

EVIDENCE BASED PUBLIC HEALTH POLICY AND PRACTICE

Putting the public back into public health

Philip Crowley, David J Hunter

J Epidemiol Community Health 2005;59:265–267. doi: 10.1136/jech.2003.019513

Public health in the British NHS has lost its way.^{1–5} It has been, or has allowed itself to be, driven down the narrow, and ultimately self defeating, road of health service performance management and finds itself unable to step back and examine the root causes of ill health in the populations served. Health is about more than simply treating illness. It must encompass improving people's chances of living a healthy life throughout their lifetime. However, in the NHS, health is being interpreted through the narrow prism of ill health and disease. How will this enable the NHS to contribute to the struggle to create communities that are truly healthy, where people participate in creating a sense of wellbeing for themselves and for their communities? The issues are not confined to the British NHS but can be found to exist to a greater or lesser degree in many healthcare systems in Europe and elsewhere.⁶

Part of the problem may result from a lack of clarity over the public health function. Arguably, there exists no other function that seeks to embrace such a broad range of discrete activities to be undertaken by a single specialty or group of practitioners. The Faculty of Public Health suggests that there are three areas of public health practice that it seeks to cover in its work: health protection, health improvement, and health service quality. While displaying some overlap, each of these areas arguably demands its own particular skills, competences, and knowledge. Perhaps greater clarity and focus is required if public health is to deliver with equal confidence in each of these areas, especially in respect of health improvement that demands skills from a range of agencies outside the NHS and located within communities.

For many engaged in public health, its core purpose is health improvement and the wider agenda in respect of the determinants of health and how these can be addressed. That is certainly our concern in this paper because we believe that it is the primary function of public health and one that is being seriously eroded at a time, paradoxically, when government policy is seeking to advance its cause.⁷

Public health will only regain its core purpose by forging partnerships with local communities. Conceivably, this might be achieved through primary care trusts (PCTs) in England and there are high, if diminishing, hopes that they will deliver on such a change agenda. But concern is mounting among appointed directors of public health, among others, that perhaps PCTs neither provide the optimal location to lead such a shift in health policy nor possess sufficient capacity to perform effectively. To be sure, PCTs are charged with the task of assessing and supporting the health needs of their populations but the reality is that they are overwhelmed with the short term needs of the NHS modernisation agenda. Delivering on healthcare targets in respect of access and waiting times is diverting public health practitioners from their core business—a classic example of the counter-productive and dysfunctional nature of a “target culture” in public services.⁸ It is making many wonder if the lead role for public health should remain with the NHS or perhaps shift to local government although such a move is not without its own problems and risks.

More to the point, what has the public health function contributed to improving the health of those with the worst health experience? Academic public health has played its part in highlighting the issue, and directors of public health annual reports have served to provide a local focus on health inequalities but may not have resulted in much positive change. The thrust of most service public health work in the NHS has been to facilitate the implementation of NHS priorities, including national service frameworks, which are primarily service oriented. In performing this role, public health practitioners tend to work in a way that is isolated from contact with local communities.

The need to tackle the dramatic health gap across the equally dramatic socioeconomic divide constitutes the most important public health issue facing the United Kingdom and, indeed, most industrialised countries. Those working in public health should be encouraged to devote their energies to improving the health prospects for many minority groups within society whose health experience, and experience of health services, have been unsatisfactory and inexcusable in a civilised society. The health inequalities picture in Britain has been well reported over many years,^{9–11} yet action to tackle these inequalities, despite the setting of national targets, remains unimpressive. Indeed, in its most recent policy statement, the government almost concedes as much. In *Tackling Health Inequalities: Programme for Action* there is an acceptance that health inequalities “are stubborn, persistent and difficult to change. They are also widening and will continue to do so unless we do things differently”.¹²

In another important policy development, and at the request of the government, former banker, Derek Wanless, completed a review of public health policy aimed at assessing progress in implementing the “fully engaged” scenario for health that he articulated in his earlier report for the Treasury that looked at the future funding of the NHS over a 20 year period until 2022.¹³ In that report, Wanless made much of the fact that investing in health was good economics.¹⁴ His second report, directed to the prime minister, chancellor, and secretary of state for health, is critical of the failure of policy over some 30 years to shift the NHS from being an ill health to a health service.¹⁵ Most of the report's 21 recommendations represent an agenda for action. The failure to make progress is perceived as principally a technical one resulting from lack of sound evidence, underinvestment in research and development, and an antipathy towards rigorous economic analysis of interventions to establish their cost effectiveness. Wanless is especially critical of PCTs and their undeveloped capacity to pursue a public health agenda. However, he regards them as critically important. To secure a population that is fully engaged in their health, Wanless recommends interventions designed to raise levels of health literacy among the public. In particular, he wants to see the public consulted about the balance between state interventions on the one hand and a person's right to choose on the other.

The government's response to Wanless II was swift. It launched a major public consultation exercise, *Choosing*

Health, to culminate in a white paper expected in the autumn 2004, which will set out the government's approach to public health to rebalance the NHS from being a sickness service to a health one.¹⁶ The policy statement is expected to be principally concerned with delivery and with the principles of change management in public health. Leadership in public health is likely to figure prominently. Empowering the public to take more direct responsibility for their health is also likely to be a major theme and is consistent with other policy themes, including local devolution, fewer centrally imposed targets, and making choice available to all to reduce inequalities.

One of us (Crowley) has worked in an inner city area in the north east of England for many years. It is clear from this experience that if we are to create the conditions in which the health of individuals and communities can flourish, action is needed on a whole range of social issues that determine the likelihood that a person will lead a long and healthy life. Working in the West End of Newcastle upon Tyne¹⁷ showed the limitations of what the NHS could achieve in economically deprived communities and with marginalised groups. People in the West End experienced some of the worst health outcomes in the country and their access to health services was limited. Those with the worst levels of heart disease had the lowest referral rates to hospital treatment and there were obstacles for ethnic minorities in accessing secondary care mirroring the experience elsewhere.

If the wider picture of health inequalities is genuinely to be transformed, action will have to tackle the broader determinants of health and actively involve the community experiencing these inequalities. Competition for funding has reinforced a national tendency to see poorer communities in terms of their deficits and weaknesses. This approach leads health professionals and others to ignore the many skills, commitments, and capacities that local communities can bring to the struggle to improve their own health. We need to start looking at communities in terms of mapping their capacities and abilities to sort out their own problems¹⁸ rather than endlessly reporting their deficits.

There are many ways to involve local communities.^{19–20} One that has a particular focus on improving the health of minority groups and tackling inequalities is the community development approach.²¹ Community development entails working with local communities experiencing social exclusion and health inequalities so that they can develop their collective agenda and then act on that agenda by engaging decision makers in the relevant organisations so that health inequalities can be addressed. The *Involving Patients and the Public in Healthcare* discussion document²² commits the NHS to involving patients and local people in health decisions. Community development linked to primary care has been the subject of publications for a decade or more.^{23–28} One study suggested that over 60% of PCTs are funding community development activity.²⁹ There has also been a long history of community development projects focusing on health, but without health service funding or connections.³⁰ Some researchers have seen PCT involvement of local communities

as the key to their developing their public health role.³¹ A systematic review suggested that involving patients has contributed to changes in health service provision, but the effects of these on quality of care have not been reported.³²

Programmes of work undertaken in Newcastle to tackle health inequalities and involve local communities (including communities of identity and interest such as the deaf community and the gay community) arose from such community development initiatives.³³

Through a community development project in Newcastle, *Community Action on Health*, contact was made with a large number of community organisations to develop with them their agenda on health. Meetings with the deaf community highlighted their lack of access to both primary and secondary care. So with health services failing those in greatest need and the issues that created ill health being ignored, community development work to engage local communities started to broaden the public health agenda to include issues that communities saw as affecting their health. Local people identified lack of access to safe play areas, lack of access to exercise facilities, poor housing, and social isolation as key health issues.¹⁷

The dialogue that developed as a result of the project's work between local communities and the health services and public health in particular led to a number of initiatives to improve wellbeing in the area. A peer led family support initiative worked to support vulnerable families from all communities. An interagency group worked with young people to develop a youth inquiry service to meet the needs as expressed by local young people at a youth base. In parallel with these developments, access to health services for local communities was also improved as the community engagement served to highlight the service access inequalities.

So what of the future role of public health? Most public health activity continues to be focused on PCTs. At first sight, this helpfully locates public health at a level that is sometimes, though by no means commonplace, co-terminous with local government boundaries and at which local communities are accustomed to articulating their concerns. Directors of public health (DsPH) in PCTs have a great opportunity to establish a new face for public health in the NHS. They can act as catalysts for partnerships with communities, local authorities, academic institutes, the voluntary sector, and the private sector and through local strategic partnerships that bring all these stakeholders together ensure a programme of action to tackle the issues that unfairly limit people's potential to achieve a healthy and long life.

PCTs must develop relationships of trust over time as communities are supported to become active drivers of programmes to tackle the health inequalities that they experience. DsPH must become funders of, and supporters of community development initiatives in their local communities. Their public health work programme will then reflect the expressed priorities of local communities. With the active participation of local communities themselves, public health could play a pivotal part in confronting its greatest challenge—the widening gap in health outcomes between rich and poor, and between majority and minority communities. In this way a new public health may emerge in the NHS, one that is relevant, effective, and seen as vital to improving health by the very communities it seeks to serve.

What this paper adds

- The fact that public health in the NHS is being directed to health service modernisation at the expense of health improvement is questioned.
- The need for public health to be relevant to and link with local communities, especially those experiencing health inequalities is emphasised.

Policy implications

Public health must rebalance its focus on health service modernisation with a greater emphasis on linking its work with local communities to tackle health inequalities.

Public health should be seizing the opportunity offered by its positioning at PCT level by engaging with local communities and community development initiatives and by working in partnership with local authorities and other key agencies. In these ways, it could play a key part in creating healthier communities for the future. But, as Wanless warns, it may be that the “downstream” acute healthcare agenda will continue to swamp public health in PCTs and make it all but impossible to achieve the gains in health improvement so urgently needed. Only if such an extreme bias and imbalance persists should serious consideration be given to relocating the leadership role for public health from the NHS and PCTs to local government. Such a move by no means offers a simple panacea but it would recognise the natural leadership role local authorities ought to be exercising in respect of their wide range of functions, virtually all of which have a health dimension. Indeed, local authorities already have a responsibility for looking after the social wellbeing of their communities. Moreover, local authorities have more experience of working with and through local communities that can form the basis of closer links between people and their health. What cannot continue is support for a status quo that is singularly failing many of the most vulnerable groups in society.

Authors' affiliations

P Crowley, Institute of Public Health in Ireland
D J Hunter, School for Health, Wolfson Research Institute, University of Durham, UK

Funding: none.

Conflicts of interest: none declared.

Correspondence to: Dr P Crowley, Institute of Public Health in Ireland, 5th Floor, Bishop's Square, Redmond's Hill, Dublin 2, Ireland; philip.crowley@publichealth.ie

Accepted for publication 5 October 2004

REFERENCES

- 1 **Lewis J.** *What price community medicine? The philosophy, practice and politics of public health Since 1919.* Brighton: Wheatsheaf, 1986.
- 2 **House of Commons Health Committee.** *Public health. Second report. Volume 1: report and proceedings of the committee. Session 2000–01. HC30-1.* London: HMSO, 2001.
- 3 **Webster C.** *The National Health Service: a political history.* Oxford: Oxford University Press, 2002.
- 4 **Milburn A.** *A healthier nation and a healthier economy. The contribution of a modern NHS.* LSE Health Annual Lecture. London: London School of Economics, 2000.

- 5 **Hunter DJ.** *Public health policy.* Oxford: Polity, 2003.
- 6 **Allin S, Mossialos E, McKee M, et al.** *Making decisions on public health: a review of eight countries.* London: London School of Hygiene and Tropical Medicine, 2003.
- 7 **Milburn A.** *Tackling health inequalities, improving public health.* Speech to the Faculty of Public Health Medicine. London: Department of Health, 2002.
- 8 **Seddon J.** *Freedom from command and control: a better way to make work work.* Buckingham: Vanguard Press, 2003.
- 9 **Department of Health and Social Security.** *Inequalities in health.* Report of a Research Working Party (chair: Douglas Black). London: DHSS, 1980.
- 10 **In: Townsend P, Davidson N, Whitehead M, eds.** *Inequalities in health.* London: Penguin, 1992.
- 11 **Acheson D.** *Independent inquiry into inequalities in health.* Report of the committee chaired by Sir Donald Acheson. London: HMSO, 1998.
- 12 **Department of Health.** *Tackling health inequalities: a programme for action.* London: Department of Health, 2003.
- 13 **Hunter DJ.** The Wanless report and public health. *BMJ* 2003b;**327**:573–4.
- 14 **Wanless D.** *Securing our future health: taking a long-term view.* Final report. London: HM Treasury, 2002.
- 15 **Wanless D.** *Securing good health for the whole population.* Final report. London: HM Treasury, 2004.
- 16 **Department of Health.** *Choosing health? A consultation on action to improve people's health.* London: Department of Health, 2004.
- 17 **Crowley P, Green J, Freaque D, et al.** Primary care trusts involving the community: is community development the way forward? *Journal of Management in Medicine* 4, 2002;**16**:311–22.
- 18 **Kretzman J, McKnight JL.** *Building communities from the inside out: a path toward finding and mobilizing a community's assets.* Evanston, IL: Institute for Policy Research, Northwestern University, 1993.
- 19 **Murray S, Graham L.** Practice based health needs assessment: use of four methods in a small neighbourhood. *BMJ* 1995;**310**:1443–8.
- 20 **NHS Alliance.** *Patients' forums and PCTs: models of engagement.* London: NHS Alliance, 2002.
- 21 **SCCD.** *Working statement on community development.* Sheffield: Standing Conference for Community Development, 1992.
- 22 **Department of Health.** *Involving patients and the public in healthcare—a discussion document.* London: DoH, 2001.
- 23 **CanagaRetna A.** *Primary health care teams, involving patients: examples of good practice.* London: NHS Executive, 1997.
- 24 **Draper A, Hawdon D.** *Improving health through community participation; concepts to commitment.* London: Health Development Agency, 1998.
- 25 **Gilbert H.** *Redressing the balance: a brief survey of literature on patient empowerment.* London: The Kings Fund, 1995.
- 26 **Heritage Z, ed.** *Community participation in primary care.* London: Royal College of General Practitioners, 1994.
- 27 **Smithies J, Webster G.** *Community involvement in health—from passive recipients to active participants.* Aldershot: Ashgate, 1998.
- 28 **Freeman R, Gillam S, Shearin C, et al.** *Community development and involvement in primary care.* London: Kings Fund, 1997:v11.
- 29 **Anderson W, Florin D, Gillam S, et al.** *Every voice counts: primary care organisations and public involvement.* London: Kings Fund, 2002.
- 30 **Peckham S, Taylor P, Godel M, et al.** *Bringing people in: participative and collaborative approaches to support public health action.* London: UK Public Health Association, 2004.
- 31 **Smithies J.** *A brief overview of community development and health evaluation reports.* London: Labyrinth Training and Consultancy, 1996.
- 32 **Crawford M, Manley C, Weaver T, et al.** Systematic review of involving patients in the planning and development of health care. *BMJ* 2002;**325**:1263–5.
- 33 **Freaque D, Crowley P, Steiner M, et al.** Local heroes. *Health Services Journal* 1997;Jul:**28–9.**