many factors, including muscle mass, bone structure and family history must be considered. Body mass index is "only one piece of a personal health profile," according to the Web site. It's a screening device, after which one may decide whether to see a physician.

In other words, it's crude. Yet its crudeness does not prevent it from being applied to the entire population. Nor does it prevent the CDC and other health professionals from declaring that 64 percent of us are overweight and nearly half of that number, or about 30 percent, are obese, and that obesity has increased dramatically -- in fact, doubled in the past 20 years.

Calculating that increase is difficult because the data over time are not really comparable. The definition of obesity keeps changing. You may remember the day in the summer of 1990 when about 25 million Americans became overweight overnight. That was because the official definition of overweight changed significantly. On one day, a man 5 feet, 10 inches tall weighing 164 pounds was normal. The next morning, he was nine pounds overweight.

The estimates of economic costs are even more crude. The medical literature says that most diseases connected with obesity tend to have

multiple causes, some of which are indeterminate. Do you have sufficient faith in statisticians to believe that they can slice and dice the data to those diseases and declare with any precision that obesity is responsible for X percent vs. Y percent versus, say, family history or smoking or any combination of these or hypertension?

The health care professions and policymakers, of course, need these numbers to set priorities, raise money for their research and, necessarily, to raise alarm. But the news media find them irresistible and take them literally. This way, something complicated becomes simple.

But obesity is not simple. I recommend the April 9 edition of the Journal of the American Medical Association to anyone interested in this issue. It's entirely devoted to obesity. What becomes immediately apparent even to a lay reader is this: When it comes to obesity, as a professor of medicine writes, "many mysteries remain."

Can we, then, engage in such foolishness as body mass index report cards? Some school systems (Chicago, and one local school system in Arkansas) think so. I can hear the conversations over the dinner table at home: "You did great at math, dear. But you flunked the fat test. Thin out." Wasn't it just a few years ago that we were so worried that kids were so worried about their bodies? Whatever became of the "self esteem" crisis?

I'm a layman, not a physician. I don't question the seriousness of the obesity problem. But there's no need for panic.

On behalf of overweight people everywhere, I ask, please, call off the dogs.

Rachel's e-mail.

parbash@washpost.com

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'Taking public health out of the ghetto': the policy and practice of multi-disciplinary public health in the United Kingdom

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Abstract

Until recently, a medical qualification was required for senior public health posts in the UK National Health Service. Since 1997, the new Labour government has expressed its intention to take public health 'out of the ghetto' and to develop multi-disciplinary public health. In particular, it has announced the creation of a new senior professional role of *specialist in public health* equivalent to the consultant in public health medicine, and open to a range of disciplines. This paper asks 'what is really going on with the policy and practice of multi-disciplinary public health in the UK?' The answer draws on recent debates in the sociology of the professions, in particular the theoretical perspectives of Freidson (Profession of Medicine: a Study of the Sociology of Applied Knowledge, Dodd, Mead & Co, New York, 1970; Professional Powers: a Study of the Institutionalization of Formal Knowledge, University of Chicago Press, Chicago, 1986) and Larson (The Rise of Professionalism: a Sociological Analysis, University of California Press, Berkeley, 1977) concerning the 'professional project', Foucault's (Ideol. Consciousness 6 (1979) 5) notion of 'governmentality' and Harrison and Wood's (Public Admin. 77 (1999) 751) concept of 'manipulated emergence'. Key characteristics of the professional project are

'autonomy', the profession's ability to control its technical knowledge and application, and 'dominance' control over the work of others in the health care division of labour. Although useful as an explanatory framework for the period 1972–1997, the concept of the professional project does not easily explain the process of change since 1997. Here Foucault's concept of governmentality is helpful. Governmentality entails all those procedures, techniques, mechanisms, institutions and knowledges that empower political programmes. Professions are part of the process of governmentality, and their autonomy is always contingent upon the wider political context. Thus public health doctors have not abandoned the professional project; they have simply accepted the political reality that the boundaries need to shift rapidly from a politically unsustainable medical/non-medical distinction to one between those with and without expert knowledge. The concept of manipulated emergence helps explain why, having expressed a commitment towards multi-disciplinary public health, the government has not supported its policy more fully.

Author Keywords: Medicine; Multi-disciplinary; Policy; Profession; Public health; Specialist; UK

Article Outline

Introduction

A noteworthy experiment in developing multi-disciplinary public health is currently unfolding in the United Kingdom: a new senior professional role of *specialist in public health* open to a range of disciplines is being established within the National Health Service (NHS). A significant milestone in this process was a speech by the English Secretary of State for Health, Alan Milburn, in March 2000. As part of his argument for a wider process of 'modernising' the NHS, Milburn turned his attention to public health:

> [T]he time has come to take public health out of the ghetto. For too long the overarching label 'public health' has served to bundle together functions and occupations in a way that actually marginalizes them... [B]y a series of definitional sleights of hand the argument runs that the health of the population should be mainly improved by population-level health promotion and prevention, which in turn is best delivered—or at least overseen and managed—by medical consultants in public health. The time has come to abandon this lazy thinking and occupational protectionism. (Milburn (2000))

Milburn's condemnation of vested medical interests is not in itself surprising: such criticism of public sector professionals has been a recurrent theme in the modernisation project of the New Labour government since its election in 1997, and reflects a policy continuity with the preceding Conservative government (Harrison). What is new, however, is the application of this approach to the field of public health. One of the distinguishing features of the 1997 Labour government was the high-profile pledge it made to improve public health in general, and to tackle health inequalities in particular. These commitments were formalised in the White Paper *Saving lives: Our healthier nation* (Secretary of State for Health (1999)). Even before publication of the White Paper, however, the government set up a project to strengthen the public health function, with an explicit reference to the development of a multi-disciplinary public health workforce. Within the White Paper, a key element in its plans to improve health and reduce inequalities was a further specific commitment to develop a new non-medical role of specialist in public health. This policy change at the centre has been reflected in related changes in the practice of NHS public health. In 1998 a process was initiated to open up the examinations and membership of the Faculty of Public Health Medicine (FPHM) to non-medical applicants. From 2000, consultant level specialist in public health posts open to non-medical applicants were advertised in the professional press. In 2002, director of public health posts in the recently established English primary care trusts (PCTs) were opened to non-medical applicants.

These developments might lead the casual observer to think that policy and practice were indeed 'taking public health out of the ghetto'. But reality is rarely so simple. Keith [Macdonald (1995), p. xiii) reminds us of the key sociological question suggested by [Glaser and Strauss (1965)] about the professions: 'what is going on here?' Similarly, this paper asks 'what is really going on with the policy and practice of multi-disciplinary public health in the UK?' To answer this question we need to review what we already know of the professions of public health, describe and analyse the new policy of multi-disciplinary public health, and assess its implementation. Developments in public health need to be located within wider sociological debates about the changing role of medicine and other health professions. In doing this, three particular theoretical perspectives will be utilised: [Freidso (1970 and Freidson (1986)] and [Larson (1977)] concept of the 'professional project', [Foucault (1979)] notion of 'governmentality', and [Harrison

and Wood (1999) notion of 'manipulated emergence'. Finally, the implications of this policy development are considered and likely consequences suggested.

The origins of multi-disciplinary public health in the UK

It is widely recognised that the effective practice of public health requires multi-disciplinary and inter-sectoral partnership ([Bagott (2000)]; [Beaglehole]; [Cowley (2002)]; [Levenson, Joule,]; [McPherson]). Community development, education, health promotion, housing, medicine, nursing, social science and other disciplines all have a part to play ([Griffiths]). Within the NHS, however, public health medicine has been the pre-eminent profession, with senior public health posts restricted to doctors until 2002. The most detailed policy study of the development of public health medicine is [Harrison and Bruce Wood (1986 and Lewis (1991) work on the UK profession between 1919 and 1984. Lewis argues that public health in twentieth century Britain has assumed a number of different 'guises'. 'Preventive medicine' early in the century, 'social medicine' in the 1940s, 'community medicine' in the 1960s, and then back to 'public health medicine' in the late 1980s. Underlying these changes she sees a continuing identity crisis, driven by a central paradox: 'if public health is about the health of the people, then much more is involved than medicine... Yet any such widening of public health's focus threatened to weaken an already weak speciality further' (Lewis, 1991, p. 197). Lewis recounts what she sees as a series of failures—of social medicine to capture the hearts of 'service' (i.e. non-academic) public health doctors in the 1940s, of public health doctors limiting themselves to the role of medical administrators, and of community medicine to carve out a meaningful role after the 1974 NHS re-organisation, or to make public health central to the medical curriculum or as a medical speciality. Thus there has been continuing concern about its status as a medical speciality and ambivalence about its role.

Lewis's analysis ends in the 1980s before a number of significant developments for UK public health including the introduction of the NHS quasi-market in 1989–1991, the Acheson report on public health ([Secretary of State for Social Services (1988)]), and the Labour victory in 1997 and its policy to develop multi-disciplinary public health. More recently, however, a number of commentators have examined the changing professional landscape of public health in the UK. [Scally (1996)], himself a public health doctor, considers public health medicine in the new era of the NHS quasi-market and identifies serious structural weaknesses in the public health function, including the need for a more multi-disciplinary workforce. He also criticises his professional peers for the lack of a commonly understood and agreed theoretical basis, and argues for a sociological study of the public health function ([Scally (1996)], p. 780). [Gorava and Scambler (1998)], p. 149) identify the 'location paradox' facing the profession: 'public health physicians firmly located "inside" the health care system are arguably deterred by their management-orientated roles and by inter-professional rules of procedure and conduct from the *effective* pursuit of precisely that political and structural change "outside" the system which is a precondition for improved public health and reduced health inequality'. Other professional groups, in particular nurses, have increasingly questioned what they have perceived as a 'narrow medical definition of public health' ([De Witt]) and called for opportunities for leadership for their professions ([Cowley (2002)]).

McPherson ([McPherson, Taylor,]; [McPherson (2001)]) and others have written on the recent development of multi-disciplinary public health in the UK ([Levenson, Joule,], [McPherson]). [McPherson] describe the debates on multi-disciplinary public health from the early 1970s to the mid to late 1990s. A key moment was the establishment of the Faculty of Community Medicine (later FPHM) in 1972. At the time there was some discussion, particularly within the Society for Social Medicine, the

academic grouping of public health, about whether the new Faculty should be multi-disciplinary. But the lure of links with the Royal Colleges of Physicians was too strong, and the standing orders excluded non-medical professionals from membership and training. From the 1970s structured training was available for medical trainees, including M.Sc. courses in epidemiology and public health, most of which were only open to doctors. Even those M.Sc. courses which were open to non-medical applicants traditionally attracted few such students as there was no funding stream or career pathway for them. Thus public health remained equated with public health medicine. McPherson comments on the subsequent growth of the description 'non-medical' to describe other practitioners of public health, a problematic term which is both negative and groups together diverse occupational groups (e.g. nurses, social scientists).

New Labour new policy

The NHS Executive began expressing interest in developing multi-disciplinary public health even before the 1997 election but the new Labour government demonstrated a much stronger policy interest. Early in its new term the government commissioned the Chief Medical Officer to lead a project to strengthen the public health function. The interim findings of this project expressed a commitment to developing multi-disciplinary working ([Department of Health (1998)]). This commitment was developed and re-stated in *Saving lives*. The White Paper argued that the potential benefit of a more multi-disciplinary approach was huge: it announced a raft of policy measures aimed at developing multi-disciplinary public health capacity, including the establishment of the Health Development Agency, Public Health Skills Audit, Public Health Development Fund and National Public Health Workforce Development Plan. But the most radical proposal was for the creation of a new senior public health post for non-doctors. The White Paper also indicated that in time NHS director of public health posts would be opened to qualified non-medical specialists.

The first practical result of the new policy was the NHS Executive guidance on establishing PCTs, a new type of primary care organisation, which was circulated to health authorities in 1999 ([Department of Health (1999)]). An appendix to this document outlined the qualifications and competencies required of the public health member of the PCT executive committee. This indicated that the post could be filled either by a consultant in public health medicine or a non-medical professional with a masters in public health (or equivalent) and senior management experience. This was the first specific guidance allowing a senior NHS public health post to be filled by a professional from a background other than medicine.

At the same time the London School of Hygiene & Tropical Medicine published a feasibility study of the case for national standards for specialist practice in public health on behalf of the Department of Health ([Lessof, Dunnelow,]). The Department then commissioned Healthwork UK, the national training organisation for the NHS, to undertake a national project to identify and produce standards for specialist public health practice ([Healthwork UK (2000)]).

This commitment to creating senior multi-disciplinary public health posts is a major policy innovation. There is only one other specialty of medicine (pathology) where non-medical health professionals have an essentially equivalent status to medical consultants and are admitted to membership of a Royal College on an equal footing ([Royal College of Pathologists (2001)]). By contrast, the Labour government has also created nurse consultant posts which are more senior than previous nursing posts but are not equivalent to medical consultant posts. However, the government willed the end but not the means for policy implementation. Neither *Saving lives*, nor the subsequent (and much delayed) final report of the

Chief Medical Officer's project (Department of Health (2001)) gave details of how, when or by whom the specialist in public health posts would be created. Nor was there any detail on how 'equivalence' would be ensured. Neither document discussed the many complex and potentially time-consuming issues of implementation including training programmes, registration, quality control and responsibility for communicable disease control. Most notably, the government has not allocated any resource to support the implementation of this policy. The *NHS plan* (Secretary of State for Health (2000)) committed the government to a major expansion of the number of clinical medical consultants (7500), nurses (20,000) and general practitioners (2000) within the NHS. The *NHS plan* section on public health contains no workforce commitment whatsoever, nor does the Chief Medical Officer's report on strengthening the public health function promise any additional resource. When in 2002 96 English health were replaced by 300 PCTs, the new PCT director of public health posts were opened to non-medical candidates, but no new resources were allocated to fund the additional posts and no guidance issued on eligibility beyond the production of a specimen job description and person specification.

Specialist practice and multi-disciplinary public health in the UK

UK policy distinguishes between public health practitioners working at a community level (e.g. community development workers, environmental health officers, health visitors) and public health consultants or specialists working at a strategic or senior management level (Department of Health (2001)).

Until March 2002, the vast majority of specialist/senior public health jobs were held by public health physicians. Directors of public health at a regional and health authority level were required to be medically qualified, as were consultants in public health medicine and consultants in communicable disease control. A 1995 survey of public health departments found consultant public health physicians made up the largest group of staff (32%) with an additional 16% being medical trainees (Smith and Davies (1997)). The largest category of non-medical staff was research or information officers and epidemiologists (16%); these staff generally are employed in lower status support roles. There was no separate category for non-medical specialists in public health, a term then not in common usage. However, four percent were categorised as directors of health promotion, a relatively senior post. From 2000 to 2002, a number of posts were advertised by health authorities as available as either consultant in public health medicine or specialist in public health. Anecdotal reports suggested these posts were in practice usually filled by medically qualified candidates. It was notable that grades and salary scales were much higher for posts advertised as consultant/specialist in public health than for those advertised simply for specialists in public health.

Following devolution of the public health function from English health authorities to PCTs in April 2002, most of the 300 PCTs advertised for directors of public health. Job descriptions and person specifications broadly followed the national specimen developed collaboratively between the Department of Health and the FPHM. The specimen job description covered a range of responsibilities, but with a clear shift compared with previous health authority posts towards partnership working and tackling the wider determinants of health. The person specification required medical candidates to be on the General Medical Council specialist register and non-medical candidates to demonstrate 'evidence of learning and experience comparable with higher specialist training in public health medicine' (Department of Health (2002)).

The divide between public health doctors working at a senior level and non-medical practitioners usually working in more junior roles has been underpinned by differences in training, examinations, registration and membership of the FPHM ([Evans]). Since 1972 the FPHM has organised the specialist training scheme, run the qualifying examinations, admitted successful candidates to its membership, and recommended them for inclusion on the GMC specialist register. In the early 1990s a pressure group, the Multi-disciplinary Public Health Forum, was formed to persuade the FPHM to include non-medical specialists. This strategy was increasingly successful, with the Faculty's decisions in 1998 to open Part I of its professional examinations to non-medical candidates and in 2001 to open Part II and full membership ([FPHM (2001)]). New training schemes for non-medical specialists have been developed in most of the English regions. However, these schemes vary considerably in their length, salary, the qualifications candidates are expected to gain, and the extent to which they are seen as equivalent to the medical training schemes. There is, as yet, no 'gold standard' accreditation comparable to entry on the medical specialist register. Plans are being developed for a 'voluntary' register of non-medical specialists, although to date there has been no agreement on how such a register should distinguish between specialists and practitioners.

Public health professional project

In order to make sense of these recent developments in public health policy and practice we need to place them within the context of the wider literature on the development of the professions. The critical literature is that of the sociology of the professions, in particular the sociology of medicine. As [Coburn and Willis (2000), p. 379) comment, 'medicine has often been used as an analytical example to advance theories of the professions because medicine is assumed to be the epitome of what "profession" means'. Coburn and Willis are among a number of recent commentators, including [Annandale (1998)] and [Macdonald (1995)], who have surveyed this literature. As Coburn and Willis suggest, there is a conventional history of analysis of the professions that moves from 'trait theories' ([Carr-Saunders]) to 'functional theories' ([Parsons (1951)]) to neo-Weberian ([Freidson (1970)]; [Larson (1977)]), neo-Marxist ([McKinlay]; [Navarro (1976)]), [Foucault (1976)] and the postmodernists. Annandale, however, suggests the central importance of Freidson to these debates: 'Eliot Freidson's concept of "professional dominance" so successfully captured the collective imagination of a generation of sociologists that it continues to serve as the lens through which debates on the power of medicine are refracted' ([Annandale (1998)], p. 224). Freidson was writing about curative clinical medicine, but his concepts of professional dominance and professional autonomy are equally applicable to public health.

[Larson (1977)] builds on Freidson's work to describe what she and later authors have called the 'professional project'. Although in overall agreement with Freidson's analysis, Larson contributes a focus on technical knowledge as a commodity produced by the profession within the market place of capitalism. She argues that market relationships penetrate into all areas of life, and in particular into interactions between professionals and their clients. Professions construct a market in scarce and intangible commodities—technical knowledge. There is an inherent tendency towards monopoly in these relationships. This leads Larson to an exploration of issues around professional training ([Larson (1977)], p. 230–232). For Larson, training is equated with 'monopolistic centres for the production of producers'. She argues that there is an assumed equivalence between the quality and length of training. It is often emphasised that professional training must be prolonged, specialised and have a theoretical base—but never stated how long, how theoretical or how specialised training must be to qualify. Larson argues that professional practitioners are typically over trained; the entrant to the profession will typically learn far

more than they will be able to apply in practice. This excessive training is linked by Larson to standard setting: 'The profession is, in fact, allowed to define the very standards by which its superior competence is indeed...professionals live within ideologies of their own creation, which they present to the outside world as the most valid definitions of specific spheres of social reality' ([Larson (1977)], p. xiii).

The Freidson/Larson concept of the professional project remains an extremely useful framework for making sense of the policy and practice of multi-disciplinary public health in the UK. The practice of public health medicine between 1972 and the mid-1990s can be well described and analysed using the concept of the professional project. During this period, public health medicine was largely autonomous in controlling the technical content of its work and was dominant in the division of public health labour. Technical expertise was largely equated with epidemiology, bio-statistics and communicable disease control, although other forms of knowledge including planning and health promotion were also required. Public health doctors had a monopoly on senior NHS positions, successfully excluding other occupational groups through the mechanisms of FPHM membership and exacting training requirements. At the same time, other occupational groups including epidemiologists, information analysts and nurses, were subordinated within NHS hierarchical structures. Thus public health doctors successfully implemented both exclusionary and demarcationary strategies for professional closure. At the same time, however, there was a strong claim to ethicality within the public health medicine profession, with a strong emphasis on maintaining high standards through the long specialist training scheme.

Governmentality

Although useful as an explanatory framework for the period 1972–1997 (and indeed for earlier in the twentieth century), the concept of the professional project does not easily explain the process of change in the public health professions since 1997. It might explain the strong resistance to change from some elements within public health medicine ([McPherson, Taylor,]; [Taylor and Saunders (2000)]), but it does not account for the way the leadership and majority of voting members of the FPHM opted to open up professional membership to non-medical candidates. Here a second theoretical perspective provides a useful explanatory framework. Foucault's concept of governmentality ([Foucault (1979)] quoted in [Johnson (1995)]).

While praising Freidson's work as seminal, Johnson argues that Freidson remains tied to a concept of the state as an external calculating subject, a state that provides 'shelter', exerts control over the socio-economic terms of professional work, leaving matters of technical evaluation in the hands of professionals. Johnson argues that this conception ultimately leads us to incoherence, an incoherence Foucault's conception of governmentality allows us to overcome.

Following Foucault, Johnson defines governmentality as all those procedures, techniques, mechanisms, institutions and knowledges that empower political programmes. Professions develop as part of the process of governmentality; that is, they are part of the apparatus that constitutes the state. Thus Freidson's distinction between the profession and the state is not meaningful. Johnson argues that autonomy as a function of governmentality requires constant re-negotiation and re-establishment. In fact, the definition of the technical and the political—that is, their boundaries—are constantly in the process of transformation. It then follows that Freidson's view that the distinctive feature of a profession, autonomy in controlling its own technical work, is always contingent. Autonomy as an outcome of political

processes far from being reduced by 'state intervention' is a product of governmentality. There is a symbiotic form of professionalisation and state formation.

Governmentality helps make sense of the policy and practice shift towards multi-disciplinary public health since 1997. First, the shift is not as radical as it at first appears since public health medicine's professional autonomy and technical knowledge are contingent not absolute. Second, governmentality emphasises the inter-connection between shifts in the political process and the technical knowledge of the profession. In the case of public health medicine, wider socio-political processes challenge its technical knowledge through the questioning of medical expertise and performance, the lessening in deference and the growing assertiveness of lay explanations of health and illness, and the focus on inequalities and the wider determinants of health. The paradox at the heart of public health medicine outlined by [Harrison and Bruce Wood (1986 and Lewis (1991) makes it particularly susceptible within the wider medical profession to shifting political boundaries.

The concept of governmentality does not negate the concept of the professional project; rather it adds an additional appreciation of its contingent and political nature. In the case of public health medicine, it helps explain why the professional project has opened so quickly to the inclusion of non-medical specialists. The majority of public health doctors and their professional organisations have not abandoned the professional project; they have simply accepted the political reality that the boundaries of the project need to shift rapidly from a politically unsustainable medical/non-medical distinction to one based on the more easily maintained distinction between those with and those without expert public health knowledge.

Manipulated emergence

One question remains unanswered. Why, having expressed a commitment towards multi-disciplinary public health in *Saving lives*, has the government not proceeded to extend and implement its policy more fully? The concept of 'manipulated emergence' developed by [Harrison and Wood (1999)] is helpful in understanding the government's approach. They use this concept to explain the shift in the character of policy making from technocratic blueprints in 1970s, to a series of bright ideas accompanied by incentives for local actors to develop them into concrete organisational arrangements in 1990s. They identify a number of policy examples starting with the introduction of NHS general management in the mid 1980s, the NHS internal market (particularly general practice fundholding) in the 1990s, through to the new Labour government's policy initiatives (e.g. primary care groups and trusts).

In manipulated emergence, the centre decides the broad brush of policy (for example, a commitment to multi-disciplinary public health), and then leaves it to local actors to make it work. If and when apparently good models develop, the centre will take these up and disseminate them. Within the public health field this would suggest that once there are high-quality training schemes established, or new multi-disciplinary posts filled and fully working, policy will be consolidated and these models more widely disseminated. Thus the concept of manipulated emergence helps make sense of what the government has done in setting high aspirations for new non-medical posts, and then giving little detailed policy guidance.

Discussion and conclusions

Something very interesting is going on in the policy and practice of public health in the UK. Following a central government initiative, there has been a rapid change from a largely medical to an increasingly multi-disciplinary public health specialist workforce: the centrally driven nature of this change in the UK appears to be without precedent or parallel in public health policy in the rest of the developed world. Although other countries (e.g. United States) have developed multi-disciplinary public health workforces, the combination of a dominant medical public health speciality, and a central policy drive to challenge such dominance, appears unique to the UK. Nevertheless, this UK policy experiment provides a case study from which wider lessons can be drawn both on the potential to develop multi-disciplinary public health in other countries, and on the utility of theoretical frameworks in understanding health professions.

This paper has drawn on three theoretical approaches to try to make sense of this policy process: the professional project, governmentality and manipulated emergence. These theories have been shown to be consistent with the empirical evidence and offer a potentially useful explanatory framework. However, one must be careful not to conclude from such apparent consistency that these theories offer the only or even the best theoretical understanding of the evidence. A number of other theoretical or conceptual approaches exist which might also help us understand the complexities of shifting policy on multi-disciplinary public health. To name but a few, one might apply [Alford (1975)] theory of structural interests, [Pettigrew, Ferlie and McKee (1992)] concepts of receptive and non-receptive contexts for change, economic approaches to incentives and health policy ([Hausman]), or recent work on the social networks of health care professionals ([West, Barron, Dowsett,]). The real test of the theoretical frameworks applied in this paper will be how well they predict the future, as well as explaining the past. These theories might be used to generate hypotheses about the future of multi-disciplinary public health which could then be tested empirically in further research, and conclusions drawn about their utility.

What then, does this analysis suggest about the future of multi-disciplinary public health in the UK? A number of commentators have suggested that public health in the UK is marginal to the mainstream health care sector, lacking in adequate infrastructure and direction and facing an uncertain future ([Hunter]; [McPherson (2001)]). There is no public pressure to invest in public health, as there is in clinical health care, and public health requires a long term perspective which does not fit well with the short four or five year election cycle perspective of governments. The current UK government exhibits something of an ambivalence towards public health. On the one hand, it has made much of its commitment to public health, and in particular its determination to address health inequalities, on the other hand, it has not matched its rhetoric with investment in the public health infrastructure. This may be partly due to its ambivalence towards public health medicine as a profession, and a sense that the profession has not delivered. There is a lack of evidence base on what public health structures, workforce and skill mix are effective in delivering health improvement and reducing inequalities ([Beaglehole])

The government has introduced a new policy to develop a more multi-disciplinary public health workforce. However, the reality of policy implementation and public health practice lags far behind the rhetoric of the policy. Previous policy distinguished between public health doctors and support staff. The current policy speaks of multi-disciplinary public health and suggests an equivalence between medical and non-medical specialists. However, it is arguable that two separate but unequal professional projects have been established: one centres on the continued role of public health medicine, the other on the creation of a new multi-disciplinary public health professional grouping. The latter is multi-disciplinary in that it includes professionals from a range of professions, but by practice and implication it is not universal: it does not include the pre-eminent profession of public health medicine. Despite the rhetoric of inclusion and equivalence, in practice there is continuing demarcation between medical and non-

medical public health jobs. Regional director of public health posts and consultants in communicable disease control remain restricted to medical candidates. Non-medical directors of public health in PCTs earn between £15–20,000 less than medical colleagues apparently doing the same jobs. Although the FPHM has opened its examinations and membership to non-medical candidates on an equivalent basis, there are many structures that remain essentially uni-disciplinary. Public health doctors are still firmly in control of key processes that confer autonomy: accreditation, training and standard setting. It remains the Faculty of Public Health *Medicine*, with an official Journal of Public Health *Medicine*, and remains a Faculty of the three UK Royal Colleges of *Physicians*.

Thus the public health medicine professional project continues. Weakened by a long-term and fundamental paradox at the heart of its project, and buffeted by a new government determined to challenge professional protectionism, the profession of public health medicine has responded by shifting the boundaries of the profession. Rather than attempting to maintain an unsustainable demarcation between medical and non-medical, the profession has redrawn the boundary line between public health professionals with expert technical knowledge and those without. To date the government has accepted this definition, but without committing the resource to allow comprehensive implementation. As suggested by the concept of 'manipulated emergence', the government may be content to wait and see what success the public health field has in developing new models of public health practice.

In the short to medium term, it is likely that public health doctors will continue to dominate the professional practice of public health in the NHS. It will take a number of years to train a new cadre of non-medical specialists in public health. Some employers will continue to prefer medical specialists, as it will be thought they are better able to fulfil the traditional NHS roles of providing support in commissioning acute health care services and managing communicable disease control. At a less conscious level, some employers may favour public health doctors due to a residual trust in doctors that may be more important than the formal certification of non-medical specialists (McDonald (1995), p. 30). The FPHM is arguing for financial equity for specialists in public health, an act which can be seen as either altruistic or a clever intervention to ensure that consultants in public health medicine are not priced out of the market. There is continuing tension and debate over the added value clinical knowledge gives to public health doctors, particularly in the area of communicable disease control.

In the longer term, it is likely to be difficult for public health doctors to sustain medical dominance of NHS public health. The current strategy of opening up specialist status to qualified non-medical candidates, while maintaining a sharp demarcation between specialist and non-specialist practitioners, will gradually dilute medical control of professional institutions. Junior doctors may be reticent to join what will be seen increasingly as a low status, marginal and threatened medical speciality. Alternatively, a new divide may emerge between public health doctors who specialise in evidence-based medicine, clinical governance and the effectiveness and efficiency of acute clinical care, and non-medical specialists in public health who address partnership working, inequalities and the wider determinants of health. Boundary tensions are likely to continue, and to increasingly focus on the divide between specialists in public health with and without registration. Public health nurses, for example, who have achieved consultant nurse status, but are without Faculty membership and/or registration, may challenge the medical model of the professional project. Much will depend on the strategies adopted by the emerging cadre of non-medical specialists. They may challenge the medical profession's strategies of exclusion and demarcation or they may adopt their own strategy of dual closure (Witz (1992), pp. 48–50) resisting medical demarcation while employing their own exclusionary strategies to non-specialist practitioners. There may be increasing lay, local authority and/or voluntary sector challenges to the NHS

orientation and control of the professional definition. If the real determinants of public health are to be found outside the NHS, a definition of public health work based on the health sector is unlikely to be accepted.

The increasing importance of european and international aspects to public health work (McKee); (McMichael) may also undermine a UK specific definition of the specialist in public health. Public health is a broad and complex movement, with competing ideologies, discourses and sectional interests. The lesson of Foucault's concept of governmentality is the contingent and political nature of professional bargains with the state. The creation of the posts of non-medical director of public health and specialist in public health is not the end of the process of change; it is more likely to mark the beginning of a wider process of turbulence and challenge in defining the boundaries and membership of the public health professional project.

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Volume 24, Issue 6, September 2003, Pages 939-967