Public health coming home

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The Sentru Matan Nasional (National Eye Centre) in Dili is a primary eye care and referral ophthalmology service. It is the only permanent ophthalmology service in Timor-Leste. When patients register at the service, all are asked to provide a contact telephone number. A recent audit of serious conditions requiring follow-up produced 62 patients. Of the 62 patients, 53 (85.5%) provided contact numbers. However, of these only 23 (43.4%) were able to be reached on the numbers provided. Therefore, overall only 37.1% of patients were contactable for follow-up.

In addition to the low numbers able to be contacted on mobile phones, it is likely that such methods are regressive—providing better communication with urbanized and wealthy elements of the population in Timor-Leste.

While it is certainly an advance to be able to contact at least some patients, we caution against reliance on mobile phones. In some countries, including Timor-Leste, local mobile phone market conditions make contact by this method unreliable. While systems are still developing we strongly recommend that health workers make concrete plans for follow-up with patients, and use mobile phones for reinforcement only.

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Dear Sir,

The article on Public Health 'Coming Home' to English local government states that it provides a historical perspective.[1] It is, however, limited and fails to address some of the issues that were important in 1974, when it joined the NHS. This letter gives the views of one 'who was There' and involved at both central and local level.

Bevan is said to have favoured the future NHS to be based outside local government on 'grounds of efficiency and quality'. But there was another reason. Most of the medical profession were opposed to governance by local authorities (LA), in particular those working in the voluntary hospital sector. Bevan was anxious to retain their willingness to serve in an NHS.

There were some very innovative LA Health departments, such as those developing health centres and co-ordinated working with general practice.[2] There were some outstanding public health practitioners, identified by Sir George Godber, the Chief Medical Officer at the time,[3,4] but these were exceptions. In Counties, PH practitioners were usually treated as professionals, in urban authorities they were more likely to be regarded as minions.

Public Health, and its practitioners, was not held in high esteem by the medical professions at the beginning of the 20th century (1920–74). They were depicted as 'drains doctors', and the TV programme 'Dr Finlay's Casebook' epitomized this. The reasons for this were many. In general, the better medical students, between the two World Wars, chose a clinical career rather than public health. It was the students who had no private means and needed to earn money who tended to choose public health where they were sure of having a salary. This certainly ensured that some of the MOHs were outstanding individuals.

At that time the academic base of public health was insecure. Although there were Professors of Public Health in some medical schools, e.g. Cardiff, Bristol, Manchester, these academics were usually also MOHs for the city. There was no academic department in any of the 12 London medical schools. The teaching of public health to medical students gained in the provinces, as it was 'practice-based', but there was little research in these schools. Academic public health was poorly represented; epidemiology and the academic disciplines such as sociology and medical statistics were located in Social Medicine Units and classified as preclinical subjects. The forum for academics to present their work and exchange ideas in the 1950–80 period was the Annual Meeting of the Society for Social Medicine.

Training for public health and the statutory qualification, the DPH, was provided by a number of bodies, e.g. London School of Hygiene and Tropical Medicine, the Royal Institute of Public Health. The courses were not very stimulating, concentrating on regulations and laws; aspects of non-communicable disease epidemiology were sparse. Professor Jerry Morris recognized that a new course was required and in 1972 founded a 2-year MSc course of training for the future community physicians at the London School of Hygiene and Tropical Medicine. This rapidly attracted a number of the future leaders of community medicine.[2]

Gorsky and his colleagues[1] identify the needs and functions of public health. Although some of these are located within LAs, their belief and hope that the current and future DPHs will be able to influence them from a base in LAs is optimistic in the current climate. Furthermore, they omit that their ability to influence health services will be greatly diminished, e.g. the lack of statutory public health representation on NHSE or on CCGs. The lack of clinical contact and separation from their medical colleagues may also reduce the attraction of a public health career for medical students, to say nothing of the possible effect on their terms and conditions of service for both medical and non-medical practitioners. Before 1974, MOHs had security of tenure by national statute, which enabled them to be forthright in their evaluation of local services. There is no indication that this now applies.

Public Health has always been a political subject, but while in the NHS it has been shielded from party political interference. As an assessor in the appointment procedures of community physicians in 1974, I can attest that the LA representatives on the appointment committees, on a number of occasions, attempted to influence the choice of candidates on the basis of his/her party affiliation. Sir George Godber, CMO at the time, was adamant that not all Area Health Authorities should be co-terminous with LAs (G. E. Godber, Personal communication). He stated, to me, that in his long experience of LAs and health matters, before and during the War, that it was important that LAs were not responsible for health affairs and that public health should be independent of LAs. If a few Area Health Authorities were not coterminous, amalgamation and take over by LAs would be much more difficult. This was in response to an article I had published.[5]

Life outside the NHS may prove much less attractive for public health practitioners. It is to be noted that neither the CMO nor the Chief Executive of PHE have any training in public health. The ability to obtain health statistics is likely to be far more difficult. Dealing with outbreaks of disease due to infections, toxicological or other agents may become fraught.

The ability of public health to be forthright in the assessment of current practice, situations, conditions or future plans is not secure either within LAs or PHE. Let us hope that this will be rectified and that my fears are unfounded.

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