This report was based on a WHO/ University of Durham meeting in 2001. It was prepared by Prof. David J Hunter, Professor of Health Policy and Management, University of Durham, England. The list of participants to the meeting is annexed.

This activity on Public Health Management is organised in the context of a broader initiative in the Department of Management of Noncommunicable Diseases of WHO. The initiative seeks to engage health care managers in broader public health issues and therefore help in bridging the implementation gap which is general in numerous areas of public health. As in many other areas in noncommunicable diseases such as cardiovascular disease, diabetes, chronic respiratory disease and cancer the issue is more about implementing what we know already. As this document highlights this implementation gap is partly due to rigid and split views across the public health and management disciplines. Public health goals cannot be achieved without a serious partnership across these disciplines.

We expect this document to be particularly useful for managers and policy makers who feel increasingly accountable for population health issues and for public health practitioners who feel increasingly interested in implementation.

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Contents:

1. Introduction

2. Why Public Health Management is Important

3. A Renewed Interest for Public Health

4. Progress on Public Health has been Disappointing

5. Public Health Management: Exploring the Concept

6. Public Health Management at a National Policy Level
   6.1 Vision
   6.2 Political Leadership
   6.3 Central Government Policy-making Approaches
   6.4 Delivery Mechanisms

7. Public Health Management at a Local Operational Level

8. Public Health Management: Implications for Education and Training
1. Introduction

A problem being experienced in probably the majority of countries across the world is that the public health function is still not receiving firm enough support at political level. Even where that commitment appears to exist, and there are signs of a new-found commitment to public health, under-resourcing of the public health infrastructure and capacity prevents public health from playing the strong role advocated for it. As a consequence, the levels of health achieved by populations are seriously below what could be obtained if application of current knowledge in public health was pursued more vigorously through a stronger public health approach and infrastructure (WHO 1999).

Modern public health practice is considerably more complex in the 21st century than it was 100 years or so ago when some of the great advances in public health were achieved. It includes not merely scientific and technical practice but also the knowledge and skills to build effective coalitions and partnerships for health and collectively to manage actions for health improvement. This applies to both national and international health efforts. This focus on managing for health has been described as public health management (PHM)\(^1\).

It is clear that public health practice in both developed and developing countries needs sustained political support and substantial development. In particular, there is a dearth of appropriate public health training and dissemination of public health experience and practice. To address these issues, a workshop, jointly organised by the World Health Organization Noncommunicable Disease and Mental Health Cluster, and the University of Durham, England, was held at the University of Durham.\(^2\) The workshop focused on public health management and on how it might serve as a unifying concept, linking policy-makers' newfound interest in public health with the ability of public health practitioners, wherever they may be located, to secure the desired policy goals. To this end, the following issues were considered:

- exploring the concept of public health management;
- the importance of public health management for all countries;
- the implications of public health management for chronic disease management;
- public health management at a national policy level and at local operational level;
- to describe the skills and competencies required of managers and practitioners working in public health management;
- implications for education and training.

None of these topics could be exhausted in a brief workshop but each of them was aired and important points were agreed which would require more detailed attention.

The remainder of this report examines each of these issues in turn.

\(^1\) (Alderslade 1990; Alderslade and Hunter 1994; Hunter 1997; Hunter and Berman 1997; Hunter 1999).

\(^2\) List of participants is annexed to this report
2. Why Public Health Management is Important

Neither managers nor public health professionals appear to be doing a good job in improving the public’s health if judged by the evidence from many countries, both developed and less developed. This shows the widening health gap between sections of society, in particular between those who are affluent and those who are poor. The gap is growing faster in some countries than others but nowhere is it closing despite the efforts of governments and their renewed commitment to the public health function. Moreover, concerns about food safety and the environment have contributed to a widespread sense that public health issues have not been given sufficiently high priority by governments. Even within health care systems, public health practitioners seem unable to make things happen to improve the health of their populations.

In contrast, health care managers can make things happen even if they do not always know why they are doing it beyond the need to attend to the latest fad or fashion favoured by their political masters and mistresses. This may include restructuring whole health care systems, building another hospital regardless of whether or not it is needed, or developing some other health care facility to improve access and/or reduce waiting lists. Even where countries have clearly articulated health strategies, these do not appear to drive their health care systems in a different direction. But unless they do they will cease to count at the end of the day. For the most part, the resources available for health, and the attention devoted to it from policy-makers, remain largely directed at acute health services. All too often, health services are viewed as predominantly sickness services. These observations apply fairly consistently around the world. In the evaluation of Health-for-All in the 21st Century (HFA21) (1979-1996) which was based on three major evaluations, the failure to achieve equity in access to all primary health care elements and the unbalanced distribution of and weak support for human resources were two key barriers to health for all implementation.

3. There is a Renewed Interest for Public Health

At the start of the 21st century, there is more attention being attached to public health concerns and to the wider determinants of health. Internationally, there is a renewed interest to push this forward. The WHO has advanced one very important reason for this development: strong public health action in Member States, many with quite different health systems, is now bringing results showing that substantive health gains for the population can indeed be achieved through new approaches to health promotion and disease prevention and by the more effective management of clinical care.3

3 WHO Regional Office for Europe – 1999 and Innovative Care for Chronic Conditions. 2000.WHO- Geneva

- The Pan American Health Organisation in collaboration with the Centre for Disease Control (CDC) has built upon work by the American Public Health Association and WHO4. The outcome is a proposal of eleven Public Health Functions. The initiative

4 Bettcher D, Yach D 1998
calls for a reinsertion of public health into all the health care transformations being undertaken in Latin America.\(^5\)

- The World Bank equally proposes a framework built along major public health functions in order to help define which ones are essential within each country context, to assess public health performance gaps and public health investment needs (Public Health and World Bank Operations Jan. 2002).

It is within this context that the content of this note on **Public Health Management** seeks to make a contribution internationally.

### 4. Progress on Public Health has been Disappointing

However, despite this renewed interest in public health among policy-makers, the function remains under-resourced at the level of its infrastructure to be able to perform the strong role advocated for it. Furthermore, there are still external forces (financial agencies, trade agreements etc) driving change in many developing countries that can give rise to pressures not experienced in developed countries. The public health agenda frequently is not their priority. There are at least two consequences:

- enormous waste of resources on downstream interventions because of lack of upstream interventions;
- the levels of health achieved by populations are grossly below what could be obtained if application of public health knowledge was more forcefully pursued though a stronger public health approach and infrastructure.

The discussion of PHM is highly relevant for developing countries. However, across all countries, developed and developing, there are also, and inevitably, different needs as countries are at different stages of development.

The historical context prevailing in countries cannot be overlooked. In the 1970s, and indeed earlier in some countries, district health systems were established in many countries including in Africa and Asia. In the 1970s and 1980s, primary health care became fashionable both as the first level of care but also through WHO’s stress on multi-sectoralism, equity, participation, and appropriate technology. In the 1990s, health sector reform has been in full sway and public health seemed to be out of the picture of these essentially managerial reforms.

Health sector reform shares certain features in most developing countries. These include: public sector reform that is economically and not health driven; and the adoption of a package of changes including a public-private mix, financing shifts from the collective to the individual, decentralisation, and prioritisation involving a minimum package or basket of services.

Many countries, some inspired by WHO’s *Health-for-All* strategy and its successor, *Health 21*, have produced their own national health strategies in an attempt to refocus the policy

\(^5\) Las Funciones Essenciales de la Salud Publica: ( FESP ). The notion of FESP goes further than population interventions and includes the responsibility of ensuring the access to quality health care.
More attention has been devoted to analysing problems rather than to action addressing them.

Despite the latest attempts in many countries to refocus, or rebalance, the policy agenda in favour of population health, progress has remained disappointing in terms of outcomes and impact. More attention has been devoted to analysing problems rather than to action addressing them. Many reasons have been advanced to account for this implementation failure but among them is a capacity problem in respect of public health management (PHM), together with a persistent preoccupation among health care systems with treatment services (Alderslade 1990). These are not unimportant matters but an undue concentration on them has served to marginalise arguably other equally important dimensions of health policy concerned with the impact of health services and of other public policies on the health of the population.

Some of the imbalances and biases in health systems are deeply embedded. Indeed, there are a number of what have been termed ‘simple truths’ about health systems that act as constraints on any attempt to reconfigure health policy (Lewis and others 2000). Six may be highlighted:

- **Health care systems want to grow** – they are by nature expansionist;

- **Higher health spending does not necessarily lead to higher health status** – some lower-spending countries such as Japan have better health status than higher spending countries like the US;

- **Universal access to health care does not lead to universally good health** – the wealthier groups in society often continue to remain healthier than those who are poor;

- **Public awareness of risks to health has improved** even if much of this is media driven with the consequences associated with such a development;

- **Health care almost always wins out in the competition for resources** – even when governments proclaim their commitment to health and prevention they often fail to back it up by shifting resources;

- **Changing the distribution of health status through upstream strategies is extraordinarily difficult** with interventions intended to benefit the disadvantaged
often benefiting the already advantaged thereby widening disparities and the health gap.

**More deep-seated biases…..**

- Health systems globally are seeking to achieve much the same outcome, namely, upstream investment to achieve downstream savings. Better outcomes are the unifying concept. But deep-seated biases in political systems combined with the temporal challenge (i.e. pressure to deliver short-term, visible health gains while paying less attention to, or ignoring altogether, long-term issues) create a major tension;

- Even where health, as distinct from health care, is high on the political and policy agenda it remains fragile and is not core despite the political rhetoric that surrounds it; health may not yet be seen as central to the goal of sustainable development;

- A link between economic and social policy, including health, is generally accepted – investment in health is regarded as economically viable on the grounds that a healthy community is also an economically successful one;

- With public debate weak or absent altogether, building a constituency for change is difficult; the public is increasingly consumer-focused and individualistic in outlook when it comes to lifestyles with weakening ties to a collectivist ethos or the solidarity principle which underpins many systems of health and social provision;

- Health systems suffer from fragmentation even at a time when governments are engaged in efforts to promote ‘joined up’ policy and implementation; there are new initiatives to establish public-private partnerships in local health economies that could either make public health management more difficult to achieve or provide the trigger for new types of partnership that do begin to demonstrate what can be achieved;

- At the same time, the countervailing pressures for greater devolution are evident, as the pressures operating to centralize control of the direction of policy-making;

- The public health function in many countries suffers from marginalization in terms of national and local policy and from lack of leadership;

- It remains unclear whether public health is best pursued from within health care systems or whether a different base is required outside health services to give it greater independence from the pressures of health care systems which invariably dominate the agenda;
- Public health suffers from there being too much emphasis on analysis and the acquisition or refinement of knowledge at the expense of acting on the knowledge base and putting it into practice;

- the attributes and qualities of the public health manager need to be made explicit and the requisite training programmes need to be put in place.

Progress appears stalled by various factions within the health field at all levels in the policy system. The exceptions seem to occur as a result of powerful leadership, which cuts through the bureaucratic inertia, and/or there is generous funding to provide an incentive to collaborate and to achieve success. For the most part, however, agencies struggle to give priority to a health mandate.

Indeed, better policy delivery is a key feature of public health management

5. Public Health Management: Exploring the Concept

Better shared understanding between public health practitioners and managers of health care systems, who occupy two rather distinct camps, might trigger a new way of thinking and hasten appropriate action. But for this to happen on a significant scale, public health has to be seen to be everyone’s responsibility.

Public Health cannot remain the preserve of a few practitioners trained in the speciality of public health medicine who are either ignored or who become co-opted into the running of health care services thereby losing sight of their core function. This is to improve the health of the populations for whom they are responsible. As the British secretary of state for health put it in a lecture ‘the time has come to take public health out of the ghetto. For too long the overarching label ‘public health’ has served to bundle together functions and occupations in a way that actually marginalizes them from the National Health Services and other health partners (Milburn 2000). The notion, public health management (PHM), is aimed at doing precisely this.

Public health has been defined as ‘the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.7 Furthermore, the synthesis of many definitions of public health has brought the evolution of six basic principles of contemporary public health theory and practice.8 Public health management has been defined as ‘the optimal use of the resources of society and its health services towards the improvement of the health experience of the population.9

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7 (Acheson 1988).
8 American Public Health Association : 6 basic principles are: emphasis on collective responsibility for health and the prime role of the state in protecting and promoting the public’s health; focus on whole populations; emphasis on prevention, especially the population strategy for primary prevention; concern for the underlying socio-economic determinants of health, disease and risk factors, multidisciplinary basis and partnership with population served.
9 (Alderslade and Hunter 1994).
PHM embraces a number of elements as displayed in Box 1\textsuperscript{10}.

**Box 1** Distinguishing features of public health management

- is multi-sectoral and professional
- combines knowledge and action
- has epidemiology at its core
- is influential across all health determinants
- involves public health reporting, leading to health strategy development
- communicates with politicians, professionals and the public
- is influential organisationally and financially
- lies at the heart of the civic society.

PHM is directed towards managing systems based on health outcomes both at the level of population-based health programmes and at the level of patient care (WHO 1999). **Above all, PHM is about leadership and managing change.** This is often weak and poorly organised and provided in respect of training and development. It includes the dimensions listed in Box 2.

**Box 2** Roles of public health management

- advocacy and management roles
- knowledge and action
- managerial capacity and infrastructure
- networking to create partnerships across organisations and disciplines
- broad involvement of people and skills
- infrastructure and curricula for education
- evidence based policy and practice
- an outcome based focus
- a national agenda for health and health services research.

The problem of language and correct terminology bedevils all health care systems. But whatever the drawbacks or limitations of the term PHM, they should not be allowed to divert attention from its key distinguishing features. PHM refers to the management of the health of a population, or to managing for health (Hunter 1999).

The problematic aspects of PHM centre on the issue of implementation reflecting its focus on capacity building in the workforce charged with the task of improving the health of communities. The notion of implementation is of growing importance across health systems as policymakers seek to strengthen the infrastructure for delivering on policy objectives. PHM is essentially concerned with action, and with effecting change.

\textsuperscript{10} (see Alderslade and Hunter 1994, Hunter and Berman 1997, Hunter 1999).
A new cadre of managers and public health practitioners is required who share a common core curriculum in their training and development.

For PHM to become a reality, a new cadre of managers and practitioners is required who share a common core curriculum in their training and development. Without an element of multidisciplinary training it is impossible to foresee any success in bringing together health systems managers and public health practitioners. Even within the public health community there are many separate groups each with its own training opportunities. All too often these serve to reinforce barriers rather than blur them.

6. Public Health Management at a National Policy Level

An issue is whether public health management is able to serve as the instrument required to bring about change and contribute to a realisation of policy. It is the weakness of the infrastructure through which policies become translated into action that has contributed to the failure of repeated attempts to shift the policy debate beyond a continuing bias towards a downstream agenda focused on treatment services.

Several countries have sought to shift policy debate towards an integrated ‘whole systems’ perspective, notably Canada, New Zealand and the UK. Their experiences share a similar outcome, namely, the disconnection between the thrust of policy and the means to achieve it. The result in each country has been frustration at the lack of progress in shifting resources, or even the attention of managers and practitioners, away from health care to health. (Glouberman 2001, Hunter and others 1998).

Over the past decade or so in many developed countries, tackling the broader health agenda has been a priority to a greater or lesser degree. But the abiding tension in health policy, namely, that between developing a long-term public health agenda on the one hand and improving rapid access to acute services on the other hand, persists and has usually found in favour of the immediate, short-term agenda. Of course, improved access to health care services can contribute significantly to health and to an improved quality of life but it is still often a case of treating symptoms rather than root causes.

What is absent from policy-making is any attempt to ensure that a balance is maintained. Both upstream and downstream determinants of health need to be tackled. Economic and social policy needs to be mutually reinforcing (Institute of Medicine 2001; Legowski and McKay 2000; Glouberman 2001).

The US Institute of Medicine’s Committee on the Quality of Health Care in America claims that the American health care delivery system is in need of fundamental change. It fails to make the best use of its resources. Service fragmentation, duplication and over-use are some of the weaknesses highlighted. These become more acute when chronic conditions are the
leading cause of illness, disability and death. There is a need for better coordinated services across the spectrum of care. Change must be radical and requires leadership the need for which has never been greater.

In Canada, despite the promise of non-medical health policy held out in the Lalonde report published in 1974, *A New Perspective on the Health of Canadians*, the reality has been disappointing. The explanations are multiple and include the biases encountered elsewhere that health care continues to dominate the agenda, marginalising public health issues, and that short-term, quick fixes hold more appeal for politicians anxious to make an impact quickly and visibly. The problem is principally one of moving from theory to action since the diagnosis of the problem is well documented and the evidence concerning the gains to be achieved from adopting a more vigorous upstream policy agenda exists. In addition *the research results from studies of population health have yet to be implemented*. What countries appear to lack is a policy instrument or intervention strategy to enable the research findings and evidence to be acted upon. The concept of PHM is an attempt to provide a framework for such an instrument by combining knowledge-based decision-making with the skills to effect change and act on the knowledge.

A related problem in public health is an inability to crystallise good practice, however it is defined, and roll it out across populations and geographical areas. PHM demands particular skills, especially in respect of change management and leadership. Traditional public health models and training programmes have not seen these as either relevant or important to the specialty of public health. But to be effective, public health managers must possess both public health and management skills. Presently there is a skills deficit. As was noted earlier, achieving health goals cannot be done through the health system acting in isolation. Partnership working is essential to build capacity.

Key issues for PHM at a strategic policy level are:

- vision
- political leadership for health
- central government policy-making approaches that support the vision and provide leadership
- delivery mechanisms through regions, localities and communities that serve as instruments for implementation.

Each issue is commented upon briefly in turn.

### 6.1 Vision

There is some debate over whether those governments that have sought to shape a vision for public health have retreated from their initial commitment to it. Ensuring effective linkages lies at the heart of the commitment by many governments to ‘joined up’ policy but it is proving difficult to secure in practice as many governments themselves acknowledge. In all countries more might be done to ensure that complementary policies are genuinely co-ordinated and effectively communicated? For example:
• there could be more debate about the relationships among policy objectives – which are overarching and which subordinate; how the achievement of one department’s objectives depends on, or contributes to, the achievement of another department’s objectives. Such a debate would raise quite complex issues, including:

- what is the hierarchy of goals – is the ultimate goal to do with economic success, social regeneration, sustainable development, quality of life, wellbeing or health?
- is health a means or an end?
- how can policy means and ends, and their interrelationships, be mapped in a way that makes sense to policy-makers, organisations on the ground, professionals, and the public?

6.2 Political leadership

In considering political leadership of the public health function, there are issues surrounding the role of ministers with a particular responsibility for public health. In particular, has the model been perceived as successful? Might it be recommended to other health care systems? There are important questions about the conditions required to make a success of a cross-departmental ‘champion’ of public health and also where that post should be located. Certain reviews 11 concluded that probably the location of the post was less important than a recognition that wherever it was based there would remain a need to ensure effective coordination with other government ministries and departments. Nevertheless, there remains a general concern that locating the post in a health department whose primary focus is health care services may result in that role being marginalised or overshadowed by more immediate pressures emanating from the health care sector.

Clearly whoever occupies such a ministerial role in any government must be able to bring influence to bear across government departments, have backing to be able to create or influence budgets cross-departmentally, and hold other government departments to account (including civil servants). There are arguments for the lead to come from the centre of government, i.e. from within the prime minister’s office, or, failing that, from another government department, for example, one dealing with environment issues or with education.

6.3 Central government policy-making approaches

‘Joined up’ thinking and action – integrated policy-making and delivery – are key ‘process’ objectives of government policy in many countries. There are various mechanisms for achieving them, including the following:

- Cross-departmental co-ordination units;
- Ministers with responsibility for issues such as public health, women, the family which cut across traditional departmental boundaries;
- Initiatives that require cross-governmental commitment – Violence and injuries prevention programmes; teenage pregnancies programmes; tobacco and health regulation and programmes.
- Common approaches to problems – e.g., targeting resources on area based initiatives or ‘zones’;

11 The House of Commons Health Committee examined this ministerial position in its review of public health in Britain
• Impact assessment of policy proposals;
• Efforts to achieve common approaches to improve performance.

Many Governments acknowledge that a truly joined up approach is some way off but they resolve to achieve this objective. The dilemma of central government initiatives that affect the same people in local areas but which are run separately and not linked together is generalised in most countries. Joined up government has to be supported not by rhetoric or good intentions but by strong incentives and sustained political commitment.

There could be greater urgency in central government about both establishing health impact assessment of policies and integrating it with impact assessment in other areas, e.g., environmental impact assessment. A commitment to health impact assessment should be viewed as one of the threshold criteria of inter-departmental partnership. The minimum requirement would be that policies should have no negative impact on health, although the expectation should be that they have some positive impact.

There remains a failure to position health in government in many countries. The numerous initiatives to tackle the health agenda, though welcomed, are not joined up. Health departments need to consider how they relate to other government departments and how they can make use of opportunities to advocate the public health interest more energetically.

In the longer term, the public health focus needs to be effectively marketed and communicated. Too often, public health reacts or responds rather than initiates or leads. In most countries there is a question mark over whether there has been an adequate ongoing communications and development strategy for public health policy. This is in contrast to the attention devoted to monitoring trends in hospital waiting lists and delays in accessing health care.

6.4 Delivery mechanisms

Effective delivery requires cross-service and cross-agency approaches with horizontal integration at the local, regional, national and international levels and vertical integration of these levels.

Improving the quality of practice requires:

• Information – evidence of what works and good practice that is tailored to local needs
• Communication – helping local agencies to see the links between their activity and the national public health framework
• Training and capacity development – taking account of the diversity of organisations, disciplines and professional cultures involved in the new public health
• The development of evidence-based standards
Short-term ‘projectitis’ is rife

7. Public Health Management at a Local Operational Level

Managing public health in an integrated health system embraces a number of issues, including:

- National policy framework
- Integration or de-integration
- Organisational options
- Management and funding.

Political commitment from the top is essential if a public health agenda is to be advanced beyond fine words. There need to be national goals and targets as well as clear and explicit policies, strategies and priorities. Funding must be population needs based.

To achieve integration, a number of conditions need to be met, including:

- Adoption of a health outcomes focus
- Security of public health resources
- Competent purchasing
- Provider organisation and network
- Political commitment.

New Zealand offers a model through its district health system. Within this, the hospital is intended to become a resource facility – a supply of resources upon which to draw. Primary care is the driver of the delivery system. Services – primary, secondary (including public health) – are all population based.

In this model, public health comprises two components: a clinical dimension, and a broader conception of public health. Clinical public health would remain inside the health care system linked to primary care that is the foundation of the system.

More radical thinking in New Zealand foresees the disaggregation of the hospital as an organisation. Clinical services will become population, rather than institutionally, based with the hospital becoming only the provider of hotel and clinical support services. This could effectively reduce the dominance and hence power of the hospital and lead to a more balanced set of district services.

These arrangements are expected to refocus the integrated provider system on public health outcomes. Public health will therefore become a key service within the set of services being
provided by the district health boards. Public health is one of a set of specialised secondary services each with an interface with primary health care as the foundation service of the district health system.

Regardless of the country and precise configuration of health policy and services, numerous barriers exist to the effective application of a public health management approach although they are not insuperable. Health care systems tend to suffer from a dysfunctional intermingling of politics and management so that structures and systems emerge which are less than optimal. As noted earlier, short-term time horizons for delivering improved health outcomes run counter to changes in the public’s health which often take many years to achieve. Within this overall policy and governmental context, the implications of public health management for education and training are considered next.

8. Public Health Management: Implications for Education and Training

Recalling the earlier discussion about the nature of PHM, it is about

- mobilizing resources
- managing the health and disease of a population
- managing for population health.

PHM may be applied to a range of health systems. In developing competence in PHM, several questions arise:

- Who is PHM for? What are their needs and those of their employers?
- What should be the objectives of a PHM education programme?
- What should it cover in terms of content?
- Which learning methods should be included?
- Who should provide this education?
- Who should pay for it?
- How should PHM education be developed?

A gaps/needs analysis is necessary to identify the skills for PHM. Different issues will arise in different countries concerning the development of capacity in PHM and the requisite training and development opportunities. The WHO Regional Committee for Europe has proposed a list of key areas of competence for public health (see Box 3).

**Box 3 Key Areas of Competence for Public Health**

- understanding health and disease, assessing health status
- evidence-based decisions, research and information management
- disease surveillance and control
- promoting health and wellbeing
- evaluating and improving health outcomes and the effectiveness and efficiency of health care
A pragmatic approach is one of the hallmarks of PHM. The purpose is not the production of experts but rather a cadre of polyglots/polymaths able to act to shift the paradigm and achieve a more ‘upstream’ focus in health policy.

PHM courses are not plentiful. Nor are those that exist, in contrast to traditional courses in public health medicine, well supported either by the numbers enrolling on them or by the host institutions offering them. Insufficient resources are devoted to market the courses effectively. There may be a role here for WHO in providing assistance in raising the profile of the issues, promoting relevant courses where they exist and encouraging their development where they do not.

In terms of PHM it is not simply a matter of looking at formal Masters programmes, although there is a need for new and innovative ones employing the latest technology in e-learning, but also at short courses, CPD, distance learning. There is scope for international learning as well as experiential learning opportunities.

The content of training for PHM might include some or all of the following topics:

- health needs assessment
- prevention
- use of behavioural change theories
- networks and alliance building
- strategic management and planning
- alternative budgeting systems
- development of performance indicators
- business planning
- managing health projects
- management in complex adaptive systems marked by intersectoral settings
- communication
- creating and enhancing policy networks
- power and politics
- local strategy development
- evaluation of clinical services
- health services research.

It may be that rather than modifying existing programmes and courses a more effective way forward might be to develop new training opportunities that are tailored to the specific needs of students in consultation with them.

Next Steps

The public health challenges in today’s complex societies cannot be met without an effective public health infrastructure but few countries either have in place the necessary policies and resources to ensure effective operation of the public health functions at national and
subnational levels or are prepared to equip public health practitioners with the requisite skills to exploit fully their potential to improve the public’s health. The notion of PHM has been advocated as one means for addressing these problems and deficits. It is not a panacea for the deficiencies, which exist, but it does recognise the importance of a public health workforce that is equipped with the requisite skills for the tasks with which it has to deal.

Health, as distinct from health care, is not yet taken seriously enough in health planning and budgeting. There is a need for incentives to encourage thinking in population terms. The link between local and national frameworks is problematic. Ministries of Health are often weak institutions. This may be the result of decentralisation, the absence of proper policy frameworks, or undue donor (often conflicting) influence over policy frameworks.

Developing policy networks is important at national and local levels. The health sector ought to be included in the general policy agenda. There is a need for models of integrated care. Above all, management strengthening is necessary through a variety of means including short courses, and other types of training. Such training might include people from sectors other than health to demonstrate the breadth of public health.

The adoption of an international perspective entails the following:

- Learning processes (including from South to North in areas like working with communities, primary care frontline workers);
- Contextualisation in preference to the importation of standard reform packages;
- Health services research to improve the knowledge base;
- Clarifying and agreeing WHO/World Bank roles: policy advocacy to Ministries of Health in developing countries;
- Capacity: the preference being for building it in country rather than imposing solutions on countries.

The focus should be on developing principles rather than devising a blueprint. Some key principles can be drawn from the experiences of a number of countries that may be fundamental in the successful application of a PHM approach. They are listed in Box 4.

**Box 4 Principles of a PHM Approach**

- Public health can find a legitimate place within an integrated set of provider services and hence be strongly supported within a provider framework

- Critical to the success of this integration is strong central government commitment to public health outcomes for all provider services thus reinforcing the contribution public health can make to an integrated provider system

- Contracting for outputs/outcomes, with ring fencing of public health funding, can ensure an appropriate place for public health within an integrated provider system

- Organised primary care is a key service division of an integrated district health system, with symbiotic relationships with public health
• District health systems need a strong central government policy framework, an important component of which is national health goals to be delivered through an integrated provider system and affecting all services, including clinical

• A service, rather than an institutional framework centred on hospitals, may serve to reduce the power of the hospital as the centrepiece of a health care system and may be a critical factor in providing a more supportive environment for the development of public health services and management directed towards improving the health of local populations.
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