A Ministry for the Public's Health: an imperative for disease prevention in the 21st century?

Stephen J Corbett

ABSTRACT

- The obesity epidemic has been described as a catastrophic failure of government and public health authorities to devise and implement concerted, effective evidence-based action.
- To respond effectively to major public health challenges such as this, Australia needs a Ministry for the Public's Health, with a budget and accountability to parliament separate from the Health Minister.
- This Ministry would be better able than current health departments to develop and implement health — rather than health care — policy, to build partnerships across tiers of government, and to present the health and economic arguments for disease prevention to state and federal treasuries.
- Such a Ministry has international precedents, with dedicated public health agencies created in Canada, Sweden and the United Kingdom, although it is, as yet, too early to gauge their effectiveness.
- The Ministry would be best placed within state and territory governments, as it is at this level that partnership building and whole-of-government cooperation would have the greatest impact.

MJA 2005; 183: 254–257

In 2004, an editorial in *The Lancet* thundered against the catastrophic failure of government and the public health professions to stem the global epidemic of obesity through concerted, evidence-based action.[1] Where, the editorial asked, is the Virchow or Snow or Semmelweis who will sweep aside ignorance, confront professional and bureaucratic inertia, and reveal the truths which will predicate action?

The obesity epidemic has national and global implications for health and well-being.[2] However, in calling for action, we need to distinguish clearly between the factors which will transform medical practice and opinion, and those which will galvanise effective responses from governments and the communities they represent. Heroic action by individuals may have its place, but the *Lancet* editorial fell short of articulating what is needed most — a coherent political response to major current public health challenges, of which childhood obesity is a conspicuous example. It is deeply intractable, imperfectly understood and its solution is not clear.[3]

I argue that, in Australia, the centrepiece of such a response should be the creation of a Ministry for the Public's Health with a budget and an accountability to parliament separate from the Health Minister. This has some precedent: alternative forms of public health administration have been introduced in countries such as Sweden, the United Kingdom and Canada.

At the outset, the term "public health" needs to be defined and, to a certain extent, reclaimed. In Australia, public health has become confused with the public hospital system and with Medicare funding of general practice. A useful definition comes from Derek Wanless, former chief executive of UK bank NatWest, who was asked by the UK Government in 2003 to review the challenges of securing good health for the whole population.[4] In this article, I will use his definition of public health:

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

Why do we need a Ministry for the Public's Health?

A health, rather than health care, system

Recent inquiries into the South Australian and New South Wales health systems found that:

- The health care system is inward looking. Debates have been between insiders, with relatively little enfranchisement of the community.
- We have a medical and hospital system, rather than a health system that places proper weight on primary care, prevention and hospital avoidance programs.
- The solutions to many health problems will not be found within this highly medicalised health care system.
- Achieving health improvements will require whole-of-government action across a range of portfolios — environment, education, water supply, police and health. This kind of cooperation can only be driven by Cabinet, not by interdepartmental committees.[5]

Past failure to implement health policy

In 1986, the World Health Organization developed the Ottawa Charter as a framework for health promotion practice and action to achieve the goal of "health for all by the year 2000".[6] This framework has been a durable guide to the planning and implementation of health promotion services. It is based on five themes: creating supportive environments; building healthy public policy; strengthening community action; developing personal skills; and reorienting health services. However, it is the implementation rather than the building of healthy public policy which often fails under current arrangements.

Nevertheless, implementation is possible. The New South Wales campaign to prevent scalds in children is an excellent example of a small injury-prevention program which was translated into concerted government action. In 1994, the Australian Standard for hot

Centre for Population Health, Sydney West Area Health Service, Sydney, NSW.
Stephen J Corbett, MPH, FAFPHM, Acting Director.
Reprints will not be available from the author. Correspondence: Dr Stephen J Corbett, Centre for Population Health, Sydney West Area Health Service, Locked Bag 7118, Parramatta, NSW 2150.
stephen_corbett@wsahs.nsw.gov.au

water services was amended to recommend that the maximum temperature of water delivered to bathrooms by new residential hot water systems not exceed 50°C. The incidence of bath scalds in children fell dramatically.[7]

Such programs are the exception. There are enormous barriers to the generalisation of demonstrable benefits and the broad implementation of policy and programs. Do seeding grants sprout, do pilots fly? In NSW, the Health Department has developed the ASSIST (Area-based Services Strategic Implementation Support Trials) funding program to provide some strong incentives to build and propagate successful programs.

This failure of policy implementation, argues David Hunter, Professor of Health Policy and Management at Durham University, is not just a failure of the evidence to persuade or a lack of resources.[3] Instead, he believes it is a failure of both political will and of the ability of public sector managers to implement programs which cross departmental boundaries.

Stewardship of public health infrastructure

Our society has a vast fixed investment in public health infrastructure. Sewers, water treatment plants, road surfacing and engineering, public transport, building design and construction, safety norms in agriculture and in the manufacture and sale of food, and effective occupational health and safety legislation are all part of the infrastructure which underpins our good health. Custody of this infrastructure is dispersed across government, and investment in it is lagging well behind population growth and urban expansion.[8]

Full engagement in chronic disease prevention

The Wanless report into public health in the UK, *Securing good health for the whole population,* imagined a future in which the community is fully engaged in decisions which affect their own health and the nature of the health care they receive.[4]

The NSW Childhood Obesity Summit in 2002 was a portent of such a "fully engaged" future. Industry, consumers and health officials met to agree on directions for a government response to the obesity epidemic in children. Subsequently, the chief executive officer of McDonald's Australia responded to criticism of his company at the summit by changing the cooking oil used in McDonald's products from beef tallow to canola oil, and by introducing a range of salads and fresh foods into the menus. These initiatives were an international commercial and public relations success.[9]

In moving towards full engagement, the role of government will change. New roles may include brokering alliances between the private sector and the community, and providing mechanisms for feedback on the acceptability of public health interventions.

What could a Ministry for the Public's Health achieve?

The defining characteristic of a dedicated public health agency would be that it looks outward — to the agencies, institutions and people who can form partnerships in the development and implementation of health policy. I nominate five issues for the initial focus of a new agency.

Whole-of-government action for health: Responsibility for chronic disease prevention needs to be placed at the heart of governments, both state and federal. A whole-of-government approach has been successful in drug policy, child and family health, and environmental health.[10] To prevent chronic disease we should, at the very least, be examining carefully the cardiovascular impact of macroeconomic decisions in agriculture, food production and marketing, and tobacco control.[2]

Effective partnerships supported by executive authority: Partnerships within and outside government are the warp and weft of whole-of-government action. They are fragile and precious. They depend on individuals but are essentially institutional relationships. They must be driven through Cabinet, and they demand the absolute commitment of senior management.

Implementation of health policy: This is frequently overshadowed by health care policy and delivery. Health policies may fail to be implemented because of bad execution, bad policy or bad luck.[3] Hunter suggests that three factors may improve the chances of successful implementation:

- Trust between agencies and individuals — essential if collaboration is to really work;
- Innovative approaches to managing performance across government; and
- Fostering the development of government networks and partnerships.

Securing investment in health: Chronic disease prevention fails to attract significant investment at both state and national levels.[11] Public health currently receives 1.7% of national health expenditure, with 15% of this spent on health promotion activities.[12] Only recently has benchmarking begun for appropriate levels of expenditure on health, rather than health care.[13]

The state and federal treasuries need to appraise the arguments for the cost effectiveness of, for example, tobacco control,[14] increasing physical activity and fruit and vegetable consumption,[15] and hepatitis C prevention.[16]

Meeting the macroeconomic challenge of chronic disease prevention: Nobel Laureate in economics, Robert Fogel, recently predicted that the economies in developed countries will be driven by developments in health care, which will account for perhaps 20%–25% of gross domestic product by 2025.[17] The conclusions of the WHO Commission on Macroeconomics and Health that non-communicable diseases and their prevention are matters of macroeconomic interest[18] are just as applicable in developed as developing countries.

Precedents and alternatives

In recent years, a number of countries have embarked on administrative reform of the public health function, often in response to revealed weaknesses in protection against emerging disease threats.

Sweden has a Minister for Public Health supported by an independent Institute of Public Health, created in 1992. The following year, the Swedish Parliament adopted the *Public Health Objectives* bill, which requires that the public health impacts of all political decisions be considered.[19] The bill binds the government to more structured follow-up and reporting of public health endeavours.

Canada has a Public Health Agency responsible to a Minister for Public Health within the Health Ministry. The Agency was created in 2004 following a report on the SARS outbreak, *Learning from SARS: renewal of public health in Canada.*[20] It marked the beginning of a new approach to federal leadership and collaboration with provinces and territories on public health. The agency focuses on

preventing chronic diseases and injuries, and responding to public health emergencies and infectious disease outbreaks.[21]

In the UK, there have been a number of significant developments. In 1997, a Minister of Public Health portfolio was created, answerable to the Health Minister. Although this Ministry made some inroads into across-government approaches to food safety, child poverty and neighbourhood renewal, it seems not to have significantly shifted the balance of policy away from health care.[4] In 2002, Treasury, rather than Health, initiated a cross-departmental review of government initiatives to reduce health inequalities,[22] which was followed by an action plan.[23] A Health Protection Agency, at arm's length from government, was created in 2003.[24]

The Wanless review received suggestions as to how public health governance could be better addressed, including:

- The creation of an independent "Commission for the Health of the People", established by an Act of Parliament;
- The appointment of a Commissioner for Public Health, accountable to parliament;
- The creation of a new Ministerial Department for Public Health; and
- The appointment of a Minister for Public Health within Cabinet.[4]

The 2004 Public Health White Paper[25] did not act on these suggestions. Rather, it opted for a package of measures, including improved regulation and resourcing of program delivery, cross-agency planning and performance assessment, and partnership building.

A way forward

Which of these precedents is most relevant to Australia? The scope and detail of the proposed UK reforms are impressive, but it is hard to imagine program development and performance assessment taking hold across the political divide of federal, state and local governments in Australia without strong and united political commitment. Local government in Australia, in particular, is disenfranchised from disease-prevention activities. Of the suggestions to Wanless, a Commission or Commissioner for Health are both unlikely to muster the authority to deliver effective across-government commitment.

In Australia, I argue for a Ministry for the Public's Health situated in state and territory governments. It is here that partnership building, effective regulation and whole-of-government activity will have the greatest impact. The Minister should have a seat in Cabinet and the support of a Ministry with the technical, economic, legal and policy resources to develop and implement public health policy. A workable template is provided by the state-based Environment Protection Authorities, which are complemented by a small federal agency dealing with standards setting and national policy.

Would a Ministry for the Public's Health, separate from a Department of Health, weaken or fragment public health effort and authority, or harm collaboration and professional good will? Managing the interface with the health care system would be a major challenge for a new agency, but this is probably better tackled from a position of strength rather than in an internal contest for priorities.

What will it take to succeed? Obvious obstacles include:

- *Scepticism from elected officials and the public.* The proposal would have to be sold as a workable solution to urgent and important problems. The consequences of the "do nothing" option would have to be well drawn, especially in the face of the solid progress made by the National Public Health Partnership in developing a core agenda for public health, modernising public health legislation, and in tobacco and communicable disease control and environmental health.[26]
- *The need for authority within and outside government.* There is a strong precedent for vesting authority in public health officers. In 19th century Britain, the Medical Officer of Health was installed as the local arbiter of health risk and its management, and this system was surprisingly robust. Health agencies and officials retain significant informal authority today and remain a trusted voice in the court of public opinion.[27]
- *Finance.* Australia already has a well trained public health workforce and support infrastructure. The new agency would be a redeployment of existing resources, rather than a totally new organisation. There are some prospects of self-funding through regulatory activities. The Canadian Government assigned $345 million over 5 years to its new agency, and the UK Government has underwritten the impacts of public health initiatives, particularly in local government.

The rapid population-wide increase in obesity is a particularly urgent and complex public health challenge, and a number of government and professional responses have been suggested: in the UK, a National Nutrition Council[28] and a Public Health Commission;[29] and, in Australia, a Ministry for Public Health.[30] Steep projected or actual increases in the costs of diabetes treatment may well trigger effective action, but history would suggest that a defining crisis is more likely to do so. In the field of child nutrition, the best analogy is the 1903 report of the Physical Deterioration Committee in the UK, which alerted the government to the miserable state of health of children and of military recruits in the Boer War. The imperial dilemma, "How can we hold on to an A1 empire with a C3 population?", became a national crisis. The development of policies on school meals and a new system of health welfare for mothers, infants and children was a direct progenitor of the National Health Service in 1948.[31]

Recently, it was suggested that lessons learnt from tobacco control could be applied to improving diet and physical activity on a global scale.[32] Six of these lessons — assertion of collective responsibility, a precautionary approach to evidence, the development of broad coalitions, modest, well spent funding programs, political leadership, and a comprehensive rather than narrow approach to risk reduction — are an excellent starting point for a vision and modus operandi for a proposed public health ministry and bureaucracy.

Acknowledgements

I am grateful for comments on earlier drafts of this article from Craig Dalton (Hunter Area Health Service, NSW), Siun Gallagher and Christine Newman (Sydney West Area Health Service, NSW), Tim Churches (NSW Health), and the peer reviewers of the Journal.

The views expressed here are those of myself and not Sydney West Area Health Service.

Competing interests

As a university-based researcher, I have received competitive research grants related to public health practice.

References

1 The catastrophic failure of public health [editorial]. *Lancet* 2004; 363: 745.
2 The Center for Global Health and Economic Development. A race against time: the challenge of cardiovascular disease in developing economies. New York: The Center, Columbia University, 2004.
3 Hunter DJ. Public health policy. Cambridge: Polity Press, 2003: 31.
4 Wanless D. Securing health for the whole population. London: HM Treasury, 2004.
5 Menadue J. Health care reform: possible ways forward. *Med J Aust* 2003; 179: 367-369.
6 World Health Organization. Ottawa Charter for Health Promotion. Geneva: WHO, 1986.
7 Elkington J, Gaffney D. "Hot water burns like fire". The NSW scalds prevention campaign. Phase 1 and 2: 1992-1994. Final report. Sydney: NSW Health Department, 1998.
8 Smith S. Infrastructure. Briefing paper 1/2004 for the Parliament of New South Wales. Sydney: Parliament of New South Wales, 2004. Available at: http://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/0/C6389C30B0383F9ACA256ECF0006F610 (accessed Feb 2005).
9 McDonald's Corporation. McDonald's salads break Olympic record [press release], 23 Aug 2004. Available at: http://www.media.mcdonalds.com/secured/news/pressreleases/2004/Press_Release08232004.html (accessed Feb 2005).
10 Webster I. Social inclusion and the public health: the case for partnerships. *N S W Public Health Bull* 2002; 13: 133-136.
11 Access Economics. Returns on investment in public health: an epidemiological and economic analysis prepared for the Department of Health and Ageing. Canberra: Australian Government Department of Health and Ageing, 2003. Available at: http://www.health.gov.au/pubhlth/publicat/document/roi_eea.pdf (accessed Feb 2005).
12 Australian Institute for Health and Welfare. National public health expenditure report 2000-01. Health and Welfare Expenditure Series No. 18. Canberra: AIHW, 2004.
13 NSW Health. NSW Chronic Disease Prevention Strategy. Sydney: NSW Health, 2003.
14 The Allen Consulting Group. Licensing of tobacco retailers and wholesalers. Desirability and best practice arrangements. Sydney: Allen Consulting Group, 2002. Available at: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-drugs-tobacco-other.htm/$FILE/licensing_tobacco.pdf (accessed Feb 2005).
15 Australian Chronic Disease Prevention Alliance. The economic case for physical activity and nutrition in the prevention of chronic disease. Melbourne: Australian Chronic Disease Prevention Alliance, 2004.
16 Health Outcomes International Pty Ltd, National Centre For HIV Epidemiology and Clinical Research, Drummond M. Return on investment in needle and syringe programs in Australia. Canberra: Australian Government Department of Health And Ageing, 2002.
17 Fogel RW. The escape from hunger and premature death 1700-2100. Cambridge: Cambridge University Press, 2004.
18 World Health Organization. The WHO report of the Commission on Macroeconomics and Health: investing in health for economic development. Geneva: WHO, 2001.
19 Government Offices of Sweden. Public health. Available at: http://www.sweden.gov.se/sb/d/2900/a/16513 (accessed Feb 2005).
20 National Advisory Committee on SARS and Public Health. Learning from SARS: renewal of public health in Canada. Ottawa: Health Canada, 2003. (Cat. No. H21-220/2003E, Publication No. 1210.)
21 Public Health Agency of Canada. About the Agency. Available at: http://www.phac-aspc.gc.ca/about_apropos/index.html (accessed Feb 2005).
22 Her Majesty's Treasury, United Kingdom Department of Health. Tackling health inequalities: summary of the 2002 cross cutting review. London: HM Treasury, 2002.
23 United Kingdom Department of Health. Tackling health inequalities: a programme for action. London: UK Department of Health, 2003.
24 Health Protection Agency. About the Health Protection Agency. Available at: http://www.hpa.org.uk/hpa/about_us/about.htm (accessed Feb 2005).
25 United Kingdom Department of Health. Public Health White Paper. Choosing health: making healthier choices easier. London: UK Department of Health, 2004. (Series no: CM 6374 207.)
26 National Public Health Partnership. NPHP news. Available at: http://www.nphp.gov.au/nphp_news/index.htm (accessed Jun 2005).
27 NSW Environment Protection Authority. Who cares about the environment in 2003? A survey of NSW people's environmental knowledge, attitudes and behaviours. Sydney: NSW Department of Environment and Conservation, 2004. Available at: http://www.epa.nsw.gov.au/whocares/index.htm (accessed Feb 2005).
28 Mayor S. National nutrition council is needed to tackle childhood obesity [news]. *BMJ* 2005; 330: 1465.
29 Mayor S. Conservative Party proposes a public health commission. *BMJ* 2004; 329: 704.
30 Van Der Weyden M. From the Editor's desk: Political priorities and the public's health. *Med J Aust* 2004; 180: 433.
31 Porter D. Health, Civilisation and the State: a history of public health from ancient to modern times. London: Routledge, 1999.
32 Yach D, McKee M, Lopez AD, Novotny T. Improving diet and physical activity: 12 lessons from controlling tobacco smoking. *BMJ* 2005; 330: 898-900.

(Received 9 Feb 2005, accepted 28 Jun 2005) ❑