



School *for* Health

Public Health Function Review in Northern Ireland: The Policy Context

A Report Commissioned by the Chief Medical Officer

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1. Introduction

1.1 As part of the public health function review being conducted by Capita on behalf of the DHSSPS, the CMO wished to commission a separate external review of the public health policy context both elsewhere in the UK and internationally.

1.2 The following terms of reference for this review were agreed:

- to consider the policy context in which the public health function is operating in the UK and is likely to operate in the aftermath of the Wanless review in England and separate policy developments in Wales and Scotland
- to consider the relevance to Northern Ireland of developments in public health policy elsewhere in Europe and in other countries, notably the US, Canada, Australia and New Zealand
- to locate the review within an academic framework and, as far as possible, within an evidence base.

Undertaking the policy review

1.3 This policy review does not take the form of a systematic review of public health policy in selected countries and health systems. Rather, it is more of a personal commentary informed by available evidence and documents. Rather than attempt to be exhaustive, the review seeks to highlight, from a critical and informed perspective, key issues and themes that might be of particular interest and relevance to the public health function in Northern Ireland and its future redesign.

1.4 The review draws on a range of material, including that produced by WHO, the World Bank, the European Health Policy Forum, the European Observatory on Health Care Systems and other relevant organizations. In addition, I have been able to draw on a review of public health in eight countries commissioned from the European Observatory on Health Care Systems by the Wanless review team. Finally, a number of informal conversations with policy-makers and academic researchers have taken place. These have provided useful insights which, where appropriate, are included in the report.

1.5 As part of the policy review, I was invited to take part in two events held as part of the public health function review being undertaken by Capita – a workshop on the emerging vision of public health in November 2003, and a project conference held in February 2004. At each of these I gave short presentations on some of the issues and challenges facing public health both in the UK and elsewhere. These are included (and developed) in this report. Both events were invaluable in providing insights into the concerns of public health practitioners and others in Northern Ireland, and into the particular policy and practice context prevailing in Northern Ireland.

1.6 In addition, I was invited by Jane Wilde and Leslie Boydell from the Institute of Public Health in Ireland to attend a conference in mid-January in Armagh to celebrate the achievements of their first leadership programme. This gave me an opportunity to witness at first hand some of the issues in public health facing students on the programme and to get a flavour of the leadership programme's aims and aspirations. In addition, the unique book launched at the conference produced by students and faculty contains many useful observations and insights on the state of public health (Denyer et al).

1.7 As a general point, there are limits to how useful the available evidence base is in respect of how policy health policies are both formulated and implemented. It is easy to locate the formal policy statements and to review their contents and the priorities governments have identified. But it is less easy to assess whether such statements are primarily of rhetorical importance rather than acting as guides for action. Even where policy goals and strategies to achieve them are similar, there is often great diversity in respect of the political contexts evident in countries. But there is little systematic evidence on the impact of such factors on policy. As a consequence, it is not possible to produce a ranking of countries or systems which demonstrates unequivocally what works well and not so well. The comparative evidence available lacks that degree of rigour or certainty. What it can reveal, however, are the mechanisms and devices that appear to work in certain contexts at particular points in time.

1.8 We need to exercise caution over the potential for international learning for other reasons, too. Mackenbach and Stronks (2002) make a strong case for increasing the international exchange of experiences with developing and implementing interventions and policies to reduce socioeconomic inequalities in health in order to increase policy learning. They insist that 'no single country has the capacity to contribute more than a fraction of the knowledge necessary to support strategies for reducing inequalities in health' (ibid. 1032). Reporting on an analysis of the findings from 12 evaluation studies in the Netherlands, the authors demonstrate important gaps in the knowledge base both in coverage of various policy options and strength of evidence. They conclude that 'the contribution of the intervention studies to strategy development was modest' (ibid.:1031). But they also acknowledged the 'remarkable progress' that had been made not only in terms of 'knowledge gained' but also in terms of 'increased confidence among policymakers and practitioners to take action to reduce inequalities in health'.

The public health function

1.9 The public health function is complex, multi-faceted and multidisciplinary. According to the Faculty of Public Health's widely accepted definition, it comprises three major domains:

- health protection
- health improvement
- health service development.

1.10 The public health function review in Northern Ireland is concerned with all three domains. This more limited policy review focuses on the first two on the grounds that arguably these constitute the core business of public health. Health service development is seen as important in respect of secondary and tertiary prevention but there is a tension over the extent to which public health resources are used (some would say diverted) to tackle mainstream acute care issues around clinical governance and commissioning. It is felt that such issues could more than adequately be addressed by a medical director rather than by someone with specific public health skills.

1.11 The remainder of the report is organized in three sections. The first reviews the principal public health challenges which have been identified globally. The second examines the development of public health policy and the organization and management of the public health function in selected countries. The final section draws out some common themes from the country profiles, and considers how public health might develop in future in the light of these.

2. Public Health in a Global Context: a policy conundrum

2.1 At a global level, there are two policy trends in evidence which pose something of a policy paradox for public health. On the one hand, issues affecting the public's health are rising rapidly up the policy and political agenda. They may have been triggered by a particular event or crisis, like the rise of bio-terrorism or outbreak of pandemics like SARS. Or they may have been the subject of intense media and other attention like food safety or the growing problem of obesity, especially among children, in developed countries, or the moves either adopted by some countries/states/cities (eg California, Ireland) or planned in others (eg Liverpool) to ban smoking from public places. There is also a view, although it is not yet as widely articulated as those above, that good health equals good economics and that investing in the health of communities also raises their economic status and worth. Indeed, this was a theme of the first Wanless report produced for the Treasury (Wanless 2002). It recurs in the second Wanless report, published towards the end of February, which sought to develop and build on the fully engaged scenario as well as critically assess the extent to which the government was successfully implementing it (Wanless 2003).

2.2 But the policy puzzle in the equation is that alongside the renaissance of public health as a legitimate concern of governments are a number of trends evident at a global level which appear to challenge traditional conceptions and modes of public health policy-making and delivery. Most prominent among them are the following:

- from welfare states to market states
- from central control to local autonomy
- from paternalism to choice
- the changing role and scope of the public sector
- the weaknesses of the public health system
- the weaknesses of the public health infrastructure.

2.3 In those countries which developed welfare states in the post-Second World War period, there is now intense questioning and reassessment over whether the arrangements which have existed for over half a century remain viable and appropriate in an age where education, technology and economic advance have changed the way in which people lead their lives and relate to government. This, in turn, has led to a redefinition of what constitutes the public realm and the role and shape of the public sector in this. Perhaps the most fashionable view is that put forward by Osborne and Gaebler that it is the duty of government to steer more and row less (Osborne and Gaebler (1993). By this they mean that while governments do not need directly to organize or deliver all public services, they do need to provide the financial resources and ensure that policy objectives are both set and achieved. There is thus a move from direct service provision and central control to more devolved service delivery arrangements involving a range of providers who are then regulated in terms of their performance and quality. The growth of the 'audit society' has been dramatic over the past 10 years or so (Power 1999).

2.4 Associated with these developments are issues about the balance between individual choice on the one hand and the notion of solidarity and collectivism on the other. Traditionally, the pursuit of public health has been preoccupied with the notion of the collective and is imbued with a strong ethos whereby it is the principal role of government to protect its citizens and promote their health. However, modern governments are often reluctant to assume such a leadership role for fear of being criticized for their paternalism or support for the so-called 'nanny state'. Such heresies stem, in part, from a belief in the superior virtues of the marketplace, in which individuals know best in exercising their choices, and in the failure of big government to deliver when it does assume responsibility for particular activities.

2.5 Opponents of unbridled free market thinking uphold the stewardship role of government and, instead of regarding its effects as largely negative, point to the many virtues of the 'nanny state' (eg seat belt legislation). They concede that in improving health and enabling appropriate public policies to be put in place, only government is in a position to carry out the necessary actions, mobilise the requisite resources, and implement regulatory frameworks. To pretend that the market can be held to account for such matters is seen as both naïve and a dereliction of the state's duty to its citizens.

2.6 Perhaps a more serious trend, so ably articulated by J.K. Galbraith, concerns the persuasive and corrosive effects of the 'culture of contentment' (Galbraith 1993). Galbraith's thesis is that a short-term preoccupation with individual comfort and self-interest has weakened a social concern for those who do not share in the comparative well-being. 'Self-regard is, and predictably, the dominant, indeed the controlling, mood of the contented majority' (p.17). Although Galbraith is writing of the American polity, his analysis has a much wider resonance. Even in a European context (the UK being something of an exception, standing somewhere between western Europe and the USA), where notions of social solidarity and collectivism have often been put forward as offering an alternative model to the American neo-liberal free market model and have been instrumental in creating through social legislation the 'contented majority', the 'politics of contentment' cannot be ignored.

2.7 Increasingly, modern politics have adopted the consumerist attributes of the marketplace which has led to a focus on presentation rather than substance, on the short-term, and on doing what is necessary to get re-elected. Maintaining economic contentment is paramount. Failure in this sphere will render the ruling party electorally vulnerable. In health policy, the focus in most advanced countries has been on addressing the ‘downstream’ problems inherent in health care services rather than on attending to the ‘upstream’ drivers of health. If the public is exercised about waiting lists and access to services then it is surely the duty of politicians to resolve these problems by the most expeditious means available even if in the long-term they offer no solution at all but, perversely, are likely to reinforce the problems – a case of ‘doing better, feeling worse’ (Wildavsky 1979). In Galbraith’s words: ‘contentment sets aside that which, in the longer view, disturbs contentment; it holds firmly to the thought that the long run may never come’ (p.173).

2.8 Other post-modern changes can be identified which largely flow from the growing marketisation of public policy: changing family patterns and gender roles, changing nature of work with an increase in flexible labour markets, loss of social cohesion and integration, new forms of social organization. For a discussion of the corrosive impact on families and relationships of the new flexible economy Richard Sennett’s seminal book, *The Corrosion of Character*, is instructive (Sennett 1999). I return to some of these issues in section 4.

2.9 It may appear to some that such trends and concerns are of little consequence to the public health function and its future development. In fact, nothing could be further from the truth. Not to perceive, and hopefully understand, these wider developments and undercurrents in respect of the wider socio-political and economic context in which public health will operate in future and compete for attention and resources can only handicap the efforts of those seeking a more effective contribution from public health than has hitherto occurred. As Mackenbach and Bakker argue

The link between the political context and the policies devised is important. If we wish to understand the health policy process in a realistic manner, political ideology and economic interests of key players in the health decision-making process cannot be avoided (Mackenbach and Bakker 2002: 338).

2.10 What is notable from a scan across countries and their health systems is that the developments and trends briefly sketched out above transcend particular funding or organizational arrangements. As Kimmo Leppo from the Finnish health ministry puts it:

One of the great paradoxes in the history of health policy is that, despite all the evidence and understanding that has accrued about determinants of health and the means available to tackle them, the national and international policy arenas are filled with something quite different (quoted in Kickbusch 2002: 215).

2.11 Despite various attempts in many countries to put health first, often encouraged by WHO’s *Health for All* strategy and its successor *HFA 21*, in the course of the 1990s and into the early years of the 21st century, health policy has retreated back into its original domain, that of providing health services and the political debate in virtually all countries (most recently in the case of France which topped the WHO’s international ranking of

health systems in 2000) has been ‘dominated by finance driven issues of healthcare provision, rather than issues of production of health in the broader societal domain’ (Kickbusch 2002).

3. The Organization and Management of the Public Health Function: selected country profiles

3.1 In this section, brief descriptions of the organization and management of the public health function in selected countries are presented. The profiles are not comprehensive but attempt to draw out the key issues and trends. Some of these, like the decentralization of the public health function, are common across countries. Others are unique to a country’s particular political economy or value system.

3.2 The countries selected for comment are:

- Australia
- Canada
- Finland
- New Zealand
- Sweden
- The Netherlands
- United States of America

3.3 These countries have been chosen because they appear to be most comparable to the circumstances prevailing in the United Kingdom and therefore also of most relevance to Northern Ireland. I am indebted for much of the material used in many of the country profiles to the review of eight countries commissioned by the Wanless review team. This has been published simultaneously with the Wanless report (Allin et al 2004). A brief section on developments in Britain, comprising England, Scotland and Wales, is also included. It is often the case that Northern Ireland looks to Scotland and, to a lesser degree, Wales, for models of policy and practice. Visits to the rest of the UK have been undertaken as part of Capita’s review of the public health function in Northern Ireland so it is not intended to go into any detail about the development of public health in these countries. But post-devolution there is evidence of greater policy diversity and the forms this is taking in health may have a greater relevance to Northern Ireland than past practice.

Australia

3.4 Population health in Australia is relatively good with positive health indicators. Life expectancy at birth for women was 81.5 and for men 75.9 in 1998. Cardiovascular disease accounts for 40% of deaths. Health spending is approximately 8.5% of GDP, and 5.3% of total health expenditure is allocated to public health and prevention (OECD 2002).

3.5 The Federal structure of government shapes the way in which public health is pursued and organized. Tax powers reside with the Commonwealth government based in Canberra while, according to the principle of subsidiarity, service provision is made available at the level closest to the community. Therefore, the States and Territories are largely responsible for local policy, planning and implementation, disease surveillance, and enforcement of standards affecting public health. Local government across Australia varies in the extent to which it is active in public health.

3.6 The Commonwealth Department of Health and Ageing ‘seeks to provide better health and healthier ageing for all Australians through a world-class system’. The public health activities undertaken by the Federal and State governments are in four areas: health protection, illness prevention, health promotion, and infrastructure development.

3.7 During the late 1980s and 1990s, the Commonwealth began to assume greater importance in supporting public health programmes and to shape the public health priorities of the States/Territories. Reflecting the move towards national approaches to public health, a number of reports have been produced that identify public health priorities in Australia. The 1986 Better Health Commission report identified three public health priorities – injury control, cardiovascular disease, and nutrition – and the report stimulated the National Better Health Program. The priorities under this programme – hypertension, preventable cancer, injury prevention, nutrition, the health of older people – were subsequently adopted by the National Health Priority Areas. Since 1996, additional national health priorities have been adopted – diabetes, asthma, and arthritis. These priorities coincided with new studies on the burden of disease.

3.8 Over the period 1996-98, the Commonwealth, State and Territory governments negotiated two public health reforms: the ‘broadbanding’ of programme funding so that the States/Territories receive a single block grant from the Commonwealth rather than specific programme funds, and the establishment of the National Public Health Partnership (NPHP). The NPHP provides a formal structure for the Commonwealth, States and Territory governments to develop a national agenda for public health in Australia. Its aims are to improve the health status of all Australians through improved collaboration in national public health efforts, better coordination and sustainability of public health strategies, and strengthened public health infrastructure and capacity nationally. The NPHP Group is a subcommittee of the Australian Health Ministers’ Advisory Council and was established to oversee the development and implementation of this national approach to public health.

3.9 The NPHP adopted a chronic disease prevention framework in 2001 as an integrated response to the National Health Priority initiative. Prevention is now a major national policy plank. Most recently, the NHPH categorises priority work areas under capacity building, health gain, health protection and partnerships. Priority-setting and decision-making are broadly based on studies documenting burden of disease and evidence of effectiveness, including cost-effectiveness, of public health approaches.

3.10 The NPHP is committed to cross-cutting approaches in addressing health inequalities, improving the quality of public health practice, engaging with key stakeholders, strengthening the evidence for public health interventions, and enhancing economic arguments for public health, integrating key risk groups and areas into all work programmes, promoting collaboration and priority-setting through public health research, and achieving regulatory reform. The NPHP has developed a series of mechanisms to improve planning and resource allocation for public health activities, including: a public health expenditure study (AIHW 2001), a study aimed at defining core functions for public health (NPHP 2000a), a planning framework for public health (NPHP 2000b), a review of resource allocation for public health (Deeble 1999), and a schema for using evidence in public health (Rychetnik and Frommer 2002). The schema provides a framework for assessing evidence concerning public health interventions. Prediction of the safety and effectiveness of specific public health interventions depends on knowledge of what interventions have worked, or failed, in the past.

3.11 A National Health Priority Action Council (NHPAC) has also been established with the goal of ‘working with others to improve health and wellbeing and reduce health inequalities across the continuum of care in Australia, by identifying, advocating and facilitating actions and strategies both within and across national health priorities’. The objectives of the NHPAC are to:

- improve the health status of Australians, in particular at risk population groups
- improve collaboration in the national public health effort
- develop better coordination and increased sustainability of public health strategies
- strengthen public health infrastructure and capacity nationally
- facilitate the contribution of all providers of public health services, such as local government, public health research and education programmes, and relevant agencies from the States/Territories and the Commonwealth, including the AIHW and the NHMRC
- establish two-way exchange with key professional, community, consumer, educational, and industry interests on the development of national public health priorities and strategies
- enhance the capacity of States/Territories to respond to local priorities.

3.12 A notable feature of policy-making in Australia is the increasing attention being focused on the use of economic evaluation in public health decision-making. The most recent manifestation of this trend is a report from the Department of Health and Ageing examining the return on investment in public health (Abelson 2003). It ‘provides an epidemiological and economic evaluation of five Australian public health programs, namely: programs to reduce tobacco consumption, coronary heart disease, HIV/AIDS, measles and Hib-related diseases, and road trauma’ (p.7).

3.13 As the report notes, the boundaries between public health programmes and other government actions are often blurred. For example, the taxation of tobacco or other drugs may be regarded as a health protection measure or as a revenue raising measure. Physical education in schools may be regarded as health promotion or as individual self-

fulfilment. Furthermore, the size, diversity and imprecise nature of many public health programmes create practical issues for the evaluation of public health programmes. One set of issues relates to the definition of the programmes. For example, are tobacco taxes part of the tobacco reduction programme? What road improvements count as road safety measures? And what are the major components of programmes to reduce CHD? A related issue is the cost of these public health programmes. Because of their diverse nature some of the programmes are administered outside health care agencies. And even within these agencies there may be no clear accounts for public health programmes. A further complication for the costing of such programmes is the division of responsibility for many programmes between the Commonwealth and the States and Territories.

3.14 Despite the commitment to the use of economic evaluation in public health decision-making, formidable barriers exist to its adoption (Deeble 2003). In practice, decision-making still tends to display the following characteristics:

- within broad programme areas funding is mainly historical which is favoured by bureaucratic methods of budgeting and staffing although there has generally been sufficient growth and flexibility to fund new initiatives
- the accountability and reporting requirements of the Commonwealth government have a major influence on both direction and organisation
- there is considerable overlap between specific preventive activities and broader service programmes
- current activity measures – and unit costs based on them – generally support decision-making within programme areas but not between them
- public health managers believe that they should develop natural measures of health gain which would be comparable across programmes (eg reductions in mortality, morbidity and disability) thus more appropriate for cost effectiveness analysis
- the time lag between the intervention and final outcome is too uncertain for direct evaluation.

3.15 Underlying all these constraints is the fact that the social environment is highly complex and therefore identifying the impacts of specific variables on health outcomes is difficult in a complex, multi-variable world. Improved living standards are likely to be a factor in a reduction in measles or Hib diseases as well as vaccinations.

Canada

3.16 Canadians consider themselves to be healthy. Life expectancy at birth is high – 76.3 for men and 81.7 for women in 1999, and deaths from cardiovascular disease and lung cancer are falling. The prevalence of HIV/AIDS is also decreasing. Expenditure on public health in 2002 was somewhere between \$2.0-2.8 billion with total health spending at \$112.2 billion. Public health accounts for between 1.8% and 2.5% of public expenditures. Public health has become a priority as a result of the recent SARS outbreak. Despite the pioneering policy pronouncements in the early 1970s under the

then health minister Marc Lalonde, public health has not been regarded as a priority in recent years (Lalonde 1974).

3.17 Reflecting Canada's federal constitution, public health is primarily a provincial responsibility. The limited federal role is located in the Population and Public Health Branch of Health Canada. The Branch is primarily responsible for policies, programmes and systems relating to prevention, health promotion, disease surveillance, community action, and disease control where action is required at a federal level.

3.18 Each province has its own public health legislation with varying capacities and expenditures. Within the provinces, the regional health authorities deliver public health services. There has been concern about the quality of these services. An Advisory Committee on Population Health (ACPH) reported in 2001 its concern over the robustness of the public health infrastructure due to declining resources. It also revealed significant disparities between provinces with some having strong public health systems and others less so. Those provinces with the weakest public health systems tended to be those with the highest prevalence of unhealthy behaviours.

3.19 A number of recommendations were made to the Canadian government to strengthen the public health infrastructure, including:

- clearly defined essential functions of public health
- defined roles and responsibilities at each level of the system – national, provincial/territorial, regional/local
- appropriate delivery structures to accomplish functions, roles, and responsibilities within each jurisdiction
- appropriate funding levels and mechanisms that ensure equitable availability of public health services to all Canadians
- appropriate numbers of well-trained staff
- appropriate information systems to support assessment and surveillance
- access to expertise and support to develop a prospective vision, carry out these responsibilities expertly and efficiently, and support innovation and evaluation.

3.20 There is growing pressure in Canada to reform its public health system in a way that will meet some of these deficits, in particular strengthening the public health infrastructure and national leadership. A barrier is the perception that Canadians are healthy although a significant health gap exists between the First Nation peoples (aboriginals) and the rest of Canadians.

3.21 Back in the 1970s at the time of the Lalonde report, health promotion in Canada received a boost. For example, social marketing promoted exercise and smoking rates have been falling steadily. For many, too, Canada is identified with the Ottawa Charter launched in 1986 by WHO. This highlights the need to reduce inequalities, increase prevention, and enhance coping mechanisms. But some of the impetus was lost during the 1980s only to be renewed as a result of the SARS outbreak in the last year which hit Canada hard.

3.22 In 1994, the Advisory Committee on Population Health (ACPH) published a report identifying broad population health strategies on which the provincial, territorial and federal government could collaborate. The ACPH adopted an approach focused on the broad determinants of health with these grouped into five categories to form the basis for intervention: social and economic environment, physical environment, personal health practices, individual capacity and coping skills, and health services. Effective population health, it was suggested, should be built on sound evidence of health impact although it concedes that, while considerable evidence already exists, there remain many gaps. The ACPH concludes that the population health framework should provide a rational basis for setting priorities and investing in population health.

3.23 The ACPH applied the population health framework to a comprehensive examination of all the major determinants of the health of Canadians at all ages, looking in particular at differences by socio-economic status and gender. The reduction of persistent inequities in health status was regarded as one of the greatest challenges to improving population health. But the policy goal was not seen to be equality of health status but the achievement of equitable access to opportunities and supportive environments. The ACPH highlighted three broad priorities for action: renewing the health sector through collaborative efforts, investing in the health and wellbeing of key population groups (children, youth and Aboriginal people), and improving health by reducing inequities in literacy, education and income distribution (ACPH 1999).

3.24 In 2001, Health Canada devised a population template to improve the health of the entire population with an emphasis on reducing health inequities (Health Canada 2002). The template sought to consolidate current understanding of population health through outlining the key elements needed to implement the population approach, and the actions required for mobilization. The eight key elements are:

- focus on the health of populations
- address the determinants of health and their interactions
- base decisions on evidence
- increase upstream investments
- apply multiple strategies
- collaborate across sectors and levels
- employ mechanisms for public investment
- demonstrate accountability for health outcomes.

3.25 The Canadian government recognizes that there are challenges in implementing this approach and proposes a long-term investment plan with six strands:

- *Theory*: to develop concepts and theoretical frameworks
- *Policy*: to adapt the approach in policy development
- *Evidence*: to develop the evidence base to ensure that decisions about health and health care are based on best available knowledge

- *Marketing*: to advance the population approach through marketing, communications and education
- *Mobilization*: to mobilize through partnerships and inter-sectoral action
- *Institutionalisation*: to establish the organizational infrastructure to sustain the approach.

3.26 Although there are initiatives in place that explicitly incorporate this population health approach, their outcomes have yet to be assessed. Health Canada intends that this be done. Health Canada has also proposed a major reform of the public health system, increasing the role of the federal government. It has recommended the formation of a Canadian Agency for Public Health, with a chief public health officer. At present, Canada has no national health goals. Nor does it have mechanisms to provide funding to the provinces to facilitate the implementation of any national strategy (unlike Australia, for example). However, a perceived need to develop a national public health strategy exists together with specified goals, the means of monitoring progress towards them, and mechanisms to ensure collaboration at all levels of government.

3.27 Calls for reform have taken on an added urgency following the SARS outbreak in Toronto. A strong national public health system is necessary because infectious diseases and other threats are no respecters of political boundaries and there is a need for common standards to allow sharing and comparison of information. There are, in addition, potential efficiencies to be achieved by avoiding duplication in areas like R&D, skills training, and knowledge management. A national approach is also deemed to be desirable in order to develop and disseminate updated reviews of the evidence based for public health programmes.

3.28 Pressure to give greater priority to health issues has come recently in a report published by the Canadian Population Health Initiative, a part of the Canadian Institute for Health Information, created in 1999 (Canadian Population Health Initiative 2004). The report, *Improving the Health of Canadians*, addresses four key themes: income, early childhood development, Aboriginal people's health, and obesity. While acknowledging the importance of individual lifestyle factors, the report places considerable emphasis on the social, economic and cultural factors (including education, employment, income, housing, environmental factors, early childhood development, and community and social supports) which influence and shape individual behaviours.

3.29 The report builds on an earlier report, *Toward a Healthy Future*, published in 1999 by the Federal, Provincial and Territorial Advisory Committee on Population Health. It concludes that while there has been progress in improving health, 'much remains the same. For instance, inequalities in health by education and income endure, and regional variations in health and its underlying determinants persist' (p.16). To make continued improvement in health and to reduce health inequalities, 'public demand and political will to create and sustain change' are required (p.17).

Finland

3.30 Finland enjoys high standards of health. It has one of lowest infant mortality rates in the world. Life expectancy at birth is 74 years for men and 81 years for women in 2000. In common with other Scandinavian health care systems, the Finnish system is characterized by a high degree of decentralization. While broad policy goals are decided by central government, considerable responsibility for the delivery of curative and preventive services lies with the municipalities. Total health spending in Finland is relatively low at 6.8% of GDP, 76% coming from public sources.

3.31 The Ministry of Social Affairs and Health is the lead central department responsible for public health. It initiates legislation in health and social care policy and monitors its implementation and is supported in these tasks by the National Research and Development Centre for Welfare and Health (STAKES). This organization has a wide-ranging remit for health care evaluation and includes a department of promotion and prevention that examines health protection, environmental health and chemical affairs, and policies on tobacco and alcohol control. The Ministry works with a council that oversees quality and equity in the provision of municipal health services.

3.32 Since 1993, the municipalities' autonomy in the health sector has increased with municipal health committees deciding on priorities and the local organization of services. The municipalities also have primary responsibility for environmental health. Their activities, which must conform to national legislation laying down minimum standards, are coordinated through the federation of municipalities.

3.33 The passing of the Primary Health Care Act in 1972 was one of the major milestones in the history and reform of Finnish health care. A key element of the reforms was the creation of health centres at primary level providing a range of curative, preventive and public health services to a defined population. The municipalities retain considerable autonomy in the operation of these centres.

3.34 Finnish health policy, in keeping with its devolved arrangements, is also characterized by inclusiveness with many groups participating in decision-making through various mechanisms. These include professional and patient organizations, employers, trade unions, service providers, political organizations, and academics. National priorities are determined by means of a process leading to five year plans with operational policies being decided by the municipalities. Successive Finnish governments have placed a high priority on health promotion, prevention and equitable access to health care.

3.35 The National Public Health Institute (NPHI) is accountable to the Ministry of Social Affairs and Health. It is the lead organization responsible for communicable disease surveillance. Immunisation is provided free by the health centres and rates are high with uptake of measles vaccine at 99% among the highest in Western Europe. The NPHI also has a broader role in promoting health. As a major research centre, it is responsible for providing relevant information to decision-makers at all levels. In 2001, Finland adopted

a resolution drawing on the WHO *Health for All* strategy and setting national health policy targets for the next 15 years with an emphasis on reducing health inequalities and increasing healthy life expectancy (Ministry of Social Affairs and Health 2001). These broad goals are complemented by specific targets and corresponding action plans. The Finnish government has identified certain preconditions that must be met in order to achieve the targets:

- involvement of all sectors and levels of government
- involvement of the private sector
- incorporation of the social dimension into the public sector's long range policies, programmes and action plans
- monitoring progress using indicators devised for this purpose
- inclusion of all main areas of everyday life such as homes, schools, workplaces, leisure environments, transport and public services in public health policy
- health promotion should take place at all phases of life from birth to old age.

3.36 Finish policies seek to incorporate an emphasis on health throughout the lifespan in all aspects of public health policies. For example, in childhood there is an emphasis on enhancing the role of day care and preschool facilities in promoting child health, providing financial assistance to help children who are at risk of marginalization, and monitoring indicators of psychosocial wellbeing among children. In adolescence, policies emphasise collaboration between schools and social and health services. During the working life, the emphasis is on strengthening traffic and occupational safety programmes, targeting male violence, and ensuring access to health care for the unemployed. For elderly people, a need has been identified to promote independent living.

3.37 Finland's national health policy targets were guided by criteria set by the National Public Health Committee in 1999, stating that health targets should:

- not be too numerous in order to emphasise the importance of each target
- be wide enough to cover major public health problems and facilitate action, and avoid focusing on specific narrow problems just because progress is more easily monitored
- be realistic, easily understandable and appreciated by the public and the politicians in order to remain credible and retain wide commitment
- lend themselves to evaluation and measurement
- be formulated in partnership with key implementers
- be devised in conjunction with process targets to show how outcome targets are to be achieved (Koskinen and Melkas 2002).

3.38 The Finish government recognizes the need for monitoring and evaluation of its strategies with both the NPHI and STAKES playing a role. Progress towards the targets is intended to be monitored every four years. In addition, the Ministry of Social Affairs and Health requested the WHO to assess health promotion activities in Finland.

3.39 As the WHO review team's report noted, 'Finland has long demonstrated strength in policy thinking, planning and implementing comprehensive health promotion programmes in important topic areas' (p.38). Finnish initiatives in, for example, tobacco control, cancer prevention and in heart health promotion have been taken up by the rest of Europe and beyond.

3.40 Nevertheless, there are weaknesses in Finland's commitment to health promotion and ability to deliver on it, and doubts over whether its national institutions are well-placed to lead and support health promotion. Historically in Finland, success has been based on well-established national public health leadership over a sustained period. As an earlier review of health policy in Finland concluded, 'intersectoral action has been an actively sought and broadly supported aim of health policies' (Koivusalo, Ollila and Santalahti 1997). This showed, however, that achieving intersectoral action has not been easy and is 'endangered due to changing policy contexts and cost constraints' (p.56). The authors also noted another trend that could reduce the emphasis on intersectoral action, namely, 'the increasing pressures from the changing role and scope of the public sector and the narrowing potential to implement national level policies' (ibid.).

3.41 The WHO review team, some years later, also commented on the potential for intersectoral action and the need for this to be strengthened. The review team noted that public health policy should be formulated in response to broad social and environmental determinants and that individual risk factors be addressed within that context. A strategic approach to intersectoral health policy should be adopted in which health is recognized as a strategic resource for social and economic development; reducing inequalities is put at the heart of the implementation agenda; and ensuring that all policies are assessed for their impact on health. The review team questioned whether the Ministry of Social Affairs and Health is able, in terms of its scope and resources, to give sufficient priority to developing the intersectoral health policy agenda.

3.42 Turning to the municipal level, there is a serious absence of public health leadership. This is despite the significant responsibilities the municipalities have for maintaining population health in Finland's highly devolved system of government. In particular, there is a need for the municipalities 'to go beyond their continuing strong emphasis on medical care services into the systematic promotion of health' (p.41). Health promotion should also 'become fully integrated with the overall social and economic agendas locally' (ibid), and be mainstreamed within the health care sector, especially primary care. The review team considered that both professional and technical skills were lacking at municipal level which prevented it responding to the critical challenges noted above. Clearly identified leadership was seen to be an essential prerequisite. The team noted that the Finnish Association of Local Authorities is well placed to provide an important link between local administration and central policy-making in health. However, the Association appears to have no clear policy focus on health promotion and extremely limited resources and professional capacity. If these deficits were addressed, 'the Association would appear to have great potential to become an important player in a constructive and functional public health alliance and to provide strong and dynamic

support to the local government sector in the promotion of health and the integration of social, economic and health development' (p.44).

3.43 In conclusion, while the WHO review team found much that was positive in Finland's health promotion/public health commitment, it also identified some weaknesses which resulted in the following recommendations:

- strengthen inter-sectoral mechanisms
- ensure adequate human resource capacity for both planning and implementation
- introduce health impact analysis to all relevant health initiatives
- ensure robust implementation of the Health 2015 strategy
- determine the best way to assist municipalities in health promotion activities and strengthen the interconnection between them and the centre
- assign and manage appropriately the national level roles in supporting and facilitating local health promotion
- make more use of evidence-based policy-making (WHO 2002).

New Zealand

3.44 If there is a country anywhere in the world that has been more active and radical in modernizing its health care system then it surely has to be New Zealand. In the 1990s, it went further than the UK in introducing competition and market principles into its health care system. The emergence of a coalition government following the introduction of proportional representation led to a reassessment of the reform of the health care system in the light of declining public confidence. Compounding the low public confidence in its health system is the poor ranking of New Zealand by WHO – 41st in the world in 2000. Health expenditure as a percentage of GDP in 1998 was 8.0%.

3.45 As part of the health reforms introduced in 1990, a Public Health Commission (PHC) was established in 1992. It proved short-lived and was abolished two years later in 1994. A review of the health reforms conducted in 1994 reflected on the role and future of public health structures about which the Ministry of Health had advised significant problems existed (Gauld 2001). The review noted that the PHC had produced many positives, including raising the profile of public health, 'ring-fencing' of public health funding, regular monitoring and analysis of public health status, linking of strategic planning to purchase priorities in public health, and widespread consultation about priorities for public health action.

3.46 However, the review also found that the new public health structures had 'failed to resolve some of the issues that were a feature of the previous arrangement – and created new complexities' (Shipley 1994: 17). A range of problems was listed, including:

- public health services remained fragmented across 21 agencies making it difficult to regulate with consistency

- the split of responsibility between the Ministry of Health and the PHC for regulatory and non-regulatory public health remained unclear causing confusion among local officials
- there was unnecessary overlap between the PHC and Ministry of Health despite the fact that contestability of advice had previously been viewed as desirable
- the chain of accountability from the Minister of Health through the Ministry of Health, PHC, Regional Health Authorities and then to local agencies was too long with the result that the PHC and RHAs were often bypassed to aid swift communications; there were also significant transaction costs among the various agencies
- there was unease at what the Minister of Health saw as a lack of a principal policy adviser to the Minister on public health.

3.47 This last problem was seen as especially critical in the abolition of the PHC. The arms-length relationship adopted by the PHC meant that it did not see it as appropriate for its staff to work closely or interactively with Ministers. The PHC saw its chief executive and staff as accountable to the PHC Board and not directly to the Minister. The PHC was also committed to developing its policy work programme and its policy advice via a process that kept the agenda and the content of its policy advice at arms-length from the Minister until such advice is presented and released publicly. Such a policy did not meet the needs of the Minister and the Cabinet for advice and support. Indeed, it risks embarrassing the Minister if (s)he is unaware of what the PHC might be proposing or recommending by way of policy initiatives or criticism. There was a need for policy capacity to advise on any issue raised by the Minister, to develop and implement Ministerial policy initiatives in close cooperation with the Minister and Cabinet Committee processes, and to respond rapidly and flexibly to changing Ministerial priorities. The PHC was simply unable to function in this way thereby leaving the Minister rather exposed and unsupported. It was perceived as unsuitable for performing as principal advisor and most of the Ministry's public health advisers had been transferred to the PHC when it was set up.

3.48 The Minister's review put forward two options for consideration. The first entailed the abolition of the PHC and the integration of its functions into the Ministry of Health. This would solve most of the problems outlined above. Second, existing structures would be retained but officials would develop proposals to improve coordination of advice, regulatory and non-regulatory activities, and the purchase of public health services. The decision to disband the PHC was taken quickly at the end of 1994 by the Minister of Health.

3.49 Gauld suggests that a number of other factors, unacknowledged by government, may have contributed to the demise of the PHC (Gauld 2001). It was alleged that the PHC, as an independent body, posed a threat to the work of the Ministry of Health and this had resulted in rivalry between the two agencies. The PHC also produced advice that clashed with government policy. It was critical of rising poverty levels and restrictions on access to housing, health and welfare services initiated under the social services restructuring programme launched in 1991. A further reason for terminating the PHC was increasing

pressure from the powerful tobacco, alcohol and food lobbies to silence the Commission (Bandaranayake 1994; Hutt and Howden-Chapman 1998).

3.50 Following the PHC's abolition, responsibilities for monitoring public health and providing ministerial advice were transferred to a Public Health Group located within, but no longer independent of, the Ministry of Health. Public health purchasing was transferred to the four RHAs.

3.51 The 1999 Labour-Alliance coalition government was committed to rebuilding the health system and to ending competition in favour of cooperation. Part of Labour's critique of the health system was its focus on treatment as opposed to the improvement of community health and the absence of a clear channel for advice to government on health issues (Gauld 2001). New district health boards (DHBs) were established with the following primary objectives:

- promote, protect and conserve the public health, and to provide health services
- to establish and maintain an appropriate balance in the provision and use of resources for population based public health services and health treatment services.

3.52 Many DHBs expressed excitement at being given the capacity to stimulate and invest in community development and link with areas such as local government and housing. DHBs were explicitly charged with giving greater attention to health determinants and public health strategies and to reducing health inequalities. The focus on health determinants and on promoting programmes that will advance health status and reduce health inequalities is also apparent in the New Zealand Health Strategy (King 2000). The Strategy contained seven principles for health care delivery, three of which focused on public health:

- good health and wellbeing for all New Zealanders throughout their lives
- an improvement in health status of those currently disadvantaged
- collaborative health promotion and disease and injury prevention by all sectors.

3.53 Furthermore, the Strategy listed a set of population health objectives for 'immediate action' by Ministry of Health and DHBs. These included:

- reducing smoking, improving nutrition and reducing obesity
- increasing the level of physical activity
- reducing the incidence and impact of cancer, cardiovascular disease and diabetes
- improving the health status of people with severe mental illness.

The Strategy listed five service priority areas of which the first was public health.

3.54 The Strategy is being implemented in two phases. Phase one, which occurred through 2000, sought to forge a framework for the sector; phase two will commence once the DHBs have established community and intersectoral links in areas such as education,

housing and employment. Phase one focused on goals and priority areas, while phase two will concentrate on galvanizing intersectoral links, developing specific strategies and implementing 'toolkits' to help DHBs best meet their population needs (Gauld 2001).

Sweden

3.55 The contribution of public funding to health care among the Nordic group is highest in Sweden (around 90%). The health of the Swedish population is excellent by international standards. In 2000, life expectancy at birth for men was 77.4 and women 82 years (OECD 2002). Death rates from many causes common elsewhere in Europe are relatively low. However, Sweden shares with other northern European countries a potential risk of heavy alcohol consumption. Efforts to tackle this problem have dominated public health efforts.

3.56 As a wealthy and egalitarian society, unemployment has been low although it increased during the 1990s. While health inequalities decreased through most of the 20th century, they began to increase in the 1990s both in terms of income and geography (ie widening disparities between urban and rural areas). This is a significant development in Sweden as equality in health has been a longstanding national goal of health policy. Since the 1930s, Sweden has pursued the goal of equity through its policies on family and child welfare, education, housing, and regulation of the labour market. The scale of income inequality and poverty is low in relative terms as a consequence of a longstanding commitment to income redistribution.

3.57 The Swedish health system is highly decentralized with many responsibilities, including public health services, devolved to county councils. Each county council has a department of public health tasked with service planning based on epidemiological data and committed to strengthening prevention. Below the county councils are the municipalities charged with the task of delivering specific public health functions and targeted prevention programmes. The role of central government is to set the overall direction for health policy and national standards.

3.58 There is a long tradition of public health reporting in Sweden. Every three years since 1987, the National Board of Health and Social Welfare has published a national public health report which has contributed to a process of strengthening the central public health function. These reports describe patterns of health and disease, living conditions and risk factors, and the distribution of health resources (Calltorp 1999). At county level, policies are informed by a system of public health reporting drawing on epidemiological and demographic data and on household surveys.

3.59 Swedish policies on prevention have been based on a series of specifically targeted programmes. One of the earliest such programmes concerned antenatal and maternity care and child health. It was wide-ranging in scope going well beyond the health sector to encompass school lunches, support for families with many children, and housing.

3.60 As in many other countries, a renewed interest in public health emerged in the 1980s with a shift of perspective from medical care to health promotion. In 1987, the government formed a public health policy group. An outcome from this was the formation of a National Institute for Public Health in 1992 which is responsible for health promotion, disease prevention, and reducing inequalities. It also draws on expert advice from other organizations such as the National Environmental Institute, the National Psychosocial Institute, and the National Council for Technology Assessment in Health Care.

3.61 The process of setting priorities within the health sector has been informed by a series of reports from the Parliamentary Commission on Choices in Health Care established in 1992. This commission was composed of members of parliament and expert advisors from the fields of clinical medicine, health economics, health administration, law and ethics. In 1995, the commission published a report, *Priorities in Health Care – ethics, economy and implementation*, which emphasized the need for a balanced health system with equitable resource allocation that would preserve equity of access and outcome (Calltorp 1999). The key principles guiding decision-making, according to the report, should be based on an ‘ethical platform’ of human dignity, need and solidarity, and cost efficiency. In 1997, the government adopted these guiding principles although their impact on policy is unclear.

3.62 A National Public Health Committee was established in 1997 bringing together researchers from various fields to develop national goals for public health and strategies to achieve them. Nineteen reports were published involving over 100 public health experts. During its three year existence, the Committee fostered a broad discussion with the public, politicians, and civil servants at national, county and municipal levels, researchers, and commercial and civil society organizations (Swedish National Committee for Public Health 2001).

3.63 In 2003, Sweden established for the first time a comprehensive national public health policy with the goal of creating the ‘societal conditions that ensure good health on equal terms for the entire population’ (Swedish National Institute of Public Health (NIPH) 2003). The policy drew on the Public Health Commission’s reports and on research-based evidence but located within an explicit ethical framework and based on a social model for health. The process was highly inclusive, involving political and non-governmental organizations, county councils, municipalities, trade unions, and academic institutions. The approach was multi-sectoral, with targets focused on health determinants rather than outcomes, given the often lengthy lag periods between changes in risk factors and their outcomes. Three health issues were identified: steadily increasing life expectancy, the pattern of declining self-estimated good health among young people, and the remaining health gap between social groups (Pearson 2000). The National Public Health Policy included 11 goals. The first set of goals, addressing the development of social capital, counteracting disparities in income, enhancing opportunities for children, supporting high employment, improving access to recreation facilities, and promoting safe environments and products, emphasizes the importance of reducing health inequalities in Sweden. Subsequent goals focus on lifestyle factors,

although emphasizing the importance of avoiding victim-blaming while supporting healthy choices. The importance of partnership with health care providers is recognized – they are challenged to focus more on disease prevention and health promotion and to foster intersectoral collaboration. Interestingly, the policy was also intended to politicize health (Pettersson 2003).

3.64 While there has been no systematic evaluation of contemporary Swedish public health policies, there has been increasing awareness of the need for monitoring and evaluation. It has been proposed that progress towards the national public health goals should be reported on every fourth year in two reports – one on public health policy from the NIPH and the other as part of the national public health report from the National Board of Health and Welfare. In parallel, the NIPH has placed a high priority on developing the evidence base for public health policy, in particular the need to understand better the relationship between health determinants and outcomes. It also has a role in monitoring and evaluating progress in public health at national, regional and local levels. A public health policy report – the first ever – is in preparation and will be published in 2005.

3.65 The quest for improved evidence has also sought to increase the use of economic evaluation in public health as illustrated by a meeting held in 2003 on the economic evaluation of health effects due to transport. This explored topics such as air pollution, noise, physical activity, psychological and social effects, road safety, and climate change. Significant health-related costs from vehicle associated pollutants were identified. Another example of the application of economic measures in the field of public health is a study of the cost-effectiveness of existing road safety policy in Sweden (Elvik 2003). It concluded that implementation of cost-effective road safety measures could prevent 50% of traffic-related fatalities in Sweden, whereas progress with current policies would prevent only 10-15% of the current number of deaths over the next 10 years.

3.66 Political anchoring for the commitment to public health has been achieved through various means including the appointment of a public health minister after the September 2002 general election. This junior minister forms a trio with two senior ministers – responsible for agriculture and the environment respectively – together with the deputy prime minister responsible for gender issues. A national intersectoral committee is being established under the public health minister.

3.67 In conclusion, Sweden has programmes and plans demonstrating political will and strong national policy initiatives to promote public health. Much progress has been made although there remain concerns that achieving equity is proving difficult.

The Netherlands

3.68 Total health spending in the Netherlands represents between 8.1% and 9.7% of GDP of which about 1.4% to 4% is spent on preventive services (OECD 2002). Average life expectancy for men is 75.5 years and for women is 80.6 years indicating that overall

health status is good although life expectancy among women is beginning to plateau largely reflecting the effects of heavy smoking (Gunning-Schepers 1999).

3.69 Dutch health policy aims to extend the healthy life expectancy of the population (Ministry of Health, Welfare and Sport 1997). Preventive health policy identifies three target groups: the whole population, specific at risk groups, and individuals. In addition, three forms of prevention are outlined: health promotion, health protection, and disease prevention. Several laws are in place to promote health. For example, the Tobacco Act prohibits smoking in public places and prohibits sales to people under 18 years.

3.70 The public health system is decentralized and fragmented, reflecting the pluralist nature of Dutch health care. Funds allocated from central to local government and designated for public health are not earmarked and consequently expenditure has been declining because of the low position of public health on the political agenda. In 1990, the Collective Prevention Provision Act was passed requiring all municipalities to organize a Municipal Health Department. This department is responsible for infectious disease control, forensic medicine, environmental health, school health services, advice to local government about health issues, and other services that are deemed appropriate by the municipality. Furthermore, the municipalities must have access to expertise in several fields: epidemiology, health education, public mental health, and supporting national screening programmes (Gunning-Schepers 1999).

3.71 The preventive services offered to the general public address infectious diseases, screening and health education. In the area of infectious diseases, municipalities offer disease-specific services such as clinics for sexually transmitted disease (STD), tuberculosis control and childhood vaccinations. Health education programmes are offered as part of the basic school curriculum and use is made of the mass media such as television and radio. These programmes address smoking, AIDS and STD prevention, drugs and alcohol, traffic injury prevention and more recently folic acid intake.

3.72 Another key element of public health in the Netherlands is occupational health. By law, every company must have access to an occupational health physician. However, these occupational health departments are commercial and for-profit organizations. This may ensure improved responsiveness to the company's needs but may conflict with the goal of prevention (Gunning-Schepers 1999).

3.73 There are several important national bodies in the public health arena. The Ministry of Health, Welfare and Sport is advised by several councils, including the Health Council, the Health Research Council, the Council for Public Health and Care, and the Health Insurance Funds Council. Several national institutes play a significant role in policy development including the Trimbos Institute for Mental Health and Addiction Care, the Netherlands Institute for Care and Welfare, the National Institute for Health Promotion and Disease Prevention, the Netherlands School of Public Health, the National Institute of Public Health and the Environment, and the Netherlands Institute for Health Services Research.

3.74 The Netherlands has experienced a growing interest in public health issues, particularly social inequalities in health. In 2001, a National Contract for Public Health Care was signed by the Minister of Health, Welfare and Sport, the Minister of the Interior and Kingdom Relations, and the chairs of the Association of Netherlands Municipalities and GGD Nederland. The signing took place at the *Health as a Common Good* conference. The four parties were entirely in agreement, and advocated incorporating health into all other areas of policy, the idea being that the contract will have a ‘snowball effect’ attracting further partners.

3.75 One of the main objectives of this contract was improved health for as many people as possible. More specifically, the goals were to strengthen public health infrastructure, reduce health inequalities, and encourage healthy lifestyles. There is an emphasis on cooperation between the curative care sector and the public health sector. This contract marks a shift towards increased central government involvement in health policy, and towards more explicit prioritizing of resource allocation. Local authorities remain responsible for implementing the contract.

3.76 There is a growing demand for evaluation of public health programmes to justify their continued funding, perhaps inspired by similar examples in Australia. Dirkmaat and de Wit (2003) reviewed 30 preventive programmes in the Netherlands of which 18 had good quality evidence on cost-effectiveness. The authors found several cost-effective programmes, including primary prevention measures such as vaccination for hepatitis, environmental interventions such as fluoridating water, and secondary prevention measures such as controlling blood pressure for people with diabetes and screening for chlamydia. The review highlights the shift in the Dutch public health decision-making framework towards a strengthened evidence base.

3.77 To overcome problems associated with the decentralized health system in the Netherlands, it was decided to develop a comprehensive information model that covers existing information sources from all sectors inside the health system, is up-to-date and flexible. Thus, the Netherlands also has a Public Health Status and Forecasts project to guide policy-making with the general objective of providing ‘an overview and analysis of the available data in the field of public health, once every four years, with explicit identification of any gaps in the information supply’ (van Oers 2002). The government, health institutions and professionals use the resulting information extensively. Socio-economic inequalities have been identified by the project as a major public health issue.

3.78 The major findings of the 2002 Dutch Public Health Status and Forecasts Report seek to guide decision-making. After reporting trends in population health, it makes a number of policy suggestions, including:

- deaths from CHD, stroke and lung cancer are decreasing
- life expectancy for men is falling behind the EU average and male mortality from lung cancer is one of the highest in the EU
- rates of infant and perinatal mortality are comparatively high

- there are persisting inequalities in health, with the least educated men living 5 years less than the most educated men
- unhealthy behaviour is the major cause of stagnating health
- there is a need for a new approach to prevention, with improved evaluation, integration of prevention within the healthcare sector, and more intersectoral work.

3.79 The Ministry of Health, Welfare and Sport has highlighted the importance of international comparisons. Lifestyle factors, particularly smoking, are perceived to be responsible for a major part of the differences in mortality between European countries, and the relatively poor performance of the Netherlands compared with other countries.

3.80 In all the countries reviewed here, health inequalities comprise one of the most frequently cited priority areas in public health. Despite the significant body of research that has been produced to explain inequalities, there remains considerable difficulty merging the research with practice and implanting effective interventions (Hunter and Killoran 2004). Further difficulties result from the need for comprehensive policies as isolated policies are unlikely to have much effect on reducing inequalities. Despite these problems, there has been considerable progress in the development and evaluation of strategies to reduce inequalities in the Netherlands, especially since 1980 (Stronks 2002).

3.81 The Dutch strategy on inequalities has produced considerable knowledge through national research programmes on the causes of inequalities and on how they can be tackled effectively. Nevertheless, there remain many gaps in the evidence on the effects of these interventions.

United States of America

3.82 Despite its considerable wealth, the US is not fully meeting its potential in the area of population health (Kindig 1997). For years, the life expectancies of both men and women have lagged behind those of their counterparts in most other industrialized countries. Life expectancy was slightly below the OECD median in 1999 and in 1998 the average life expectancy at birth for women was 79.5 years and 73.9 for men. This compares with 81.9 and 76.9 years respectively in Sweden and 84.0 and 77.2 years respectively in Japan. In 1998, the US also ranked 28th in infant mortality among 39 industrialised nations. Chronic disease is escalating at a faster rate in the US than many other industrialised nations. The prevalence of obesity and chronic diseases like diabetes are increasing.

3.83 The USA is different from all the other countries briefly considered in this section. Not only is of a population size comparable to the present 15 member state European Union but it is alone in not having a state health system as such serving the needs of the whole population. Indeed, the US is noted for its 'non-system' of health care. Hardly surprising, therefore, that an Institute of Medicine report, *The Future of Public Health*, published in 1988 presented strong evidence to show that the governmental public health infrastructure was in disarray (Institute of Medicine 1988).

3.84 Since this time, attempts have been made to give a higher priority to public health. These include a national plan as part of *Healthy People 2010* to strengthen the public health infrastructure.

3.85 In 2001, a second Institute of Medicine study was launched. It was intended to be more inclusive than the 1998 report. A Committee on Assuring the Health of the Public in the 21st Century was convened and its 500 page report, *The Future of the Public's Health*, was published in 2003. It reviews national health achievements in recent decades but also identifies the 'hidden vulnerabilities that undercut health potential, and that, if not addressed, could produce a decline in the future health status of the American people' (Institute of Medicine 2003: 1). The report is wide-ranging, discussing health as a public good and pointing to the fundamental duty of government being the promotion and protection of the public's health. Health as a primary public good is defended on the grounds that 'many aspects of human potential such as employment, social relationships, and political participation are contingent on it' (p.2). The report adopts the vision articulated in *Healthy People 2010* – healthy people in healthy communities.

3.86 To meet the challenges identified, the report proposes six areas of action and change:

- adopting a population health approach that considers the multiple determinants of health
- strengthening the governmental public health infrastructure, which forms the backbone of the public health system
- building a new generation of intersectoral partnerships that also draw on the perspectives and resources of diverse communities and actively engage them in health action
- developing systems of accountability to assure the quality and availability of public health services
- making evidence the foundation of decision making and the measure of success
- enhancing and facilitating communication within the public health system (eg among all levels of the governmental public health infrastructure and between public health professionals and community members (p.4).

Public Health Developments in Mainland Britain and Ireland

3.87 In all three countries making up mainland Britain – England, Scotland and Wales – there is evidence of growing diversity in those policy areas, like health, for which the devolved institutions have responsibility. This diversity has led to important developments in respect of public health policies in recent years although it is hard to identify how far the rhetoric, backed up by numerous detailed and impressive policy statements, are resulting in change in practice. Principally, this is because it is too early to pass judgement on whether the perceived diversity in policy pronouncements and intentions is being translated into substantive differences in policy outcomes.

3.88 There follows a brief assessment of the position currently prevailing in each of the three mainland countries. This avoids going into detail because the Capita public health function review has undertaken site visits to each of the countries to assess progress. Moreover, arrangements for delivering improved health are still evolving and some, like the Community Health Partnerships in Scotland which will replace Local Health Care Cooperatives, have yet to be established. The subsection on England focuses on the Wanless II report, published in February 2004, and the government's plans for a white paper on public health to be published in the summer. Although Wanless's terms of reference were confined to England, it seems likely that the report will have wider ramifications across the UK in much the same way as his first report on NHS funding did.

3.89 Given the increasing emphasis on strengthening cross-border links and networks between Northern Ireland and the Republic of Ireland in the area of health policy, visibly evident in the work of the Institute of Public Health for Ireland, a brief comment on public health developments in Ireland is in order, following the tour round mainland Britain.

England

3.89 In England, the government's initial commitment to public health when it first entered office and established the first ever Minister for Public Health has been seen to have weakened as a result of its primary focus on acute health care and the modernization of the NHS (Hunter 2003). The government clearly decided that the poor state of the NHS has demanded its full attention. It has been reinforced in this decision by focus group findings which show that the public is especially concerned about waiting lists and waiting times in respect of health care.

3.90 But in recent months, the government appears to have acknowledged that public health is important. As a consequence, it has risen rapidly up the political agenda. A number of reasons account for this sudden conversion to an 'upstream' stance, including:

- a perception that the government has sorted the NHS or at least is well on the way to doing so through a heady policy mix of achieving key targets in respect of access and waiting times, encouraging patient choice, devolving responsibility to local organizations and public and patient fora, moving to fewer targets, and establishing new inspection/regulatory mechanisms
- the need to redefine the Department of Health's role following a decision to move away from a command and control approach to management and in response to criticism that the Department is not concerned with health but primarily with ill-health
- a growing concern among the public with public health issues, notably obesity where there is evidence to suggest that people would welcome and support a more interventionist stance by government on matters like regulating advertising to children

- the review by Derek Wanless of the government's commitment to public health and a perception that he would be critical of this and of the means for securing its effective implementation (see below).

3.91 As a result of these, and possibly other, factors the government has been stung into action in the form of a promised White Paper on public health to be published in the summer 2004. The policy statement will be produced through an extensive public consultation exercise over the next four months. One of the issues on which the government is seeking views is on the relationship between the state and the individual in respect of action on public health issues and who should have responsibility for it. The government is anxious to avoid the charge of creating a 'nanny state' and in many ways regards its role as a facilitating, enabling one whereby the public must be given the information on which to make their health/lifestyle decisions. On the other hand, the government does not want to be accused of shirking its legitimate stewardship duties or of neglecting the protection of the public's health in areas where only it can act.

Wanless II

3.92 Although invited by the Chancellor to undertake a review of progress in implementing the fully engaged scenario set out in his first report, Derek Wanless insisted that his report was to the Prime Minister and Secretary of State for Health as well as the Chancellor on the grounds that it was a report to government rather than to a single department.

3.93 The fully engaged scenario was one of three advanced in Wanless's first report published in 2002 and the most ambitious. Under this scenario, levels of public engagement in relation to their health are high; life expectancy increases go beyond current forecasts; health status improves dramatically; and people are confident in the health system, and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. There is also more efficient use of resources. Over the 20 year period to 2022, the fully engaged scenario delivered the best health outcomes with life expectancy 2.9 years higher for men and 2.5 years higher for women than the slow uptake scenario (ie steady state). It was also the least expensive scenario modeled with a potential saving to the NHS of some £30 billion.

3.94 Importantly, achieving the fully engaged scenario did not simply mean meeting the objectives already set for, for example, smoking prevalence. It was intended to represent a step change in the design and delivery of services and interventions. The achievement of much more stretching and comprehensive aims were required. As Wanless II notes, 'it would also represent a massive shift away from seeing the NHS primarily as a 'sickness service' (Wanless 2004: 14).

3.95 The terms of reference for the 2003-4 review focused on prevention and the wider determinants of England. The review was to

- make recommendations to the government on implementing cost-effective approaches to improving population health, prevention, and reducing health inequalities consistent with the public health aspects of the fully engaged scenario
- help enlist support from across government and other agencies in addressing these issues
- advise on whether the delivery plan to implement the government's cross-cutting review on tackling health inequalities, and other follow-up action including public health delivery plans at the national and local level, is consistent with delivering the public health aspects of the fully engaged scenario.

3.96 Going beyond the widely accepted definition of the public health function put forward by Donald Acheson, the review offers a new extended definition of public health as

the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organizations, public and private, communities and individuals.

3.97 If a single clear message comes through the report it is a negative one. Despite 30 years of analysis and worthy promises to put health before health care, the government's record has largely been one of sustained failure. The fine rhetoric of numerous policy statements has not been translated into effective action. 'What is striking is that there has been so much written often covering similar ground and apparently sound, setting out the well-known major determinants of health, but rigorous implementation of identified solutions has often been sadly lacking' (Wanless 2004: 3). There has been greater success in public health in respect of communicable disease control.

3.98 Apart from the claim that 'in the race for resources public health runs the risk of trailing well behind healthcare services' (para. 2.69: 38), Wanless's critique of the public health function and the weak commitment to it on the part of government contains the following highlights:

- the small public health resource in most Primary Care Trusts and a corresponding reduction in the ability of DsPH to undertake and practice public health
- confusion over the lines of responsibility, and overlap of these, between the Health Protection Agency and PCTs
- the imbalance between public health targets and those concerned with access and waiting times – the latter take precedence over everything else with the consequence that 'public health targets are not considered to be equally important' (para.3.39: 48)
- the distorting effect of targets, especially when 'based on what can be measured rather than what should be measured' (para.3.43: 49)
- a perception that allowing the leadership for public health to remain within the Department of Health is seen as detrimental to public health and to indicate a failure of government to consider fully the importance of all departments in relation to public health as well as to result in a focus on the NHS and on treatment services

- lack of capacity in the public health workforce and the absence of a long-term vision for it
- an almost complete absence of an evidence base on the cost-effectiveness of public health interventions
- gaps in the evidence base persist with only limited understanding of what can be done effectively to prevent illness, and what research does exist offers little with regard to the practical implementation of interventions
- the lack of an evidence base has resulted in part from a lack of investment in public health research
- the body of economic evidence relating to public health interventions is small in comparison to that related to health care
- low levels of health literacy in the population which demand the provision of better health information
- failures in the social context which can significantly influence individuals' decisions
- the limits to government intervention especially if they entail a significant reduction in personal freedoms.

3.99 Wanless II ends with a plea for 'delivery and implementation, not further discussion'. The review wants to see an NHS evolve which will 'need to shift its focus from a national sickness service, which treats disease, to a national health service which focuses on preventing it' (para. 9.1: 183). Wanless puts forward 21 main specific recommendations which are underpinned by a suggested set of principles for adoption by government. The principles are (p.183):

- interventions should tackle public health objectives and the causes of any decision-making failures as directly as possible
- interventions should be evidence-based, though the lack of conclusive evidence should not, where there is serious risk to the nation's health, block action proportionate to that risk
- the total costs of an intervention to the government and society must be kept to a minimum and be less than the expected benefits over the life of the policy
- interventions should be prioritized to select those which represent best value
- the distributional effects of any programme of interventions should be acceptable
- the right of the individual to choose their own lifestyle must be balanced against any adverse impacts those choices have on the quality of life of others.

3.100 Among the recommendations proposed are the following key ones:

- the Secretary of State for Health should be given the role of ensuring that Cabinet assesses the impact on the future health of the population of any major policy development' (para.9.8: 184)
- the efforts of arm's length bodies should be coordinated at local level, for example, the Health Development Agency, Public Health Observatories and the Health Protection Agency

- a commitment of adequate resources for monitoring and feedback should be an integral part of the planning of any national programme of action to tackle the key health determinants
- an annual report about the state of the people's health and of the major determinants of health should be made available at national and local authority levels to encourage understanding
- the new Commission of Health Audit and Inspection should develop a robust mechanism for the performance assessment of the public health role of PCTs and SHAs
- a strategic plan at national level should be produced to implement a coordinated approach to developing the public health workforce; the competencies required to play new roles must be identified.

3.101 Although welcomed, the Wanless II report received a mixed and, on the whole, a rather lukewarm reception. The report is highly descriptive and does not say anything that the public health community and academic researchers have not been saying *ad nauseam* for many years. However, this may be to misjudge what is significant about the report and its author. In short, the message may matter less than the messenger. A former banker, Derek Wanless is held in high regard in government and this will count for a great deal in the months ahead both in the run up to the promised White Paper on public health and in its subsequent implementation in accordance with the tenets of the fully engaged scenario.

3.102 Perhaps most frustrating, although perhaps not altogether unwisely in the prevailing political climate, is the tendency of the Wanless II to avoid taking stances on key issues such as the balance to be struck between government intervention on the one hand and individual freedom on the other. The review leaves such tricky political issues for the pre-White Paper public consultation to explore. Nevertheless, whereas a great deal is said about the need to engage individuals in their health choices rather less mention is made of the role of government in creating the conditions for the actions of individuals.

3.103 Wanless draws sparingly on the study of international comparisons of public health policy commissioned for the review from the European Observatory on Health Care Systems. This is principally because international experience does not provide a framework for a consistent judgement of the effectiveness of interventions within or across topic areas, as the presentation of similar material in section 2 above suggests. Wanless concludes from the international review of eight countries that

that there is still much that needs to be improved in evaluating public health interventions and making decisions to implement based on evidence of effectiveness. The extent of monitoring and evaluation of public health policies appears to be quite limited in the countries examined (box 6.6: 136).

Most progress seems to have occurred in Australia.

Consultation and White Paper on Public Health

3.104 The Secretary of State for Health launched the *Choosing Health?* consultation on action to improve people's health in early March, hard on the heels of Wanless II (Department of Health 2004). Outputs from the consultation will feed into the production of a White Paper to be published in the summer. The timing of the initiative suggests that it was an attempt to blunt Wanless's critique of the failure of successive governments, including the present one, to move beyond fine words and worthy aspirations. But the government sees it differently. Its priority to date 'has been to use the massive investment in the NHS to tackle the public's top priority in health – improved and faster access to high quality health services' (Department of Health 2004: iv). With real progress having been made, 'we have an opportunity to focus on improving health and preventing illness...Wanless has given us a real challenge to strengthen the drive for better health'.

3.105 Among the topics to be addressed in the forthcoming public consultation are:

- restricting smoking
- encouraging walking and cycling
- access to fruit and vegetables
- food labeling
- advertising
- preventing and treating sexual infections
- employers providing healthy workplaces.

3.106 Through its consultation exercise, the government wants the public's views on the role individuals, central and local government, the NHS, the public sector more broadly, the voluntary and community sector and industry, the media and others should have in helping people to be healthier. The White Paper will then set out a 'concerted action' programme 'to generate sustainable improvement in health' (para. 13: 5). The consultation is intended to stimulate a debate that will help:

- define roles and responsibilities
- prioritise what should be done
- engage all partners in improving health
- establish a clear course of sustained action and evaluation.

3.107 Underpinning the entire exercise is a conviction that government's role 'is to ensure that the right balance is struck between individual freedoms and the public good' (para. 5: 7).

Wales

3.107 The health strategy for Wales, *Better Health – Better Wales*, appeared in 1998 with an emphasis on

- health gain and how it can be achieved

- better coordination between local health and environmental services
- increasing local capacity in conjunction with local health promotion specialists
- facilitating a network for sharing health and environmental information
- supporting communities in action to improve health, living conditions and life chances.

3.108 In its own version of the NHS Plan, *Improving Health in Wales*, there is a greater emphasis on public health than in the English Plan. The Welsh approach places the emphasis on strong partnerships among the key stakeholders. The aim is to ensure that the NHS develops ‘into a health service and away from a primary focus on illness’ (National Assembly for Wales 2001: 18). To achieve its goal of realizing the full health potential for all the people of Wales, the plan focuses on four main areas for action:

- multi-sectoral strategies to tackle the determinants of health, ensuring the use of health impact assessment
- health-outcome-driven programmes and investments for health development and clinical care
- integrated family- and community-oriented primary health care supported by a flexible hospital system
- a participatory health development process that involves relevant partners for health at home, school and work and at local community and national levels (National Assembly for Wales 2001: 19).

3.109 The plan acknowledges that none of these actions is new but that they must now be applied to decision-making about improving health. For them to be taken seriously and lead to action, it will be necessary for structures, habits and thinking to change. New skills will be required. The plan shows awareness of the barriers to change when ‘the forces of inertia are strong’.

3.110 Two new agencies have also been, or are being, established to develop the public health function and to provide improved information on which to base policy in Wales. The National Public Health Service (Wales), created in 2003, is intended to improve the delivery of public health services. It provides public health services at a local level supported by the resources and specialist advice of a national organization. The organization is sponsored by the Office of the CMO in Wales and is managed by an NHS Trust. It embraces health protection services as well as broader public health functions. The Service provides each of the 22 Local Health Boards with a Local Public Health Director.

3.111 The Welsh Centre for Health is an independent body working to improve public health and reduce health inequalities in Wales. It was created in shadow form in 2002 and will be fully established as an Assembly Sponsored Public Body on 1 April 2005. The Centre’s functions are

- to advocate on public health issues
- to speak independently on health, free from corporate or economic interest

- to develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales
- to undertake and commission research into such matters
- to contribute to the provision and development of training in such matters
- to establish networks and liaise with relevant professionals and organizations to improve health and well-being.

3.112 These institutional arrangements are too new to offer any judgement on their efficacy or to provide lessons or models for others. However, in the case of the Wales Centre for Health, New Zealand's experience with the short-lived Public Health Commission may be salutary in respect of how independent an advocacy body can be before it upsets or embarrasses its political master or mistress.

Scotland

3.113 Developments in Scotland in respect of giving a greater emphasis to health have paralleled developments in Wales. The Scottish NHS plan follows a similar approach to the Welsh one. *Our National Health: A plan for action, a plan for change*, published in 2001, has as its core aim 'to build a national effort to improve health'. The challenge is particularly acute in Scotland with its reputation, borne out by the statistics, as the 'sick man [*sic*] of Europe'. The plan stresses that 'improving people's health comes first. The organization of health care comes next' (Scottish Executive 2001: section 2).

3.114 To assist with public health capacity-building and to provide evidence about what works, the plan mentions the creation of a public health institute for Scotland. This followed a review of the public health function in Scotland set up by the former CMO (Scottish Executive 2000). Among its recommendations, the review wanted the 15 health boards to become known as 'public health organisations' working closely with local authorities and others. They would have the central role in improving population health. Each board would provide high-profile leadership for public health, developing well-managed multi-agency partnerships for health. The board's organizational development will reflect public health values and methods and many of its resources will be devoted to the public health function. Its decision-making will be driven by public health principles.

3.115 The review also identified a number of threats to a policy for health ever becoming a reality:

- health improvement is not seen as 'a long game' but is subject to short-term gains
- the importance of a good 'sickness' service continues to overshadow the need for a 'health improvement service'
- an inadequate response by all stakeholders to the new public health agenda could limit demonstrable health improvement, thereby leading some to question the 'added value' of the public health function.

3.116 Building on the NHS Plan for Scotland, the Scottish Executive produced a health White Paper in 2003, *Partnership for Care: Working together for a healthy, caring*

Scotland. It seeks ‘a step change in our approach to health improvement’. The model ‘lays strong emphasis on partnership, integration and redesign’ and ‘foresees a central role for primary care teams in new Community Health Partnerships...and in new relationships at community level between NHSScotland and local authorities’ (Scottish Executive 2003a: 8).

3.117 The White Paper claims that it is no longer acceptable for health improvement to be seen as a task for the Director of Public Health. Support and leadership are required from Ministers and departments across the Scottish Executive; local authorities; employers; all professionals in health, education and social inclusion; local community leaders; trade unions; and voluntary groups. ‘Only by putting health improvement onto everyone’s agenda can we join together the various initiatives and achieve an impact which will be more than the sum of its parts’ (Scottish Executive 2003a: 12). The new approach being fashioned will ‘focus on four’: early years, teenage transition, workplace, and communities.

3.118 Also published in 2003 was a further document from the Scottish Executive, *Improving Health in Scotland: The Challenge*. It sought to build on the NHS Plan for Scotland and on the foundation of a 1999 policy statement, *Towards a Healthier Scotland* and is the first in a series with a follow-up document planned for mid-2004. It seeks to provide a ‘strategic framework to support the processes required to deliver a more rapid rate of health improvement in Scotland’ (Scottish Executive 2003b: 5). A key objective announced in the document, and enacted in April 2003, is the creation of a Special Health Board formed by the integration of the Public Health Institute for Scotland (PHIS) with the Health Education Board for Scotland. The new organization is known as NHS Health Scotland and its creation has not been met with unanimous support, especially from those who believed that PHIS, as a new organization with unfulfilled potential, should have been given longer to prove its worth rather than undergo the dislocation and upheaval of yet another structural reorganization.

3.119 Among the other actions proposed in the framework document are the following:

- create a new Directorate of Health Improvement within the Scottish Executive
- ensure Health Improvement is ‘mainstreamed’ by active inclusion of Health Improvement in public sector plans and organization
- create and maintain networks to drive health improvement activity.

Republic of Ireland

3.120 Overall health policy in Ireland is being moulded by the government’s 2001 *Health Strategy – Quality and Fairness: A Health Strategy for You*. Like its predecessor, *Shaping a Healthier Future*, it establishes a sound context for the development of public health policy. The current strategy proposes to put ‘the health of the population at the heart of public policy’ by means of the following:

- health impact assessment

- statements of strategy and business plans of all relevant government departments will incorporate an explicit commitment to sustaining and improving health status
- a population health division will be established in the Department of Health and Children and in each health board.

3.121 The policy intentions are good and Ireland has taken the lead over other countries in implementing a ban on smoking in public places. But problems have arisen over implementation of the government's overall strategy. Plans for this and for new organizational arrangements are being driven by other considerations, notably, mounting concerns over the acute sector fuelled by high profile media exposure of health service failure. Echoing recent developments in the NHS in England, health sector reorganization has taken precedence and overshadowed the public health agenda. Other factors include:

- the extent of the medicalisation of public health in Ireland as demonstrated by the public health doctors dispute in late 2003
- the absence of compatible organizational frameworks between the various sectors at regional and sub-regional levels – the coterminosity issue
- the weakness of local government and general poor performance perhaps linked to the absence of significant powers which mean it is unattractive as a career option
- the absence of an information strategy on cost grounds although a revised information strategy is expected shortly which will make reference to public health observatories (there have been discussions between the Association of PHOs in England and the Institute of Public Health in Ireland).

4. Some Common Themes and Future Prospects

4.1 The selected country profiles presented in section 3 demonstrate a number of common themes which are considered in this final section.

4.2 First, notwithstanding a diversity of political values and governmental and organisational structures, there is a similarity across the countries examined of broad policy strategies and goals in respect of public health concerns. All countries appear to be exercised by the persistence of public health problems especially in respect of communicable diseases and a widening of health inequalities in society, even in those countries which traditionally have not experienced a significant problem in this area.

4.3 Second, virtually all of the countries selected for review have decentralized structures in respect of health policy-making and implementation. Local or regional government plays a more prominent role in public health than is the case in the UK. Although local authorities in England do have a statutory responsibility for the social wellbeing of their communities, few appear to regard this as giving them a powerful public health role. Moreover, local government in the UK is not the vibrant force it appears to be elsewhere in Europe. And while devolution exists within the UK in respect of devolved political arrangements for Wales, Scotland and perhaps in time Northern Ireland, there is as yet no

elected regional tier of government in England with the prospects still uncertain. Such a democratic deficit contrasts sharply with federal arrangements in Canada and Australia. On the other hand, especially in respect of health protection and epidemiological surveillance, centralized arrangements may be more appropriate and fare better than fragmented ones operating at a sub-national level.

4.4 Third, for all the well-meaning, and no doubt genuine, concern over public health all countries struggle to maintain a political commitment to it in the face of competing pressures from acute health care services. Some countries, like Sweden, are seeking to rediscover public health as part of a focus on social reform rather than health sector reform, while countries like England and Wales, perhaps as a result of the influence of Derek Wanless in both countries, are adopting a more instrumental stance seeing progress in public health as ultimately easing demands and cost pressures on the NHS and therefore representing a sound investment strategy in respect of claims on public finances. Although public health is rising rapidly up the political agendas in many countries there remain concerns over how sustainable this will prove to be given that the timescale for results can be decades rather than months and years.

4.5 Fourth, despite the new-found enthusiasm for public health, countries have remarkably little to show for investing in it when it comes to sound evidence over what works and is cost-effective. Australia appears to be leading the way in this area but it is too early to judge whether the cost-effectiveness approach is resulting in a greater determination to put public health first. Having good evidence is no guarantee that action on it will follow – just as an absence of evidence is not necessarily the overriding factor in a government's determination to act in areas where it feels strongly motivated to do so.

4.6 Fifth, there is a lack of effective connection between policy formation and its implementation. The outpourings of governments in the form of policy statements of various kinds are not matched by successful achievement on the ground. It was an issue which exercised Derek Wanless in his review of public health in England. He was clear that the causes lay in poor leadership, weak information systems, a poor evidence base, and a workforce that is not fit for purpose. But arguably these are all symptoms of a deeper and more pervasive vacuum in political will. Indeed, the World Health Organisation has no doubts that this is the root cause of the absence of progress in improving population health. A WHO review of health policy developments in Europe concluded that the health sector 'still appears to act largely alone, and tends to be dominated by medical models' (Ritsatakis 2000: 353). It continues:

even when attempts have been made to carry out more community-based programmes for health promotion, it is not unusual for this to be carried out almost as a sideline, parallel to actions in the traditional health sector where it is 'business as usual'.

4.7 More recently, in its review of the state of global health, WHO has asserted that the impediments to change owe as much, if not more, to an analysis centred on politics and power as to one centred on technical or managerial defects or deficits. It is not primarily a lack of knowledge that is hindering progress but the absence of political will and governments are urged to adopt bold policies (WHO 2002).

4.8 This leads to the final theme which is evident in many countries, namely, the pressure of globalization and the emerging market state. These forces are putting pressure on public services and on what the appropriate role of the state should be vis-à-vis the individual. It amounts to a supreme policy paradox: on the one hand, public health enjoys a much higher profile for reasons noted earlier, while on the other hand the changing conceptions of the public realm and the role of government may make it even more difficult to achieve good public health. Or it may be that the public health function needs to adapt to these new realities and acquire new frameworks and skills in order to develop effective levers for change. The challenges posed by these new realities are the subject of the final sub-section.

What of the Future?

4.9 If there are the glimmers of an international consensus emerging about the importance of public health and the need to take it seriously in the face of numerous global threats, some new and some familiar, then what are the prospects for public health and the policy context surrounding it? And how might the paradox noted in paragraph 4.8 be resolved if, indeed, it can be?

4.10 If Philip Bobbitt's thesis that we are witnessing the replacement of the nation state by the market state with 'its indifference to the state's role in ensuring justice' is accepted, then what is the place of public health in the new world we are not merely approaching but have already entered (Bobbitt 2002: 232)? This is a crucial question since the market state is both sceptical about government and has a compact with individual choice. Bobbitt maintains that

the transition to the market-state is bound to last over a long period and put into conflict the ideals of the old and new orders. It should be emphasized that just what particular form of the State ultimately emerges from this process cannot confidently be predicted. It is a failure of imagination, however, to assume that the only thing that will replace the nation-state is another structure with nation-state-like characteristics, only larger (pp.233-4).

4.11 Bobbitt believes that the market state will live within three paradoxes:

(1) It will require more centralized authority for government, but all government will be weaker, having greatly contracted the scope of their undertakings (a process that is already well underway in England in respect of public services and their management and delivery), having devolved or lost authority to so many other institutions, including agencies and organizations which are in, but not of, the State, and non-governmental organizations which are in, but not of, the market.

(2) There will be more public participation in government but it will count for less and the role of the citizen as active participant will greatly diminish while the role of citizen as spectator will increase.

(3) The welfare state will have greatly retrenched, but infrastructure security, epidemiological surveillance, and environmental protection – all of these being matters of general welfare – will be promoted by the State as never before (indeed, developments along these lines are already evident in countries like the UK but also at a European level with the recent announcement of the creation of an EU disease surveillance centre located in Sweden).

4.12 If Bobbitt's depiction of the market-state owes more to how it will play out in the US, this should not be taken to obscure the point that different cultures will adapt the market-state in different and distinct ways. Three possible forms of market-state are possible:

- the entrepreneurial market-state
- the mercantile market-state
- the managerial market-state

4.13 The *entrepreneurial market-state's* basic ethos is libertarian – it is society's role to set individuals free to make their own decisions. There is minimal state intervention in the economy as well as the private lives of citizens. Public services are all privatized and regulation is discouraged. The market is king and the consumer, armed with extensive information, is expected to look out for themselves. In this model, 'the role of government in protecting the public has to some extent been taken over by the media and by private groups acting on the information from, and in concert with, the media' (Bobbitt 2002: 671).

4.14 The *mercantile market-state* relies upon strong central government to protect national industries, subsidise R&D, and steer important enterprises towards success. Social cohesion is maintained in part by suppressing income disparities. Elaborate social welfare subsidy systems are in place for those eager to work.

4.14 The *managerial market-state* consists of three basic elements: free and open markets within a regional trading framework, a government that provides a social safety net and manages a stringent monetary policy, and a socially cohesive society. Private enterprise is valued but only where it contributes to the public good. The goal of the managerial state is to achieve social equality since advocates of the model recognize that extreme social inequalities and alienation from the economic system breed crime, family breakdown, drug addiction and other social ills.

4.15 These different models or conceptions of the market-state are helpful in charting the likely course of countries in future. At present, no European country seems intent on putting in place the entrepreneurial model although there are elements of this evident in some of the accession countries in central and eastern Europe. Only the US and some Asian states appear to aspire to this model. Most other developed countries seem to be closer to either of the other two models. The UK is perhaps an example of the managerial model with elements of the mercantile model apparent.

4.16 Along with the rise of the market-state comes what has been termed by a Cabinet Office discussion paper as the ‘development of a post-materialistic ethic’ (Cabinet Office Performance and Innovation Unit 1999). A new generation is emerging that will become:

- disengaged from mass democracy and more interested in individual self-expression and lifestyle
- less respectful of political and legal authority
- more tolerant of cultural diversity
- more concerned with quality of life and female values as opposed to material wellbeing.

4.17 There are implications contained in these trends for public health, for how it is pursued and delivered, and by whom. If the future society being created is likely to take the form of what might be termed ‘altruistic individualism’ then this has major implications for traditional public health approaches and delivery mechanisms. Any consideration of the public health function and how it is enacted cannot remain blind to such societal and economic trends where the respective roles of the state and the individual are thrown into sharp relief. It is precisely such forces that underlie both Derek Wanless’s approach to public health in his review of progress in, and future prospects for, England, and the government’s *Choosing Health?* consultation exercise in which the public is invited actively to contribute to the direction to be taken in the public health White Paper.

4.18 But even if there is general acceptance of the market-state thesis sketched out above, and drawing upon Bobbitt’s sprawling epic discourse, issues remain about what constitutes the public realm and the role of government. Such lofty concerns also have a very practical and direct bearing on the public health function and its operationalisation.

4.19 In a World Bank policy research working paper on public management and the essential public health functions, the authors stress what many in the public health field already know, namely, the importance of viewing essential public health functions (EPHFs), by which they mean disease surveillance, health education, monitoring and evaluation, workforce development, enforcement of public health laws and regulations, public health research, and health policy development, as pure public goods (Khaleghian and Das Gupta 2004). EPHFs are therefore akin to core government functions such as revenue collection, maintaining law and order and so on. The authors are critical of new public management (NPM) thinking (see Hunter 2003 for a discussion of NPM thinking applied to health policy). NPM doctrines had a major influence on health reforms in the 1990s and into the 21st century, taking as their role model private sector notions of management and competition. Collaboration across agency lines is seen as crucial to EPHFs and therefore quasi-market precepts and competitive incentives based on individual performance are seen as antithetical to effective public health management.

4.20 Although primarily concerned with developing countries, some of the key lessons put forward in the World Bank paper are instructive and have a wider applicability:

- promoting competition among agencies responsible for public health functions does not improve efficiency; on the contrary, it impedes collaboration
- contracting has only a limited applicability in respect of the public health function
- decentralization can be a risky strategy where local government is weak and/or has little incentive to invest in public goods and may even be likely to neglect them
- central coordination, oversight and technical assistance may be important in respect of the public health function
- incentives to raise performance should not be targeted on individuals but should be team- or network-based.

4.21 Some of these concerns may be relevant in the context of the review of public administration in Northern Ireland which reviews five different models for improving the performance of public bodies. Their relevance for the public health function needs to be considered in the light of the unique aspects of public health to which the World Bank draws attention.

4.22 As an alternative both to new public management and old public management (ie command and control), network management is sometimes invoked. The notion of networks has entered the NHS lexicon following a review of acute services in Scotland in 1998 which introduced the notion of managed clinical networks. In England there are also public health networks intended in part to compensate for the lack of capacity and critical mass in PCTs and SHAs. However, work to be published by the Health Development Agency shows such networks to be patchy and uneven in their impact. For the most part, network management remains poorly understood and not well developed. It is an issue which concerned Derek Wanless in his latest review. He recommends that there be further evaluation of public health networks and guidance issued to enable networks to function more effectively (Wanless 2004: paras.3.27-3.31, pp.45-6).

4.23 In a review of networks, the researchers define the term broadly (Goodwin et al 2003). A network is an interorganisational or multi-organisational system that exhibits

any moderately stable pattern of ties or links between organizations or between organizations and individuals, where those ties represent some form of recognizable accountability (however weak and however often overridden), whether formal or informal in character, whether weak or strong, loose or tight, bounded or unbounded.

4.24 Although difficult to define, networks have appeal and seem well-suited to situations of complex collaboration like public health. They are no panacea for poor organizational performance but they ‘may well prove to be an effective method for reducing professional and organizational boundaries’ (Goodwin et al 2003). Networks come in different forms and *hierarchical* networks may be appropriate for some public health activities like managing a major local outbreak of an infectious disease such as meningitis or SARS. For wider public health activities, so-called *enclave* networks (ie weakly regulated but strongly integrated) may be more appropriate.

5. Conclusion

5.1 It was never the purpose of this policy review of public health to come up with recommendations. Rather it has sought to review the pursuit of public health policy in selected countries and to identify any trends and/or potential lessons or models for Northern Ireland. There may be particular initiatives and/or organizational arrangements which appeal and merit closer scrutiny. But what is unequivocal, and perhaps even reassuring, is that virtually all the countries looked at are confronting similar problems and pressures. None has found a perfect model or approach to the public health function that can simply be lifted and exported. All policy initiatives have to be rooted in their particular economic, social and political cultures and contexts.

5.2 Yet, for all the cultural differences on display, countries are facing similar dilemmas in respect of how best to organize public health to ensure a more effective translation of policy to practice. The implementation gap, to a greater or lesser degree, remains a feature of all countries and is perhaps best articulated by the Wanless II review of successive policy failures in England over 30 years (indeed, UK for most of this period). At the same time, no country seeks to abrogate its responsibility for improving population health or tackling the health gap which not only persists but appears to be widening in virtually all countries. There is no enthusiasm for the hedonistic entrepreneurial market-state described by Bobbitt even where societies display features of such a state. And this is the issue facing all countries seeking to give higher priority to public health and to organize its delivery to achieve greater effectiveness and impact. How far is it the task of government to lead by example and, where necessary, put in place appropriate laws and regulations (eg smoking bans in public places) to modify behaviour, and how far should individuals simply be allowed to exercise free choice having been armed with the necessary information which they may, or may not, choose to trust? Certainly, the early pioneers of public health in the 19th century did not see their role as informing citizens to decide how best to lead their lives. They saw themselves as advocates for improved health conditions which demanded action by government.

5.3 In the 21st century, faced with new pandemics such as obesity, is such an approach still tenable or do we need to rethink how public health messages and actions are crafted and implemented? Bobbitt's depiction of the move from traditional nation and welfare states to a form of market state may be instructive here. We are only just coming to terms with the implications of such an analysis of the future role of government in shaping and leading public policy.

5.4 But not all is so uncertain or full of foreboding. Although successive attempts by governments in all the countries reviewed here to move upstream and put health before health care have at best only been partially successful, no government has abandoned trying or given up hope. Moreover, the attempts, even if unsuccessful, still have a value and offer lessons for future developments. Ritsatakis (2000) puts forward five reasons for why the experience of formulating and implementing a policy of health is of intrinsic value:

- it has led to an improvement in information for health policy development, particularly in the area of inequities
- mechanisms for wider participation have been put in place
- cross-sectoral attempts at collaboration have been articulated and even tried, and our knowledge and understanding of partnerships has increased as a result
- even where implementation has not been successful, the attempt to do so while working with others has provided important lessons and identified possible opportunities for change
- the work on policy formation has raised the profile and importance of a health agenda, thereby making possible incremental progress towards the fulfillment of health goals.

5.5 What is clear is that a consensus is emerging that it is time for action. There has been sufficient description of the problem and diagnosis of what needs to be done. We may lack complete evidence on what works and is effective but until we begin to shift the paradigm significantly away from a downstream focus on health care then it is unlikely the evidence base will ever provide sufficient confidence to guide policy. Moreover, the dynamic of evidence influencing policy tends not to operate in such a rational, linear manner (Hunter and Killoran 2004). As two commentators have concluded, intellectual frameworks are only a beginning when it comes to the reform of health policy. ‘Simply put, to be useful, they must be used’ (Evans and Stoddart 1990: 119).

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