

# Manchester Medical Society

## *Public Health Forum*

2<sup>nd</sup> November 2006

The State of Public Health Practice in 2006 –

Fit for Purpose?

# So what is Public Health?

**“A network of public, private, and voluntary entities that contribute to the health and well-being of a community”**

*(WHO 2004)*

# According to Faculty of PH:

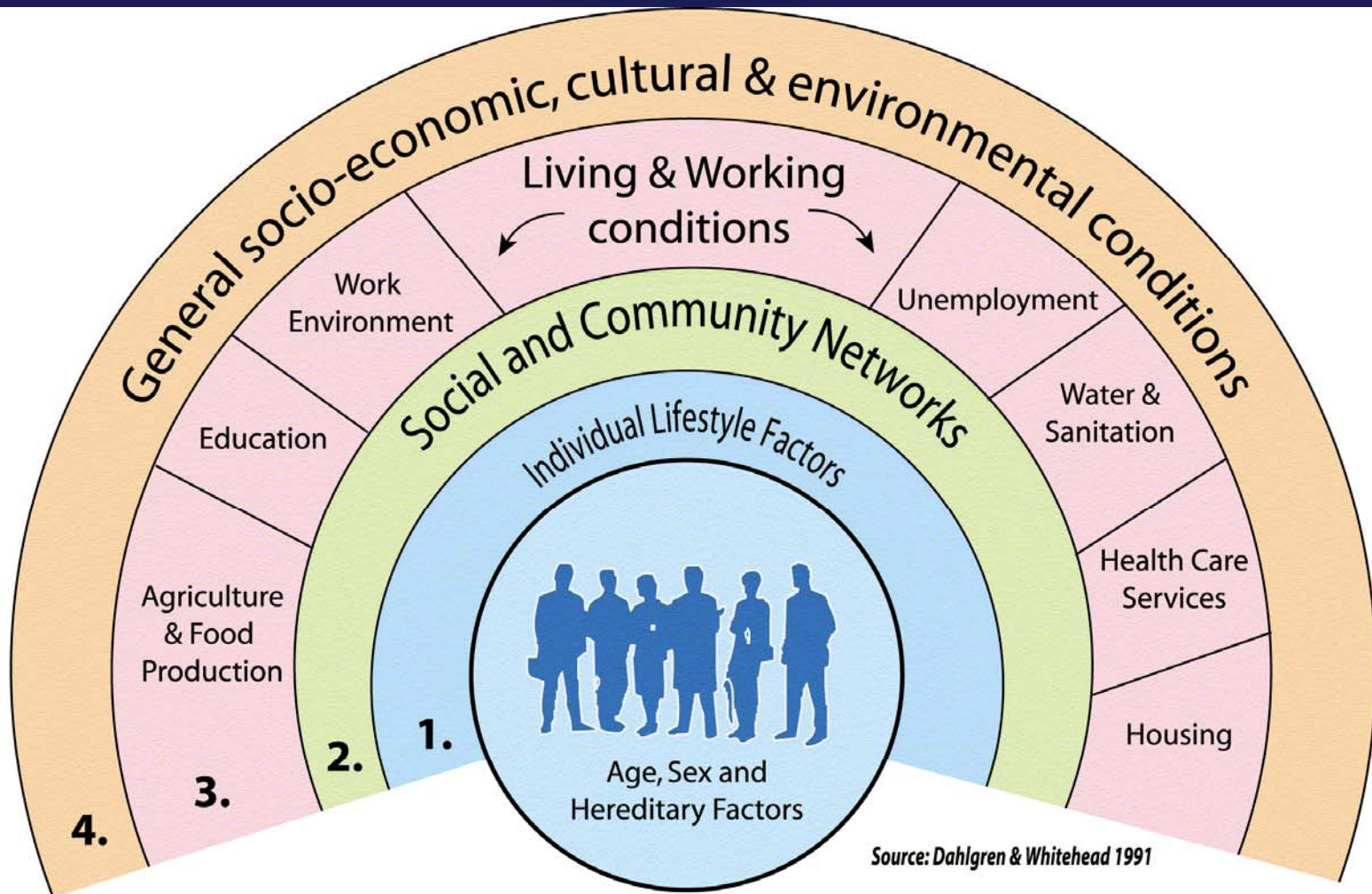
**“the science and art of preventing disease, prolonging life and promoting health through organised efforts of society”**

*(Sir Donald Acheson, 1988)*

## C E A Winslow, Professor of PH at Yale, 1920:

“Public health is the Science and Art of preventing disease, prolonging life, and promoting health and efficiency through organised community effort for:

- the sanitation of the environment,
- the control of communicable diseases,
- the organisation of medical and nursing services for the early diagnosis and preventive treatment of disease, and
- the development of social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organising these benefits so as to enable every citizen to enjoy his birthright of health and longevity”



## ***The Main Determinants of Health***

# **In this lecture, I shall discuss:**

- 1. levels of effective public health working**
- 2. organisation of public health**
- 3. government initiatives v autonomy of public health professions**
- 4. conclusions and possible routes towards solutions**

# 1. Levels of effective public health working

*(“locus of control” of health determinants)*

# Origins

**Go back to the ancient civilisations of Rome, Greece, and many others**

**(e.g. Albumasar in Baghdad)**

# Origins for our purposes...

**Dr William Henry Duncan (1805 – 1863)**

- **born in Liverpool**
- **qualified in medicine in Edinburgh in 1829**
- **appointed MOH in Liverpool in 1847**
- **saw link between housing and cholera, smallpox, typhus, etc.**
- **worked to tackle poor housing and sanitary provision**



# Sir Edwin Chadwick



# **Sir Edwin Chadwick, 1800 - 1890**

- **born in Longsight**
- **educated in Longsight and Stockport**
- **called to the Bar in London**
- **friend of Bentham and John Stuart Mill**
- **1832 appointed to Poor Law Commission**
- **1833 Royal Commission on condition of factory children**
- **1839 first Sanitary Commission appointed**
- **1847 Commission on the health of London**

**Dr Duncan and the early fathers of public health saw clearly that the main determinants of health of the populations around them were to found and tackled locally**

**So what of the mid-  
twentieth century?**

# **Dr John Lancelot Burn, 1902 - 1973**

- 1924 entered Durham Medical School
- 1930 essay: “Some modern attempts on the treatment and prevention of pulmonary TB”
- 1933 MD      1934 DPH
- 1941 appointed MOH in Salford
- identified many health problems as poor housing, pollution, high infant mortality, diphtheria, low immunisation rates

**For Dr Burn and his contemporaries, the “locus of control” of health determinants still remained mainly local**

# **In a typical 1950 county town (e.g. Preston):**

- food produced in surrounding countryside**
- no national food retailers**
- almost no national or international firms**
- workers employed by local firms**
- decisions on housing, education and control of the environment made by local government**
- a local MOH had opportunity to influence most of the main health determinants locally**

# **Now let us compare this with 2006 situation:**

- decisions on location of industry and employment made by firms in context of global economy**
- legislation on agriculture, nutrition, employment, environmental control, regional development, trade – located in Brussels**
- decisions on housing, education and health services made in London**

**So for our  
contemporaries in  
2006, the “locus of  
control” of health  
determinants is now  
hardly local at all!**

# Determinants of Health - where are decisions taken?

"Global" Economy 30%

At EU level 50%

At member state level  
(e.g. UK) or below 20%

Source: Luxembourg seminar 1998

# **A recent WHO Study -**

**put the proportion of  
decisions taken “below”  
EU level as around 25% of  
the total**

# So where is most PCT public health activity and training concentrated?

- is this local concentration appropriate?
- are we using our resources most effectively to serve our populations?
- are we “fiddling around with trivia” rather than trying to address the real (but perhaps more difficult) challenges?

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## **2. Organisation of Public Health**

# Prior to 1974:

- Medical Officers of Health (MOsH)
- part of local government
- significant influence on housing and education
- communicable disease control and immunisation
- maternal and child health
- seen as public health`s “golden age”
- but MOsH “trapped” in LA horizons

# After 1974 (in England):

- translation to “community medicine”
- consensus management
- locked into the acute hospital agenda –  
an NHS “ghetto” (David Hunter)
- blurring of notions of health, health  
services, and the public health function
- “general management” from 1982
- public health agenda nearly ceased to  
exist
- public health physicians “lost and  
disillusioned”

# Public health professionals in the NHS:

- what priority should be given to the Chief Executive`s agenda?
- for public health physicians, where does the “Hypocratic Oath” come in?

# **The position of the DPH is an absurdly awkward one!**

**S/he is expected to be, in the one post:**

- both a member of the management team of a health authority (PCT), and accountable as such to the chief executive, and**
- the leader of an “independent” public health department responsible for improving the health of the local population!**

**Almost inevitably the  
DPH gets stuck to the  
NHS agenda, and sucks  
the rest of the Public  
Health Department also  
in that direction**

**So the public health  
agenda gets low  
priority, if any  
attention at all!**

**“In practice, the community  
physician tended to be  
preoccupied with his (sic)  
responsibility to the health  
services rather than to health”  
(Lewis 1986)**

**Thus the position of the public health  
physician or specialist has been at the  
mercy of the ever-changing structure of  
the NHS**

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# **3. Government Initiatives v. Autonomy of the Public Health Professions**

# **Lalonde Report (1974): health policy should take account of:**

- **human biology (e.g. genetics, ageing, etc.)**
- **environment (all external influences on health, including social and economic factors)**
- **lifestyle, concerning which individuals have the capacity to influence**
- **health-care organisation, including quality, quantity, financing, etc.**

# The Acheson Report on PH

- lack of coordinated information on which to base decisions
- lack of emphasis on health promotion
- confusion on role of public health doctors
- confusion on responsibility for communicable disease control
- inability of health authorities to evaluate outcomes of their activities

# **UK Government initiatives in England:**

- **Prevention and Health: Everybody's Business (1976)**
- **The Health of the Nation (1992)**
- **Saving Lives: Our Healthier Nation (1999)**
- **Shifting the Balance of Power (2001)**
- **Tackling Health Inequalities (2001)**
- **The Wanless Reviews (2002 and 2004):  
“solid progress”, “slow uptake” and  
“fully engaged”**

**but a recurring feature has  
been:**

**lots of strategic intent, but  
lack of follow-through, and  
little finance to support  
implementation!**

# **It is also noteworthy that**

- **“Improving Health in Wales”, and**
- **“Our National Plan” (Scotland)**

**both give much higher priority to public health and to health improvement than does the NHS Plan for England**

# Managing for Health in England

- Health Action Zones
- Health Improvement and Modernisation Programmes
- Local Strategic Partnerships
- Local Area Agreements

# “Wicked” issues

- formal authority less effective than previously
- development of common vision is difficult
- lack of power to effect change; “traditional” management methods inappropriate
- targets, indicators, performance management lead to fragmentation
- dominant interests intent on maintaining supremacy of health services in NHS

# **Simple truths on health-care systems (Hunter):**

- 1. health-care systems want to grow (vested interests, etc.)**
- 2. higher health spending is not necessarily associated with higher health status**
- 3. universal access to health care does not lead to universally good health**
- 4. public awareness of risks to health has greatly improved**
- 5. health care almost always wins out in the competition for resources**
- 6. changing the distribution of health status through “upstream” strategies is extraordinarily difficult**

# The science base...

- clinical medicine now expected to be “evidence-based”
- the evidence base for many public health interventions is improving
- however, health service restructuring seems to occur largely in the absence of any clear or compelling science base

# Health Care Management

- management for what?
- confusion over the nature of the management task
- preoccupation with health care services
- perpetuates dominance of medical paradigm

# **Why managers find public health programme implementation so difficult (Gunn 1978)**

- **constraining circumstances external to implementation agency**
- **adequate time and resources not available**
- **right combination of resources unavailable**
- **policy not based on valid cause and effect theory**
- **relationship between cause and effect indirect; multiple dependency relationships**
- **lack of clarity on objectives**
- **tasks not specified in appropriate sequence**
- **imperfect communication and coordination**
- **managers cannot achieve complete compliance**

# and also

**conflict between utilitarian and egalitarian approaches is often fudged; are we in the business of:**

- **improving health generally and maximally, or**
- **tackling inequalities in health?**

**But it is to this  
agenda and in this  
culture that PCT  
public health  
departments find  
themselves locked!**

# Result:

- public health departments just implement what the D of H tells them to, without any real critical appraisal of these initiatives, including of their scientific credentials
- public health departments take few initiatives of their own in response to local health needs

**Surely this makes us  
little more than civil  
servants, and not  
ethical public health  
professionals?**

# An example: alcohol

- clear that we have a major alcohol problem
- northern Europe has a tradition of “prohibitional” attempts at control of alcohol abuse; these have consistently failed
- popular press demands more of this, and D of H response is more of the same approach
- science shows that alcohol needs to be linked to food and healthy nutrition
- successful health promotion might be based on such an approach

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# **4. Conclusions and possible routes towards solutions**

# To sum up so far:

- too many PH practitioners have lost sight of the ball (vision directed only at the ground locally)
- organisation in the NHS “uncomfortable”
- chief executives` agendas may lead to unethical situations
- government has promised much but delivered little (especially money!)
- practitioners have been expected to implement policies based on expediency

## **But I generalise, and am unfair to many:**

- plenty of PH professionals are fully aware of the location of determinants of health (e.g. the Regional taskforces, Heart of Mersey, some PCTs)
- there are some excellent PH departments in NHS
- not everyone follows slavishly failing unscientific policies led from the centre

**And although PH training  
reflects all the deficiencies  
listed,**

**current public health trainees are  
better trained than ever before  
(even if their training is  
somewhat blinkered!)**

**so I am confident that  
there are plenty of  
well-trained and able  
recruits for senior PH  
positions in the future**

# Possible solutions (1)

## organisational options:

- the status quo (NHS) option
- the local authority (LA) option
- the “shared” NHS / LA department option (currently in favour)
- the “Lithuanian” option
- organisation within networks

# Possible solutions (2)

## more appropriate targeting:

- more attention to health determinants needed, and better analysis of how to influence them
- new skills required to enable multi-level functioning
- training needs to reflect this cultural shift (e.g. with more training at EU level, etc.)
- more suitable organisational arrangements should make this easier

**Thank you for  
listening to me!**