Development of Public Health Function and Policy: Lessons based on United Kingdom Experiences for Developing Countries

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As a faculty member of Public Health Medicine from the United Kingdom, I will examine our experiences developing the public health function in the United Kingdom, which may help other countries in their efforts. By "public health" function, I refer to the context, and particularly the organization, of public health. As the Director of Public Health for Oxfordshire (the county surrounding, and including, the city of Oxford), I have extensive practical experience with a public health department at a local level, as well as involvement with some national initiatives. This paper briefly reviews the development of public health in the United Kingdom, highlighting current key issues. While I am not an expert in international health, I will refer to what we have learned, and are learning, to suggest some implications for developing countries.

History

The best method for tracking public health development is by looking historically at one of its key functions. The first Medical Officer of Health (MOH) was employed in the city of Liverpool over 150 years ago. For the remainder of the nineteenth century, the MOH was preoccupied with environmental improvement and sanitary reforms, including the improvement of housing conditions, clean water supplies, and working conditions, particularly of industrial workers. The collection of statistics, especially concerning birth and death, was a key issue. As government legislation began promoting the public's health through a series of Acts of Parliament, the focus of public health broadened from a focus on environmental concerns to include concern for personal health and social welfare — immunizations, mother and child health, and prevention.

To quote from "The Recent History of the National Health System (NHS)" by Rivett, "By 1968, MOH had a smoothly running empire, managing community nursing service, social work services, the aftercare of people who were mentally ill or handicapped, the ambulances, and the child and school health services."

However, in 1974 the role of MOH was changing, and public health physicians became a component of the NHS, along with public health nurses, while environmental health officers and social workers remained within local government. Community physicians assumed increasing roles in management. With successive reforms, they no longer remained district community physicians, but became, initially, district medical officers (with a focus on medical management) and then directors of public health. Perhaps their nadir occurred when the government of 1989 introduced the purchaser/provider split, which, for many public health professionals, became synonymous with antagonistic contract negotiations between hospitals and health authorities. The delivery of public health services became fragmented and uncoordinated. Simultaneously, academic public health was developing in epidemiology and social medicine, focusing on populations, instead of the health services of local government.

Concern about the future of public health was recognized by the Acheson Inquiry, established by the Secretary of State and chaired by the Chief Medical Officer, Sir Donald Acheson, in 1988. Its objective was, "To consider the future development of the public health function, including the control of communicable disease and the speciality of community medicine, following the introduc-

tion of general management into the hospital and community health services." The inquiry highlighted the following five essential problems:

- Insufficient coordinated information to formulate policy decisions about the population's health
- Inadequate emphasis on health promotion/ prevention
- Confusion about the role and responsibilities of public health doctors
- Confusion about communicable disease control
- Inadequate capacity of health authorities to evaluate their activity outcomes and, therefore, to make informed choices between competing priorities.

In summary, the transition from a focus on the broader determinants of health, coupled with a climate of financial pressures and organizational change within the NHS, had led to a weakening of the public health function. The report proposed a variety of steps to address these problems and also proposed a working definition of public health, which is widely used: "The science and art of preventing disease, prolonging life, and promoting health through the organized efforts of society." In tandem with this focus on the public health function was the increasing, if suppressed, awareness of the relationship between poverty and poor health.

However, it was not until the governmental change in 1997 that public health in the United Kingdom began experiencing a renaissance. The Labor government created a new post, Minister of Public Health, one day after its election to office in 1997. In 1998, a Green Paper was drafted, to create a public health strategy for the United Kingdom, and was published as a White Paper early in 1999.

In his foreword to the National Strategy for Public Health, the Prime Minister wrote: "I believe that, by working together, we can tackle poor health and achieve the aim of better health for everyone, and, especially, for the least fortunate. This White Paper is a significant step towards better health. It sets out a new modern approach to public health—an approach which refuses to accept that there is no role for anything other than individual improvement, or that only government can do something."

The White Paper, with its emphasis on action, stresses the five key areas for action from the Ottawa Charter:

- Building healthy public policy
- Creating a supportive environment
- Strengthening community action
- Developing personal skills
- Reorganizing health services.

The White Paper identified our primary goal, which is the improvement of everyone's health, especially the health of the poverty-stricken. The strategy has emphasized the following highlights:

Confrontation of social inequalities: Poverty and social exclusion are recognized as major contributors, not only to poor health, but also to inequalities in health and society. These fundamental problems need to be addressed, not just by the NHS, but by actions of all sectors at all levels.

Emphasis on local government's role in social, economic, and environmental factors: This role is formally recognized by various partnerships; the development of health impact assessments for all policies is encouraged.

Balanced action for people, communities, and government: The earlier policy focused on either the individual, a blame culture, or the attitude that government is solely responsible for health. The current philosophy emphasizes collaboration among individuals, communities and government.

Targets: National targets, in four key areas, have been identified concerning the major causes of death: cancer, coronary artery disease, accidents, and suicide. In addition, a variety of strategies will be

established for alcohol abuse, HIV/AIDS, tobacco use, teenage pregnancy, and communicable disease. All targets have specific objectives, separate from relevant objectives defined by other government departments concerning health outcomes.

Local targets and action plans: Local targets are being set by Health Improvement Plans (HIP). Each of these plans is strategic in nature, consisting of a three year rolling plan for a defined population, recognizing all the factors that impact health in its broadest context for that local population. These plans signify the transition from the public health label being applied to the NHS purchaser and from the conflict of the internal market towards participation and collaboration between all sectors. Interestingly, there is also a reversal of the organizational changes of 1974: Social care and health services are expected to work together closely, as are environmental health and health services in a variety of ways.

Emphasis on NHS's important role in Evidence-based Effective Practice: While environmental and socioeconomic issues are important, effective health care contributes to improved health. Issues concerning effectiveness, efficiency, evidence-based access, appropriateness, and quality of care are all important elements for improving the quality of life, especially in primary care. An emphasis on the importance of public health approaches within this sector is increasing.

Translation into action: The final section of the strategy details criteria for action, especially creating the capacity to deliver these public health programs. The need exists to ensure that all professional staff can, as necessary:

1 Manage strategic change

2 Act as leaders and champions of public health

3 Collaborate with other agencies and individuals

4 Help develop communities that have a health focus

5 Familiarize themselves with public health concepts and apply them where appropriate evidence is available for guiding their work.

Implication

The variety of consequential implications includes the need to:

- Strengthen public health nursing
- Recognize contributions of multidisciplinary public health, developing training and accreditation programs to allow career progression to consultants/directors of public health
- Invest in public health academics
- Strengthen public health research
- Ensure better coordination of the public health network
- Develop an education and development strategy.

Lessons for Developing Countries

Differences exist in the challenges that the United Kingdom (as a developed country) face in terms of disease patterns, scale of poverty, and public health structures. However, lessons can be drawn from our recent experiences in the United Kingdom, which may currently be relevant to developing countries. These can be summarized in the following nine points:

- Poverty is the essential cause of much illness and increasing inequalities. Programs must target the most poverty-stricken of our population.
- Political support is essential for the public's health; investment in good health's contributing factors (education, employment, and health services) is needed. Cooperation is needed throughout government.

- Participation is needed, at all levels, for community development.
- Population perspective is required, with good statistics to define needs and measure progress.
- Prevention, a frequently neglected measure, needs emphasis.
- Primary care is important.
- Professional development concerns capacity, investment in research, and academic public health, as well as continued education for practitioners.
- Public engagement, both in knowledge and action, is needed.
- Persistence is needed to ensure the shift from the present emphasis on cardiac surgery (in the coronary heart disease agenda) to a focus on underlying public health issues of prevention and control of tobacco smoking.

The hope exists that the United Kingdom's experiences will help developing nations in Southeast Asia to organize and refine their public health policies and programs, as well as implement and evaluate their programs.