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'Engaging health professionals in action on unhealthy housing'

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The views expressed are those of the author and are intended to open debate. They are not necessarily shared by the organisations he is associated with.

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'Poor people live in poor houses, and suffer from poor health. They use more primary medical care and die earlier than wealthier people who live in better housing. This association between poor health and poor housing is partially causal.

From a public health perspective a major housing priority is fuel poverty. The primary focus of the fuel poverty strategy should be directed at improving the thermal efficiency of housing in a more cost-effective way. Fuel prices, income and employment, and the residents of houses change over time. But the house is a constant. Improvements in thermal efficiency are therefore a sustainable benefit for all future residents no matter what their income, health, or age.

Cold, damp, thermally inefficient houses which people cannot afford to heat sufficiently to protect their health are a peculiarly British public health scandal and an affront to human rights. Successive governments, over many decades, have done far too little to introduce evidence-based public health regulations into housing standards. As a result millions of people live in houses, which damage their health and quality of life, add to their financial problems, and contribute massively to excess winter mortality and pressures on the NHS.

The problem of the vast numbers of thermally inefficient houses has been recognised by the current government after effective parliamentary lobbying. The Fuel Poverty Strategy was introduced in 2001. During this Parliament new laws on housing standards will introduce the Housing, Health and Safety Rating Instrument (HHSRI). This is a risk-based assessment system. Over time it will provide a regulatory fulcrum; public health evidence can then be used as a lever to improve housing standards.

The sheer size of the housing problem will take time to deal with and some priority must be given to vulnerable people. Health service professionals have considerable contact with them, and are often the most trusted confident of elderly, isolated people. They provide a means of accessing many of those in the greatest need and are a source of effective advocacy. This should run in parallel and be supported by a community development programme.'

Dr Noel Olsen, Draft from a Report to Fuel Policy Advisory Group, April 2003.

'There is nothing more difficult, more perilous to conduct, nor more uncertain in its success than to take the lead in a new order of things. The innovator has for enemies all those who have done well under the old conditions and lukewarm supporters in those who may do well under the new. This coolness arises partly from fear of the opponents who have the law on their side and partly from the incredulity of men who do not readily believe in new things until they have experience of them.'

The Prince, Niccolo Machiavelli, 1469-1527.

Introduction

Engaging health professionals on housing and health may seem a rather dismal prospect as one reads of the increasing concern from doctors and others about their new contract proposals. High work pressures from an open-ended demand based primary care system, staff shortages and above all low morale are not an auspicious time to engage in discussions to widen yet further the responsibility and workload of the primary care team.

To most NHS health care professionals the concept of referring a patient for a home improvement grant creates an image of yet more work and responsibility beyond this current, stretched, contract. They are concerned about breaching confidentiality, and anxious about acting as advocates to vulnerable patients for something they may see as akin to double-glazing salesmen.

Most GPs have little contact with housing departments. When there is contact it is usually at times of crisis - crisis on both sides when telephoned emergencies from an anonymous professional from another agency arrive to usurp working priorities already stretched. Usually both sides are seeking solutions which are not to hand. In addition, for many doctors contact with housing officers brings back memories of endless letters seeking medical priority points for rehousing. Doctors knew that all extra points did was move the patient's position in a queue from behind to in front of another of their patients who already had a letter. As the housing queue was not moving forward[1] because of shortage of supply the exercise promoted frustration. The problem was compounded when, for example, after enormous effort a family with a child with asthma of increasing severity was moved from a cold, damp flat. No changes were made to alleviate the structural problems and a few days later another crisis family with a new baby moved in to restart the cycle.

However, I believe that the somewhat dormant altruism of health care professionals is powerfully on our side. Housing improvements to improve thermal efficiency and alleviate fuel poverty are the sort of project, which could re-ignite the tremendous job satisfaction, which used to give such pride to working in the NHS. Provided the housing and health evidence and benefit of referrals can be shown, the bureaucracy minimised and identifiable health improvements achieved, it is the sort of programme that will attract participation. It reduces health care workload, improves the quality of patients lives and adds to job satisfaction. It may also appeal to the concerns of many about environmental sustainability and climate change.

It is also necessary to get commitment from the Department of Health and the NHS bureaucracy. Concern for process rather than health outcome, and slowness to give priority to evidence based intersectoral working is a problem in all bureaucracies. The Americans have bunker busting weapons - the internet does not record whether these can be deployed against bureaucracy!

Benefits of the Fuel Poverty Strategy

The benefits and outcomes of the Fuel Poverty Strategy can be measured in:-

- **Health and improved quality of life, and in particular:**
  - **'feel good'**
  - **reduced excess winter mortality,**
  - **reductions in the incidence, prevalence, or severity of a variety of diseases including:**
    - **coronary heart disease**
    - **strokes**
    - **asthma**
    - **bronchopneumonia and other respiratory conditions**
    - **symptomatic improvement from arthritis and rheumatism**
  - **reduction in depression**
  - **reduced home accidents**
- **reduced bed-blocking and winter pressures on the NHS,**
- **reduced demands on health care professionals**
- **Delay in loss of independence particularly in elderly or severe chronically disabled people, with maintenance of autonomy and pride**
- **Increased practicality of care at home in chronic disease and terminal care**
- **Reduced social isolation in winter**
- **Improvements in capacity for homework and consequent improvements in GCSEs and A levels particularly in disadvantaged families**
- **Financial savings and opportunities to spend energy savings on healthier diet, or other chosen priorities**
- **Perhaps most importantly in the longer term, reduced energy consumption and some reduction in the health and environmental effects of global warming**

Successful implementation could provide an exemplar of joined-up government. It is also the sort of programme much needed to bring back to many health service (and other) staff a sense of job satisfaction through a feeling of altruistic contribution to a wider health, environmental and societal benefit than is possible in routine, often repetitive work.

Housing and Health Research

There has been a paucity of good health and housing research In the UK over many years as Thomson et al from the Medical Research Council showed in a systematic review of intervention studies[2]. Many have struggled because of the lack of a research culture in housing organisations and the difficulty in getting funding for inter-sectoral, multi-professional work. As chair of a small statutory research council, the Alcohol Education and Research Council, the difficulties you face are only too well known. There is no equivalent in housing and health to the British Heart Foundation or Cancer Research UK with their massive fundraising and support to researchers. Rowntree does what it can, but in housing and health, government has largely ignored the need for research and evidence.

Consequently, the attributable proportion of premature death, disease and ill-health due to poor housing is not accurately known. Similarly, we cannot predict the extent of the health gain that will result from improving housing. This is not an excuse to delay housing improvement, nor to ignore the input that a health perspective can contribute to

raising housing standards. It does however emphasise the need for more and better evaluation of housing programmes. Combined health, social, and environmental impact assessment[3] is seen by many as the way forward.

Justification for Action and Intervention Research

There is more than enough evidence to draw clear conclusions and there have been a range of first class and authoritative reviews. For example, last week the National Heart Forum published a toolkit on Fuel Poverty***[4].*** This was endorsed by all of the Medical Royal Colleges, and supported by a range of other organisations. Last month, the Royal College of General Practitioners published their report 'Housing and Health'[5] and next month the British Medical Association Board of Science will publish a hard-hitting report on the same subject with many recommendations to government.

The link between housing and health has been explicitly made by the Prime Minister in the health white paper

> ***'In our country today, too many people suffer from poor health. Too many people are ill for much of their lives. Too many people die too young from illnesses which are preventable…. there is a vital role for government too. Not as the so-called nanny state in action. But the government addressing the big issues which affect our health, like housing, jobs and education'***
> ***Tony Blair, Prime Minister. In Saving Lives: Our Healthier Nation 1999. Stationery Office***

Acheson in his Report on Inequalities and Health stated

> **'We recommend policies which aim to improve the quality of housing. Specifically: we recommend policies to improve insulation and heating systems in new and existing buildings in order to reduce further the prevalence of fuel poverty.'**
> **Sir Donald Acheson, Independent Inquiry into Inequalities in Health, 1999. [6]**

In terms of promises for funding the Treasury in their crosscutting review on inequalities identified housing as one of the four health inequality priorities for the Spending Review 2003-2006.

> ***'The review identified a number of specific actions for the Spending Review (2003-2006) period, …..Improved housing conditions for families with young children and for elderly people'.*** **HM Treasury, 2002 -** Cross cutting review on tackling the causes of health inequalities, Chapter 29, **2002 Spending Review New Public Spending Plans 2003-2006 Opportunity and security for all: Investing in an enterprising fairer Britain HM Treasury** July 2002.

Medical evidence on health and housing

In this paper and particularly before this audience I do not intend to describe in any detail the links between fuel poverty and health nor the public health consequences of cold, damp, poorly ventilated housing. Only a few references are included, but the Toolkit and BMA report enable access to the literature.

> ***"The impact of multiple housing deprivation would appear to be the same order of magnitude as addressing the issue of smoking and the risk to health posed by multiple housing deprivation seems to be, on average, greater than that posed by excessive alcohol consumption…' ..'Overall once other factors have been controlled for housing plays a significant role in health outcomes. The two exhibit a dose-***

response relationship: greater housing deprivation at a point in time will lead to greater probability of ill-health. A sustained experience of housing deprivation over time will increase the probability of ill-health. Housing history matters. Living in non-deprived housing conditions in adulthood is more likely to be associated with ill-health among those who have experienced housing deprivation in earlier life than others.

Marsh, Gordon, Pantazis & Heslop. *' Home Sweet Home? The impact of poor housing on health*[7]*'*
(data from the National Childhood Development Study)

An editorial in the British Medical Journal is available free on line from *BMJ.com*

'Few people choose to live in cold damp homes that they cannot afford to heat well enough to protect their health. Yet for millions of British households this is the reality of poor quality housing, inefficient heating systems and inadequate building standards stretching back over generations.

Olsen N, British Medical Journal (Editorial), 2001; 322: 748-9

The three major medical reports published between January and May 2003 from the National Heart Forum, from the Royal College of General Practitioners and from the British Medical Association, Board of Science provide up to date information and are from sources seen as authoritative and acceptable to health professionals.

Aims of this paper

This paper concentrates on:

1. **how to achieve greater engagement from health service professionals on the ground.**
2. **the need for the Department of Health and NHS to monitor Fuel Poverty and housing action through performance reviews and Health Service Frameworks**
3. **the need to create a housing, fuel poverty and health forum to catalyse knowledge and action and drive improvements.**

The Law school is an appropriate venue because of the human rights issues.

'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control'. Article 25 (i) Universal Declaration of Human Rights.

The European Charter, as enacted in British Law, does not expressly incorporate the Universal declaration, but excess winter mortality would appear to breach one part of the charter and landlords who wilfully refuse to improve thermal efficiency would seem be challengeable under others from a public health perspective!

Drawing from comparators and modelling

The evidence Marsh produced from the National Childhood Development Study, put poor housing between smoking and alcohol abuse as a health hazard.

"The impact of multiple housing deprivation would appear to be the same order of magnitude as addressing the issue of smoking and the risk to health posed by

multiple housing deprivation seems to be, on average, greater than that posed by excessive alcohol consumption…'

I will digress to draw from my experience in these other areas to suggest how health professionals can be engaged

My early medical career was in chest diseases. Early on I developed an interest in medical audit - the study of how well doctors do their job. 30 years ago if you studied how good your boss was at his job and how appropriate and effective prescribing was you tended to move rapidly and far!

Soon I found myself working as an isolated Consultant Physician in a desperately poor area of East London. The benefits of the Clean Air Act were already clear, but tuberculosis, asbestos, asthma, chronic bronchitis and lung cancer filled my time. Poverty, poor housing and smoking were the main up-stream causes of the diseases I tried to treat but I had to work with drugs and surgery rather than embark on the sort of social engineering that was so obviously needed to deal with the causes of the causes of the diseases that filled my clinics and wards.

My first review as a Consultant was into the outcome of patients with lung cancer. I found my unit had a 95% mortality rate. In other words, a disease entirely preventable by giving up smoking was effectively untreatable. I presented my results at a clinical meeting in one of the major centres. Attacked by some colleagues, others, more aware of outcomes, agreed and showed virtually the same results.

One of those Consultants who encouraged was Professor Charles Fletcher, the first doctor ever to give penicillin to a patient. The first TV doctor, he made a series of programmes called 'Your life in their hands' which opened up medicine to popular scrutiny and did so much to demystify it. He was also the author of a seminal book on medical communication and one of the great epidemiologists of his day. Charles had been responsible for the first report Royal College of Physicians report on Smoking and Health in 1962. Despite the overwhelming medical evidence government had not taken action to reduce smoking. So after an interval of 10 years, he had produced the second College report and was starting an organisation called Ash (Action on Smoking and Health).

It is interesting to note that the vast majority of doctors had already stopped smoking. Not just because they had read the evidence and made a decision, but in part because of the British Doctors study which personalised it.

Doll and Hill, who first showing the link between smoking and lung cancer in 1952, had initiated this by collecting smoking and health information from every Doctor on the Medical Register. As doctors died details of age and cause were collected. Soon every doctor was very aware of the overwhelming evidence linking smoking and doctor's health. They took action in relation to their own addiction. Charles Fletcher was determined to recruit doctors as an agent of change. Ash was set up to keep the issue in the public eye and to politicise it through medical advocacy.

After Doll and Hill's first paper on lung cancer in 1952, there had been some publicity and the powerful and wealthy tobacco industry began to entrench. The first College report in 1962 led to massive publicity and for a short while there was a small drop in smoking nationally. Soon this effect wore off and the inexorable rise in tobacco

consumption fuelled by advertising and an improving economy continued. From the time of the second College report it began to level off and as Ash began to campaign, armed with little money but first class science and phenomenal support from the medical profession, smoking began to fall. From 1975 to 1994 smoking prevalence fell from 45% to 27% of the adult population. The Chancellor, under pressure from many health bodies, increased taxation in every budget except one. We did not achieve significant legislation until after a change of government. It may have been significant that Mrs Thatcher later became a highly paid consultant to Philip Morris, owners of Marlborough the biggest selling brand in the World. She would jet off to wherever an advertising ban was suggested. Kenneth Clark, the former Health Secretary and Chancellor of the Exchequer became vice Chairman of BAT!

The input of health professionals was phenomenal. Smoking became the most heavily researched risk factor of all time, and gradually non-smoking became the norm in hospitals and clinics, and also in doctor's homes. After initial research into effectiveness, GP advice moved fairly quickly to becoming routine. Today, it is considered unprofessional for a doctor not to advise a patient about smoking.

Health organisations and individual doctors bombarded politicians with demands for higher taxation, bans on advertising, action on passive smoking and tighter controls on marketing. It was a formidable lobby and almost entirely unfunded. It was also great fun, and if the reaction of the tobacco industry means anything it was effective. A side-effect was that tobacco companies became a pariah and employment by them was something people hid. The industry had increasing difficulty in recruiting the most able and more strategically thinking graduates. It became increasingly desperate and ruthless, and became dominated by marketing people with little concern for the morality of the issue. They also spent a fortune suborning scientists and denying the evidence[8,9]. This has been the cause of some of he most costly legal settlements in history as cases are won in courts around the world, but sadly not in the UK.

I became Honorary Secretary of Ash in 1975, a post I was to hold for 19 years. I am still Honorary Secretary of the International Agency on Tobacco and Health (IATH), which supports tobacco control advocates in over 120 developing countries across the world. Later I spent 6 years as Hon Sec of the National Heart Forum, and was also Chairman of the Policy Committee of Alcohol Concern. It is this sort of experience that I want to draw on to describe how to engage the medical profession on housing and health.

Engaging health Professionals

- **Clear but narrow objectives and realism about responsibilities**

Clarity of objectives and realism about current responsibilities is essential. It is not the job of the health service to provide decent housing for its patients, but it is health service professionals who see the effects of bad housing - and particularly the effects of cold, damp, poorly ventilated housing - on the health of their patients. They have the added burden on their workload. Professional commitment and involvement in intersectoral fuel poverty or housing improvement referrals to benefit health does not require doctors and nurses to become experts on energy efficiency or housing. The objective is to enable referral to housing professionals and improvement agencies.

- **awareness and recognition of fuel poverty and poor housing as a health issue - marketing health information**

The BMA and the Royal College of General Practitioners reports together with the Heart Forum Fuel Poverty Toolkit provide evidence, legitimisation and advice for professional action. Unfortunately, the existence of a report in a library does not guarantee awareness of content. All health professionals - nurses, midwives, occupational therapists, GPs, receptionists, cardiologists, chest physicians etc must be aware that a cold, damp, poorly ventilated home might be one of the contributory causes of a patients illness such as a coronary, stroke or pneumonia. Depression, social isolation or premature admission to care in an old person; exacerbation of asthma or failure to thrive in a child are all prompts to look for remediable causes and an opportunity for preventive action on fuel poverty or poor housing. The Pharmaceutical industry has expertise in marketing information to doctors. It is how they sell their products. The techniques they use should be studied. Organising conferences and inviting representatives is only a small part - what works is personal contact and the use of existing networks and professional distribution systems and peer-reviewed journals which are routinely used and trusted by the target audience.

- **Access to vulnerable people**

Health professionals have most contact with vulnerable people and are often the most trusted confidants and advisers of isolated, old people. 21% of people over 75 have consulted their GP in the last two weeks[10], and over 90% in the last year. By comparison around 2% of over 85 year olds receive social service home care and about 1% meals on wheels.

- **Support from other community contacts**

There are other professionals with high levels of contact with vulnerable people. Postmen, village post office staff, chiropodists and a vast array of volunteers and voluntary organisations, such as Age Concern can all contribute to raising awareness and referrals. All can contribute, by involving the NHS there is opportunity for targeting the most vulnerable people in society, and building on the many networks they are part of. Voluntary organisations and community networks raise awareness and reinforce messages. Warming the village hall through improved energy efficiency might be one appropriate and effective way of getting a message over!

- **Personal experience**

Not all health service workers are as well paid as doctors, and fuel poverty will be a personal problem for some. Many others will have elderly relatives or neighbours who will also benefit. Good experience of improvements will augment referrals and improve advocacy.

- **Simple referral systems**

Health service professionals are busy. If their support is sought, it is beholden on scheme managers to establish simple referral systems. These should not require more than a few seconds in a short consultation to activate. If awareness of the possibility of intervention is linked to a simple referral system, action becomes easy. The arrangements must be compatible with professional duties of confidentiality. Limited feedback should be provided about process, time-scale and outcome so that patients do not turn to the health professional to find out when the promised service will be made available. The system must not create extra workload or responsibility for the NHS, it must be friendly and ideally it should be comprehensive. It can, for

example, be associated with a welfare benefits check, a review of home security, and a home-health check.

- **Involving management and bureaucracy**

Unfortunately, building evidence of benefit, raising awareness and interest in health professionals, endorsement by the major professional organisations and the Chief Medical and Nursing Officers[11] and establishing simple referral systems so that this interest can be appropriately channelled, are not sufficient. There must also be organisational buy-in at every level and legitimisation by what is widely seen as a burdensome and inhibiting NHS performance management system. Ministerial support and rhetoric is strong, and many key professionals up and down the service have contributed. But the NHS has not yet joined up. Waiting lists, national service frameworks, public service agreements, priorities, performance management reviews and the perambulations of Ministers round the NHS could all provide fleeting endorsement by comment or question on fuel poverty action. At present there is noise but no signal. The NHS Chief Executive needs to be reminded of the Celsus dictum.

'Diseases are cured by remedies, not by rhetoric' *Celsus AD 52*

Primary Care Trusts are the lead NHS organisation in assessing need, and improving health. Their responsibilities include participation in Local Strategic partnerships. They are also responsible for health improvement Plans (HIMPS). HIMPS are part of wider local plans for the delivery of services. They and their staff have been subject to repeated reorganisation.

'We trained hard; but it seemed that every time we were beginning to form into teams we would be reorganised. I was to learn later in life that we tend to meet every new situation by reorganising and a wonderful method it can be for creating the illusion of progress while producing confusion in efficiency and demoralisation.' Usually but incorrectly attributed to Gaius Petronius 66AD.

Some PCTs are fragile, most are overburdened and few are looking for yet more to do. Fuel poverty is however the sort of win, win, win programme that can engage enthusiasm but require little from the NHS other than legitimation.

- **Disease is the justification for action, but not necessarily the best method**

In the past there has been medicalisation of many issues. This is neither necessary nor desirable. The purpose of the exercise is to improve housing and to identify vulnerable people so that they can be given priority in what is inevitably a massive programme over many years.

'The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social' Geoffrey Rose[12]

- **Building wider organisational support**

In the future Local Strategic Partnerships may become the driver for housing and health improvement. In the meantime the Director of Public Health provides a potential access point into all the agencies and to health professionals at the local level. All have received a copy of the Fuel Poverty Toolkit from the Faculty of Public Health. Targeting Primary care trust non-executives may also provide valuable

reinforcement. Their contact in other local spheres may be invaluable. It should be emphasised that it does not matter who puts an issue on an agenda and drives it. What matters is that someone does and that all see opportunity for participation by identifying with the benefits. A sense of corporate ownership is desirable.

Summary and conclusion

Health professionals go through stages in taking on new issues. Achieving behavioural and particularly professional change can be difficult and needs catalysts. The following checklist summarises the key principles.

Awareness

- Links between housing and health
- Recognition that problems presenting to them are linked to housing conditions
- Postgraduate education and reading about association and causality
- Authoritative reinforcement by professional bodies

Interest

- Local agency makes friendly contact - 'need your help how can we work together to benefit your patients'
- News of successful local pilot study
- Simple system, minimal work, no ethical conflict
- Consistently good news about scheme from patients and colleagues

Trial

- Easy referral system, ethical approval
- Acknowledgement of referral, with timescale for action
- No hassle implementation
- Good patient feedback
- Final summary letter to referrer - work satisfactorily completed, basic information on expected outcomes and benefits, thanks for referring, supply of simple forms, offer to fund search for more cases through records

Adoption as routine professional practice

- After trying a few more and seeing that arrangements are straightforward and beneficial trialists will begin to mention to colleagues, and perhaps raise the issue at practice and professional meeting,
- Gradual shift from experimenter, to routine user, to advocate
    - system within practice
    - advocacy with colleagues
    - professional pressure through LMC
    - support for priority within primary care trust

Sytematise

Look for opportunities to systematically achieve benefits for all patients - practice protocol

- Antenatal booking clinic
- New patient registration, retirement visit, elderly visits
- Chronic disease registers
    - Chronically disabled
    - Asthma
    - Heart disease
    - Stroke
    - Chest infections in elderly

    - Arthritis
- Systematic receptionist review
- Council tax band A and B housing

Cultural norm

Mopping up the residue - 'hard to reach people'

- **Tudor Hart's 'inverse care law[13] (paraphrased)**

  'those who get are those who know and demand, rather than those in greatest need who do not know. Inequity occurs because no one goes out and finds those in the greatest need.' **Julian Tudor Hart**

  In a 30 year follow-up to his inverse care law paper Tudor Hart [14] states: ***'the inverse care law is not a law of nature, but of dehumanised market economies. It could be unmade by a rehumanised society'***

Support for a Housing, Fuel Poverty and Health Forum.

Lack of research funding, poor service interaction and collaboration, the different language and approaches of the voluntary and professional organisations and diversity of objectives have hampered identification of the synergies between programmes. Energy efficiency, housing design and regeneration, poverty and public health have had no meeting place where disciplines and organisations meet routinely. The creation of a Housing, Fuel Poverty and Health Forum could catalyse better collaboration in research based policy development and help identify and disseminate good practice. The multiplicity of governmental departments and the absence of a well-funded charity driver suggests that initial funding will be difficult. Each organisation will see it as marginal to their core business, and a potential threat to their autonomy.

Experience from the National Heart Forum shows that bringing together many organisations and key experts provides synergy. It has proved highly effective in developing effective heart disease prevention. If established the new Forum should not seek to own but rather to facilitate.

The author:

Dr Noel Olsen is an independent public health physician and lives in Devon. He works in areas where clear and compelling medical evidence justifies social policy and legislation. He Chairs the Alcohol Education and Research Council of the UK, WaterVoice SW (Ofwat consumer committee), and is Hon Sec of IATH (International Agency on Tobacco and Health). He represents the National Heart Forum on the Fuel Poverty Advisory Group, the BMA on the Air Quality Strategy Forum at DEFRA, acts as a Consultant adviser to the Fuel Poverty Unit in DEFRA, was a Consultant Adviser to DoH on Health and Environmental Impact Assessment and Health Action Zones, and has acted as a WHO Consultant Adviser on poverty and health and to the Healthy City programme.

Dr Olsen is a Trustee of the National Heart Forum and was its Hon Sec for 6 years. He has been Hon Sec of the International Agency on Tobacco and Health since 1990 and before that was National Hon Sec of Ash (Action on Smoking and Health) from 1975-1994. He serves on the Public Health Medicine Consultative Committee of the UK, having chaired it for a maximum four years. A former member of BMA Council he serves on the Board of Science, The Board of Medical Education and the Central Public Health Committee. He has recently demitted office after 10 years as a non-executive on the British Medical Journal committee. He had five years as public health representative on the national GP Committee.

He was employed as a NHS consultant, and taught in Cambridge and then at the Royal Free Hospital Medical School in London. He was Director of Public Health in Camden and then Plymouth, and spent 17 years as a NHS Chief Officer. He retired from the NHS at age 50.

After an early career in clinical medicine and three years as a Consultant Chest Physician, medical audit showed that the results of treating lung cancer were very poor, but the condition was completely preventable. He moved into prevention and retrained in public health developing interests in tobacco control, poverty and health, community development, Health and Environmental Impact Assessment and evidence-based public health campaigning. He has a particular interest in the health consequences of poverty. He is currently involved in legislation before parliament on alcohol licensing, water, sustainable energy and housing standards. Past campaigns include tobacco, drink and driving, health and environmental impact assessment, medical education, seat belts, child nutrition, fluoridation, healthy food, and physical activity.

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