Public health changes over my career

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In 1968 the world changed: students occupied Paris, Prague, and my university; I had my appendix removed; and Martin Luther King Jr and Robert Kennedy were killed. By the end of the year the tanks were in Prague and Nixon was elected president. My appendicitis meant that I was convalescing when the university was occupied and witnessed it first-hand. Despite the optimism of the Prague Spring, the world was a worse place at the end of the year than it had been at the beginning but for me it meant a change from asking 'why don't they do something' to 'why don't I do something'.

I'd gone through medical school with every intention of being a brain surgeon – I won the neurology prize and secured the neurosurgery house job – but something in me had changed and, through the connections made in 1968, I was appointed to a community health council (CHC) when they were established in 1974. Four years later I was chairman of the National Association of CHCs, a steep learning curve for someone so young, and was set on a track that took me into public health. I passed the exams quickly and was appointed Director of Public Health (DPH) in Central Birmingham in 1982 (the chairman at the time was Edwina Currie).

My first task was to plan the development of what was then called 'priority services', a code word for mental health and mental handicap (later re-coded as 'learning disabilities'). The NHS called them priority services because if they were not given priority they wouldn't get any money at all. It was a difficult time, not only was the NHS settling down from being reorganised but the ancillary staff were also on strike. I spent the year pulling together advice, evidence and epidemiology to support a plan of development. A service model with a heavy emphasis on the community was used, something that was just emerging as practical, and a plan was put together that needed about a million pounds in the first year. In spring 1983 I took my first holiday in a year and went skiing. I returned after a week to find that the finance department had added up the accounts and realised that they were a million pounds short. Their only solution was to 'steal' the money put aside for the priority services. I asked the district management team what I thought was an obvious question 'will this happen again next year?'. No one had any idea. I persuaded the team to make the cuts temporary and asked for three months to find out what had gone wrong. I don't think anyone believed that I could find such an answer so it didn't seem dangerous to give me the three months.

This quest took me into the next phase of my life; there was no point in planning priority services if there would never be any money. I made the entire public health department stop what they were doing and set about pulling apart every set of data that revealed anything about clinical activity or money. My department consisted of one other consultant and several trainees. I figured we could teach epidemiology and train our registrars on patterns of acute activity just as well as on priority services. In three months we discovered a pattern, several high-cost services, staffed by new energetic consultants, had expanded enormously during the industrial dispute while no one was looking. Elective activity and some emergencies were reduced during the dispute but the saved money was spent by the expanding regional specialties, and no one in the finance department had noticed. The expansion of high cost specialties continued after the dispute but other activity returned to previous levels and the money simply ran out. Once the pattern was identified it became possible to persuade the region and the Department of Health that some of these regional and supra-regional services required separate funding. It took brinkmanship and a lot of diplomacy but we eventually got our million pounds back and established 'priority services' that became recognised for their excellence. For me once again the world had evolved, I was now dragged into a close relationship with general management, spending a lot of my time finding ways to monitor, predict and control acute activity.

Holding on to the money

Many people think it is not 'public health' but rather if the acute sector is not kept under control it takes all the money and some of the things it does do contribute to the general good. Acute services find it all too easy to mount a shroud waving raid on NHS funds and pull money away from services that do not put terrible stories on the news. After about two years of holding the lid on acute spending my department started to get restless and we decided to go on the attack. We set about writing an annual report on the health of the population, something

that was not required in those days but an idea that was being pushed in a few districts. The department in Coventry beat us to it by a few months but our report, *A picture of health*, gave us extra leverage in the district and forced the district health authority to think hard about its priorities.[1] It ensured that we were able to keep up the momentum on those services which were of most benefit to the population.

The model of public health practice that emerged in our department and a few others around the country was very much based in the NHS, using health services to help and treat the disadvantaged and using public health skills to support strategic management in the NHS as a whole. It was a long way from the community service model seen in many local authorities prior to 1974 and was to a significant degree disconnected from a wider health agenda that might have been pursued through local authority contacts or work across government. It was a model made possible by the 1974 and 1982 reorganisations, there is no denying that it was incomplete but it was new and exciting.

In the UK as a whole in public health things were not going well and particularly in England there was a severe workforce shortage. In Birmingham there were five districts, one had no public health staff, two had single-handed DsPH (Directors of Public Health) and the other one had a DPH and one consultant. Two of the DsPH were not members of the faculty, and effectively had no consultant-level qualification in public health. Some parts of the country were in even worse shape. Almost all the trainees in Birmingham were in my department because we were the only group with consultants who had obtained the Membership of the Faculty of Public Health (MFPH) by examination. If the trainees wanted to pass the exams they came to us. The district existed until the reorganisation in 1990 and in that time every trainee passed the faculty exams.

Stanley Royd and Stafford

After the two infectious disease outbreaks of the mid-1980s – legionnaires disease in Stafford District General Hospital and salmonella in Stanley Royd, Wakefield – the crisis in public health was so evident that something had to be done and the Acheson Committee on Public Health was established. I was invited to become a member. For me that was fortunate as there were a number of clinicians who tried to encourage the health authority chairman (no longer Edwina Currie who was now a member of parliament) to fire me. I think my efforts to insist that clinical developments only went ahead when we had funds had upset many in the teaching hospital who were used to getting their own way. While Acheson was sitting I was safe, there was no way the chairman could fire the only district director of public health on the committee set up by the secretary of state to find out what was wrong with public health.

Acheson established a new model of public health practice which suggested that the training of public health doctors and environmental health officers should take place in schools of public health. The definition of public health adopted by Acheson was comprehensive and has stood the test of time but we were a long way from being able to deliver it. At the time there were no schools that fitted the model and there was no plan to invest money in academic public health. Acheson did, however, pave the way for an expansion of training in order to fill the gaps in the public health workforce.

While Acheson was sitting the HIV epidemic was steadily getting a grip across the world. Early campaigns in the UK limited its spread but no country was spared. The combined effect of these events ensured that Acheson had to make solid recommendations on infectious disease resulting in the introduction of consultants in communicable disease control (CCDC). Acheson offered committee members a bottle of champagne if they could think of a catchier name but no one collected the prize. Over the next few years almost a hundred CCDC posts were created and the future of health protection was secured.

Within two years of the Acheson Report the government had embarked on creating the internal market and it became much more difficult to work in an integrated way across the NHS.[2] Prior to 1990 my department had a member of staff on the management committee of all hospital committees who did detailed work in planning the relationship between hospital services and the community and also worked to create health promoting hospitals. Once the internal market was in place this became almost impossible and certain key issues, like smoking control and healthy food in hospitals, regressed.

In 1990 I was appointed professor of public health at Birmingham University, a new NHS-funded post established to try and create a school along the lines described in the Acheson Report. We were able to set up a master of science degree in environmental health and a master's degree in public health alongside an existing masters course in occupational health. There was less overlap between the course than I had hoped, issues like accommodation often turning out to be crucial barriers to integration. I was able to obtain funds from the Birmingham City Council for the chair in environmental health and from the regional health authority for a new building. The university refused to call it a school of public health; a school would have meant that public health was given too much independence, and so it was called an institute.

The internal market

After the introduction of the internal market some aspects of public health were able to develop. Health protection was clearly still a part of the health authority's remit and epidemiology was crucial to needs assessment and commissioning but health promotion suffered. In many places this was seen as a provider function and it often found itself stationed within community trusts. Unfortunately, in most cases, there was no one in the senior management who knew what health promotion was and it suffered accordingly. Trusts were unlikely to make much money out of it and in many cases dedicated staff were put in impossible positions, professionally isolated and leaderless. However much commissioners may have wanted good health promotion, and not all did, it was unusual to find a district in which enthusiastic purchasing was matched by high-quality delivery. Usually one or the other was missing.

Over the next decade health promotion declined until finally it had to be resurrected by the *Choosing health* White Paper.[3] This was a welcome development but little effort was ever made to work out the reasons for the decline or learn any lessons from it. *Choosing health* also suffered to some extent from an excessive attachment to health promotion, tending to ignore the other domains of public health.

Running an academic department in the early 1990s created a different set of issues: the Research Assessment Exercise (RAE) was just getting into its stride and I was running a unit that had inherited a large hole in its finances and virtually no staff on permanent contracts. I developed funding sources from local authority and NHS sources that created some stability and allowed our high-quality performers to begin to build a track record that could increase ratings in the future. My careful planning was interrupted by catastrophe at the regional health authority when the combination of financial problems and some disastrous ventures with computers led to almost the whole of the board being replaced. By the time the dust had settled I had been invited to be the regional director of public health. Funding the academic department became more difficult as the lawyers determined that I had a conflict of interest and I had to leave the room whenever the university was discussed. We did, however, get the new building and fortunately the staff I had appointed did a great job securing the future of the department. Unfortunately the RAE completely undermined the Acheson concept of a school of public health serving public health in its region. What the department did for the NHS contributed very little to its RAE score, what mattered was international standard work. Across the NHS the connection between academic public health and service public health which had never been good became a lot worse. Only in the area of research and evaluation of evidence was it possible to make much progress, eventually leading to the establishment of the National Institute for Health and Clinical Excellence (NICE) in 1999 but even their work tended to be looked down on by the purists in aetiological epidemiology.

The mid-1990s were remarkable for some major advances in system thinking. The 1995 Calman-Hine report on cancer services and the introduction of National Service Frameworks (NSFs) made the assumption that it ought to be possible to change the way the whole system worked in order to make it work better.[4] Neither Calman-Hine nor the NSFs, the first of which covered heart disease, made much attempt to think through what it would take to get the system to change, they simply stated how it ought to be different. In many ways that was a major mistake because successive health ministers started to assume that they could simply issue an edict from Whitehall and things would be different. The world is not like that. To implement site specialisation in cancer surgery, for instance, required many surgeons to give up some of the work that they were doing. It takes time to persuade people to do this, they need other work to replace what is lost, they need to feel valued and require reassurance about their private income. Such changes do not happen overnight but must be monitored over time with a consistent approach by senior management, which is difficult to do if senior management is disrupted by reorganisation.

Since Labour came to power in 1997 there have been several alterations which have led to a loss of management experience and corporate memory. Changes in health indicators do not correlate with the organisational adjustments. As the changes occurred, large amounts of new money were pumped into the health service. In 2006, newspaper headlines spoke about nurses finishing their training with no jobs available to go to. It takes about four years from funding and advertising a training place to completing the training of a nurse. The organisation associated with this activity has been rearranged to some extent in the last four years. Is it any surprise that things do not go exactly right?

Despite all these changes much has been achieved. Ten years ago there was no doubt that the right way to treat a heart attack was to administer thrombolysis as soon as possible, yet many hospitals still took two or three hours to start the treatment, it took an hour or more to get the patient to hospital and the patients themselves rarely called their doctor quick enough. Similarly dismal figures applied to post-infarct treatment, with most patients not getting secondary prevention.

Thrombolysis and MINAP

In the early 1990s we embarked on a regional project to cut pain to needle time. All the relevant professional groups were included and a monitoring system was established, working with John Birkhead's small national audit group. The data were used to evaluate the performance of trusts, and issues were raised in review meetings when the regional officers met district managers. It produced steady changes in the right direction. I was able to use this experience to persuade the group designing the NSF that performance management of target times for treatment of heart attacks was possible. Since then, performance has changed beyond recognition. Pain to needle time across the country is now under two hours for almost all cases and nearer to 90 minutes for most. Even more advanced treatment for heart attacks are now commonplace and reliably delivered; mortality from heart attacks has fallen appreciably. Compliance with secondary prevention is almost universal. This has been achieved by a combination of public health activity and professional leadership. When we embarked on that road I was in favour of performance being managed by the regional office of the NHS, a body that, at the time, had a clear overview. Instead the task was given to the Royal College of Physicians and the Myocardial Infarction National Audit Project.[5] This structure took longer to establish but ultimately was the best situation since the regional tier of the NHS has been reorganised three times since then and it is doubtful whether consistent management of performance could have been sustained. It is an interesting lesson, when something needs to be driven in a consistent direction over a period of time it may be better to manage it outside the normal NHS management because that seems to change twice in every parliamentary cycle. Similar advances have been made in cancer treatment despite the fact that cancer networks cut across the NHS structures and would probably work even

better if the internal market was abolished, something that was included in the first Queen's speech under Labour but does not seem to have happened.

One major change that does offer the possibility of consistent management over time is the creation of the Health Protection Agency which brought together all the organisations associated with health protection including radiation, chemicals and infectious agents. Half of the organisation has come from national bodies, eg the Public Health Laboratory Service, but half came from the NHS. The organisation is still struggling to find the right balance between field services and central support. It has a realistic ambition to be an important global organisation but it also has to deliver on local services.

The launch of the White Paper *Choosing health* marked a return to an emphasis on health promotion but much of the so-called 'earmarked' money has been hijacked to meet other deficits.[3] Derek Wanless made much of our inability to delivery on things that work to prevent disease rather than treat it once it happens.[6,7] Research in public health has always been a difficult matter. When the cause of a disease is discovered it is usually the case that treatment will be carried out in another specialty. The agenda in public health moves on to the next unknown. It is hardly surprising that it always appears that we do not know what to do but it is also the case that we have eradicated small pox, contained most infectious diseases of childhood, identified smoking as a major cause of mortality and made strides to contain it. Public health will always be concerned with the next problem.

The last 25 years have been fascinating and fun. Life expectancy has risen as has health expectancy, and many diseases are controlled or contained. Much more could be done – we desperately need a period of stability in which those who know what to do are allowed to get on and run services for the public benefit.

It is quite right that the NHS should be influenced by politics, given the amount of public money that is spent this is inevitable, but we need a more deliberative method of introducing new ideas. It would be better if politicians spent more time discussing ways in which services could be held to account and the views of the public brought to bear, rather than reorganising. Constant changes in structure do not hold anyone to account, they simply reward the ambitious and those who are good at presenting themselves at interview. I began my career in public health in the run up to the 1982 reorganisation. Most management textbooks suggest that reorganisations take two years to stablise. On that count although we have made major strides in understanding many diseases we have wasted about half of the last 24 years making further changes in the structure of the NHS. We have shown that the greatest benefit comes from making the system work as a whole, bringing together prevention, health promotion, and service development to bear in a coordinated fashion. We seem to find it very difficult to do.

Alcohol, drugs and obesity

What will the next 25 years bring? The most important threats to health now come from alcohol, obesity and, possibly, illegal drugs. Tackling them will require a unified effort. Alcohol consumption has risen steadily over the last few years, the price of alcohol has fallen compared to spending power and there has been a tendency to increase the content of alcohol in a variety of drinks. Beers and wines are stronger than they were and alcopops have alcohol where there was none. It is hardly surprising that consumption has risen but so has the damage done. Liver disease has doubled, violence has increased and alcohol is at least part of the reason behind many teenage pregnancies and much crime. It is starting to have an impact on life expectancy, beginning to cancel out some of the gains made in other areas. Tackling alcohol will require not only a new consensus that rejects its misuse but also action across society. We need a taxation policy that encourages manufacturers to reduce rather than increase the percentage of alcohol, we need an education programme that encourages responsible drinking and we need NHS interventions that are available as soon as someone thinks they need them.

Similar conclusions could be drawn about drugs. A range of illegal drugs are now available virtually across the whole country, almost no area of society is protected from their effect. Very large numbers of those in prison are there because of drugs, yet services are patchy, and far too often require long waits.

Obesity is even more complex because there have been changes in availability and consumption of food as well as changes to our daily lives that mean we consume less calories. Mechanisation of almost every aspect of life has reduced the amount of energy we need to burn in our bodies. Compared to 25 years ago more homes are centrally heated, more people have cars, and most jobs require less manual effort. It is very unlikely that these trends can be reversed but if we burn even 100 less calories a day and take in the same food we gain more than five kilograms per decade. If we are enticed into consuming an extra 100 calories the gain is twice as fast yet these are quantities that are almost too small for most people to appreciate. If we are to reverse these trends we need to find new ways of making calorie burning attractive and at the same time make less calorific foods the norm. The pharmaceutical industry will no doubt produce products what will help but it is a forlorn sort of society that allows itself to get too fat by taking too little exercise and eating too much then seeks to put things right by taking pills. A much more cost-effective alternative is to design and govern our cities so that walking and cycling are safe and enjoyable, and shift our dietary habits towards salads and vegetables.

Diet, fruit and Jamie Oliver

I am optimistic that change in our diet is possible, in the last 20 years we have moved from a boring cuisine based on 'meat and two veg' to one that includes dishes from every corner of the world, it is obvious that we can change; we just have to get the direction right. A start has been made with the school fruit scheme. This grew out of a seminar attended by regional directors of public health and the senior staff in the Chief Medical Officer's department. I gave a presentation on fruit and vegetable consumption in the West Midlands, in the ensuing dis-

cussion I asked the question, 'Why can't we give out fruit in schools like we used to give out milk?'. The scheme was launched in the West Midlands and subsequently rolled out across the whole country. What was surprising was the way that we got reports of better attention and behaviour by children as well as more consumption of fruit and vegetables outside school, something that is less surprising now that we have seen similar effects from Jamie Oliver's school dinner's campaign.

Changes in our diet and activity have been monitored and commented on for more than a decade and we have not done enough to create change in the right direction. As a result we will now have to plan NHS services to deal with increasing numbers of people developing diabetes, cirrhosis and other diet- and lifestyle-related diseases. Doing this in a cost-effective way and producing services that are welcomed by patients will be a challenge and at the same time we must continue to work across society to change the underlying causes. The next 25 years will probably be just as interesting as the last.

References

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CURRENT KEY DEVELOPMENTS

Public health issues with counterfeit medicines

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Clinicians who prescribe medicines in the UK at primary care and at hospital level are facing the possibly disastrous consequences of a global crime wave – the supply and distribution of counterfeit medicines and healthcare products. Indeed such counterfeiting could result in a threat to public health similar to that posed by illicit controlled drugs. In the developing world, it has become responsible for fatalities. In China during 2005 more than a dozen infants died after their mothers unknowingly fed them fake milk powder that had little or no nutritional value. How can prescribing doctors recognise and try to ameliorate this threat in their clinical practice?

The World Health Organization (WHO) has grouped counterfeit drugs into seven distinct categories:

- fake packaging, correct quantity of correct ingredients
- false packaging, wrong ingredients
- genuine packaging, no active ingredient
- genuine packaging, incorrect quantity of correct ingredients.

WHO calculates that China's State Drugs Administration has closed 1,300 illegal factories and investigated cases of counterfeiting medicines worth $57 million in 2003 alone.

Although the problem was believed to be restricted to the developing world, there is increasingly robust evidence that the manufacturers and distributors responsible for the sale and supply of a wide range of counterfeit medications are now active in the developed world, particularly in the UK. Although WHO estimates that counterfeit drugs represent around 1% of pharmaceutical sales in industrialised countries and nearer 10% in the developing world, counterfeiters are increasingly turning their attention to industrialised countries.[1]

The European Commission now estimate that counterfeiting in general represents around 5–7% of world trade and as much as 15% of the global medicines supply chain could, at any time, be counterfeit. WHO estimate that substandard and ineffective medicines have contributed to the emergence in developing countries of drug-resistant strains of cholera, salmonella, tuberculosis and other diseases.[2] In line with this estimate more than 1,000 admissions to hospital in Russia in 2005 were the result of counterfeit insulin.

Although illegal internet trading is a key part of the story of counterfeit supply and unquestionably this has contributed hugely to the explosion of counterfeit medicines in recent years, in Europe and especially the UK counterfeit medicinal products