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A diverse public health workforce is more important than ever

Using the lessons learnt from the covid-19 pandemic can prepare us for the future of public health, write Kazim Beebeejaun and Kerry Littleford

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The covid-19 pandemic provided an opportunity to learn and rethink what a well equipped public health workforce looks like. To tackle health inequalities meaningfully and build long term trust with deprived communities in the UK, we must first confront inequities and biases in our own profession.

At its core, public health promotes broad and multidisciplinary thinking about health issues, examining structures and barriers that influence unjust and avoidable differences in people's health. As a community we are strong advocates for greater health equity and social justice. The covid-19 pandemic exposed and exacerbated longstanding health inequalities in our society. Communities living in the most deprived areas and ethnic minorities were up to twice as likely to die from covid-19 and had higher levels of vaccine hesitancy and distrust of government.[1 2] The pandemic presented numerous stark lessons for public health in terms of preparing for the inevitable next pandemic. However, evidence is growing that the public health workforce does not always represent the diversity of the populations it serves, prompting the question—how ready is our public health system to act on the lessons of the pandemic and to meaningfully engage with the populations it serves?

The public health speciality training programme is a primary training pathway for future public health leaders across local and national government, academia, health protection, and healthcare trusts in the UK. Many directors of public health, government consultants, and deputy chief medical officers have been through the programme.

The UK Faculty of Public Health has been proactive in addressing diversity in the public health workforce by first commissioning an investigation into differential attainment in public health training, with a recent report showing stark differences in the success rates of certain groups.[3] Black candidates were 90% less likely to be successfully appointed to the public health training programme than white candidates, Asian candidates were 30% less likely. Fran Bury and colleagues also found that older candidates and those from backgrounds outside medicine were less likely to be appointed.

Differential attainment by ethnicity in medical speciality programmes is nothing new. Thirty years ago, research showed that doctors with English names were twice as likely to be successfully appointed to medical specialties as those with Asian names, despite having the same professional backgrounds.[4] In 2020, a report using data from the General Medical Council found that public health had the greatest disparities of all 14 medical specialties, with one in seven ethnic minority candidates appointed, compared with more than one in three white candidates.[5]

Questions remain over mistakes made in response to the pandemic and implications for how to prepare for future pandemics. For instance, a key theme at the UK Health Security Agency conference in October 2022 was how to address the health inequalities exposed by the pandemic. Plenary panels of senior leaders across public health discussed the importance of building trust in communities, not only during public health emergencies but at all times. The pandemic emphasised the need to regain trust in those communities who were hit worst by covid-19.

Putting aside issues of equity and fairness in recruitment, we argue three reasons why greater diversity in the public health workforce is needed to act on the lessons learnt from the pandemic. Firstly, cultural competence is essential in gaining a rich understanding of the perspectives, needs, and concerns of marginalised communities. Complex sociocultural and historical factors interact to influence marginalised communities' view of healthcare. For example, vaccine hesitancy in black communities in the UK is heavily influenced by historical mistrust of government and medicine linked to British colonialism and unethical experimentation.[6 7]

Cultural competence rooted in lived experience is a powerful tool for positive change. Public health messages from trusted sources within communities are a valuable to increase confidence, trust, knowledge, and acceptance of public health interventions. Public health professionals cannot become culturally competent by reading academic sources alone. A workforce with real world experiences that reflect the diverse society it is serving is key to tackling the challenges ahead.

Secondly, a more diverse workforce is more innovative. Covid-19 exposed gaps in our thinking at a systemic level, despite a decade of evidence of the health inequalities present in ethnic minority communities. A growing body of evidence from the private sector illustrates the benefits of a more diverse workforce.[8] For example, a recent large meta-analysis of more than 170 companies found that more diverse companies had significantly higher levels of revenue from innovative services and products.[9] Similarly, psychological studies have found that experiences of diversity challenge our ways of thinking, driving innovation in ways that homogeneity cannot.[10]

Thirdly and most importantly, building trust requires consistency in our values as a profession. We cannot

advocate for our core values of equity and social justice in health without tackling inequalities within our own community. If current and future decision makers are drawn only from certain areas of society, how do we expect to build genuine trust with marginalised communities.

The next pandemic is inevitable. We are in the midst of a cost-of-living crisis that will likely exacerbate health inequalities further. How prepared we are and how well we adapt to the lessons learnt from covid-19 will be a key challenge in public health. However, we will not make meaningful progress in building trust with communities most in need without first addressing the inequity in our own profession.

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