Pilot Profile of Chalkwell Ward

The History

of Health Information

HEALTH INFORMATION

The United Nations' World Health Organisation defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’

Historically, there has been a close link between health and disease. Since deaths were associated with illness, health information has been closely linked with disease. The cause had to be confirmed by a professional namely, a doctor.

During the 19th century, the industrial revolution and rapid rise of population in cities led to outbreaks of contagious diseases, which spread rapidly and became a threat to everyone rich and poor alike (Porter 1994). The State became involved in public health and concerned itself with the collection and analysis of disease in population.

19TH CENTURY –FOCUS ON INFECTIOUS DISEASE AND HYGIENE AND SANITATION

CONCERNS
EPIDEMICS
Prevention of the spread of disease such as cholera

HIGH INFANT AND MATERNAL MORTALITY

KNOWLEDGE

GERM THEORY
Drs. Snow, Koch, Pasteur and others developed the germ theory of disease (as opposed to the prevailing miasma theory).

STATISTICS
William Farr (1807-1883), Chief Statistician to the General Register Office for more than 40 years, was the most significant medical epidemiologist and statistician of the Victorian era. He helped to bring about many advances in hygiene and public health as well as developing a modern approach to the classification of disease and the collection and analysis of medical information.
Drs. Snow, Koch, Pasteur and others developed the germ theory of disease (as opposed to the prevailing miasma theory).

REPORTS
Edwin Chadwick's 'Report on the sanitary conditions of the labouring population of Great Britain' (1842)

LEGISLATION
The 1848 Public Health Act. The act also instigated the setting up of a general board of health to oversee these reforms.

APPLICATION
Dr John Snow -observed and noted that the number of people who drank water from a well in Broad Street London were more likely to get infected by cholera. After the well was taken out of public use the number of people affected reduced dramatically.
LOCAL AUTHORITY INTERVENTION

ENGINEERING –BAZZELGETTE BUILT SEWERS AND PROVIDED CLEAN DRINKING WATER

MEDICAL OFFICER OF HEALTH
(COLLECTED INFORMATION ON DISEASE –EPIDEMIOLOGY)

ENVIRONMENTAL HEALTH

LADIES SANITORY REFORM ASSOCIATION (EARLY HEALTH VISITORS)

WARS	INFORMATION	ACTION
BOAR WAR 45% OF RECRUITS UNFIT FOR SERVICE SUFFERED FROM RICKETS DUE TO POOR NUTITION HIGH INFANT AND MATERNAL MORTALITY	ARMY MEDICAL STATISTICS DISCOVERY OF LINK BETWEEN VITAMIN deficiency AND DISEASE	LEGISLATION LA PROVISION OF SCHOOL MEALS
WORLD WAR 1(WW1) INFECTIOUS DISEASES HOUSING. POST WW1‘HOMES FIT FOR HEROS’ POST WW1 –PANDEMIC INFLUENZA OUTBREAK HIGH INFANT AND MATERNAL MORTALITY	INFECTIOUS DISEASES HEALTH OF MOTHERS AND CHILDREN A CONCERN OVERCROWDING –SLUMS UNFIT FOR HUMAN HABITATION CAUSING DISEASES TO SPREAD	LA CLINICS FOR MOTHERS AND CHILDREN COUNCIL HOUSES
WORLD WAR11 (WW 11) HEALTH ISSUES BECAME CLEAR THROUGH MIXING OF THE POPULATION THROUGH THE EVACUATION OF CHILDREN AND CONSCRITION POST WW11 POLITICAL WILL TO CHANGE	CENTRAL GOVERNMENT BEVERIDGE REPORT (BROAD PERSPECTIVE ON HEALTH) 5 WANTS	WELFARE STATE EDUCATION POVERTY NHS TRIPARTITE SYSTEM

Attempts to shift the focus from disease to wellness (The Pecknam experiment)

In the 1930s there were some experiments to connect lifestyle with health such as the Peckham experiment namely, the' Pioneer Health Centre. In an interview with Pam Elven Jonathan Freedland of the Guardian newspaper ' It was not a surgery, treating the sick, but rather a place dedicated to spreading - and studying - health. The founders, the husband and wife team of George Scott Williamson and Innes Pearse, reckoned health was a lot like disease, that it was contagious. The trick was to create an environment in which people would infect each other with wellbeing. The result was a beautiful club, boasting an enormous swimming pool, a gym, boxing rings, a dance hall, a library, a creche with "room for perambulators" and a cafeteria serving "compost grown" - organic in today's language - food, produced at the centre's own farm a few miles away in Bromley. Local families could join for 6d a week, thereby ensuring they felt like members rather than recipients of charity. And they joined in their hundreds. '. Experts noticed that babies born to Peckham mothers - those who had eaten the centre's organic fruit and vegetables - had a "bloom, sparkle and bounce" lacking before. 'The Health Centre closed in 1950; weeks before Pam was due to hold her wedding reception there. "It felt like news of a death," she says now. "We were like one massive family." The reason for the closure can be summed up in three letters: NHS. There was no room for an independent outfit, focusing on wellness rather than disease, in the new, centralised National Health Service. '(http://www.guardian.co.uk/profile/jonathanfreedland wednesday 31st oct 2007

During the second world war, the government commissioned a report into the ways that Britain should be rebuilt after the War, Beveridge published his report in 1942 and recommended that the government should find ways of fighting the five 'Giant Evils' of 'Want, Disease, Ignorance, Squalor and Idleness'. The Welfare State therefore aimed to provide comprehensive services "from the cradle to the grave", through a system of education, health, housing and social security.

Disease by the establishment of a new health service;

Idleness by the State aiming for full employment

Ignorance by reform of the educational system;

Squalor by a new house building and slum-clearance programme.

Following world war 11, the new aim for health services was to 'provide the service free of charge…and to encourage a new attitude to health - the easier obtaining of advice early, the promotion of good health rather than only the treatment of bad" (Ministry of Health 1944). The National Health Service (NHS), like many health care systems, was intentionally structured for dealing with illness rather than functioning as a health or wellness service. The 1950s and 1960s were a time of high-technology medicine. Epidemic infectious disease was viewed as a thing of the past, as 'magic bullets' were developed for tuberculosis and smallpox (smallpox was eventually eradicated). With the advent of potent vaccines and antibiotics, public health took a back seat in the development of the health care model (Berridge2005).

Tripartite System 1948 –1974

Local Authority	Hospitals	General Practitioners
Public Heath **MOH collected local information on disease and immunizations Managed** • **Community and public health nurses in localities and schools** • **Environmental health** • **Linked with other agencies involved with health e.g. LA housing, social work**	**NHS- Provincial** **Hospital committees Teaching Hospital Boards received the bulk of the money**	**Contracted into the NHS** **Collected and sent information on notifiable diseases to MOH** **Treated individual disease and referred patients to hospital consultants**

From 1948 - Up to 1974 All Public health under Local Authorities

Medical Officer of Health (MOH)
Collected & analysed PH data. Wrote annual PH reports on the locality
(Chief nursing officer managed the health visitors and district nurses)

Health visitors and district nurses working in geographical areas promoting health Immunisations, screening health education care of the sick in their own homes working with LA schools, Housing .etc

Environmental Health officers - ensuring food hygiene clean environment etc

1974 NHS Reorganised

LA Environmental Health only.

Hospitals and public health nursing under one organisation.

District and Area Health Authorities set up to manage them. MOH placed in Area health authorities (AHA)

GPs still contracted into NHS.
Health centres built to accommodate GPs and community NHS staff (that had previously been worked under LA MOH.) called Primary care teams.
Focus on Community medicine rather than Public heath

1970's

1972 Local Government Act brought the post of MOH to an end. In 1974, the National Health Service (NHS) was reorganised (see diagram above)
Since The reorganisation of the NHS 1974, public health has been somewhat sidelined in favour of primary care teams linked to general practice. Also, the organisational structure became hospital rather than community focussed. (See diagram above)

Critique of Modern measurement of health and focus on curing disease rather than prevention and promotion of health.

Individual Behaviour
The work of Lalonde (1970 and McKeown (1976) provided a historical critique of "modern curative medicine". McKeown argued that improved nutrition and better standards of living contributed more to decreased mortality rates than high-technology medical interventions (Berridge; V' 2005). In 1976, the British government produced a document entitled, "Prevention and Health: Everybody's Business", which emphasised individual responsibility for health (DOH 2001).

The World Health Organization adopted the 'new public health' in 1977, the "Health for all by the Year 2000" and the Healthy Cities movements began to spread across Europe (Berridge V 2005). This was a new approach whereby a change in individual behaviour was seen as the key to improving the health of the population as a whole, thereby improving the general health of populations.

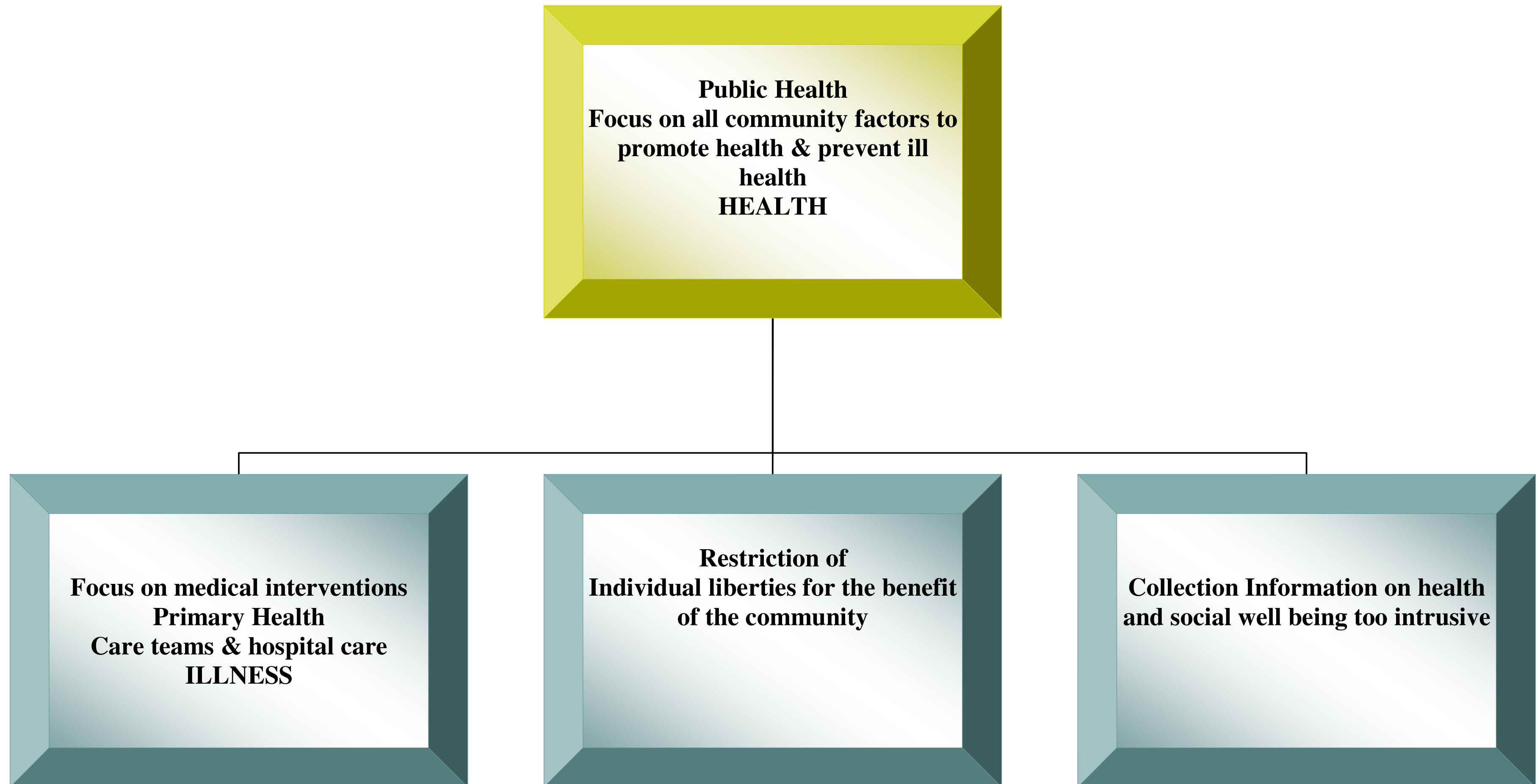
The new agenda focused on individual responsibility, behavioural changes and fiscal policy through taxation and marketing techniques. The basis of these changes was the epidemiological concept of risk and the role of statistical association between behaviours such as smoking and lung cancer; (Berridge V 2005) other successful interventions such as the clean air act 1963 were sidelined in favour of the drive to change individual behaviour.

International shift towards New Public health
International bodies such as the World Health Organisation (WHO) recognised that whilst Primary care had a powerful base in medicine, public health, had historically, lacked leadership partly due to the demise of Medical Officers of Health in the 1970s (WHO 2000,')

Inequalities

In the 1980s sociological and economic research highlighted the inequalities in the health of populations that in many cases were outside of individual citizens' ability to change (Black (1980) Townsend et al). In doing so, they challenged the power of the medical profession. Tudor Hart (1971) coined the phrase 'inverse care law' to show that the greater the needs for health care the less likely the person was to get it.

Debates around Public Health



Acheson Reports 1988 & 1998 -Public Health as the 'science and art of preventing disease'.

- Reorganisation of the National Health Service in 1974 served to break working partnerships between medical officers of health, environmental health officers and health visitors within geographical communities (see fig.).

- Health visitors, although frequently designated as 'public health nurses', have often had their role marginalised by 'organisational barriers' (Cowley, 1995).

- 'Saving lives' (Department of Health, 1999) emphasised that health visitors, school health nurses and all community nurses should be involved at some time in the public health agenda for the next millennium.

- Inequalities in health. Listed the factors that caused inequalities in health such as poor housing, poverty, unemployment etc and made recommendations to address the health and social issues that would serve to improve the situation.

Wanless Report published by the Treasury

The Wanless report (2002, 2004, 2007) focussed on

- Public Health and the reduction of health inequalities in England
- Made a financial argument for a broader focus on public health.
- Assessment of local need, by Primary Care trusts,
- Collection of health data,
- Public health research
- Greater efforts should be made to prevent illness through changes in lifestyle, health education and legislation.
- Health secretary should be responsible for ensuring that the cabinet assesses the impact on the future health of the population of any major government policy.
- Regular monitoring of the effectiveness of a national strategy to improve public health and an annual report on the state of the nation's health.
- Legislation on public health should address the balance between an individual's right to choose an unhealthy lifestyle, such as smoking, and the impact that behaviour has on wider society.
- 2007In 2007 Wanless argued that whilst there have been improvements in the number of full-time GPs per since September 2002 (including for the most disadvantaged areas), there had not been a significant narrowing of inequalities – with some signs of a widening in absolute terms by September 2006. . (Health Inequalities: 2007 Status Report on the Programme for Action page)

The shift in focus onto inequalities and health

Local information on the health and social needs of local populations

Joint Strategic Needs Assessment (JSNA)
The process of JSNA will establish the current and future health and wellbeing needs of a population, leading to improved outcomes and reductions in health inequalities. It comprises a partnership duty, which involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services

Since 2008 local authorities and Primary care trusts (PCT) have been under a statutory duty to produce a joint strategic needs assessment (JSNA) to:

- Inform Local area agreements and the sustainable communities' strategy.
- Inform PCT operational plans.
- Underpin a number of the world class commissioning competencies on health and well being
- Develop a procurement model and best practice guidance to underpin a joint commissioning framework for health and well being.
- Strengthened and widen the role, of directors of public health,

Joint health and social care and public involvement.
'Better joining up of services at the local level'.
The Local Government and Public Involvement in Health Act (2007), enabled ***Local Involvement Networks (LINks)*** to be established. Section 116 introduced a requirement on responsible local authorities and Primary Care Trusts (PCTs) to undertake a ***Joint Strategic Needs Assessment***

A new National reference group for health and well being in England (http://www.healthengland.org/) was also set up provide a sound evidence base for commissioners and the public.
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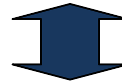
Public health emerging in reorganised NHS and Local Authorities since 2000

Current ideas

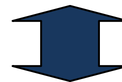
Partnership working - "joined up thinking"

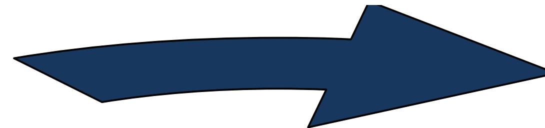
Devolving decision making

Inequalities & A Healthier Nation



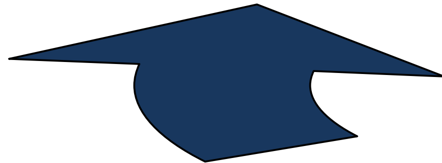
Secretary of state
Health protection Agency

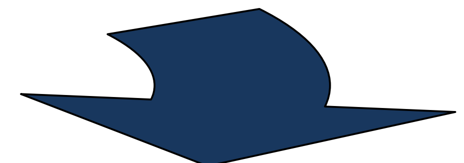




Regional
Health & Local Government Authorities
Public health observatory

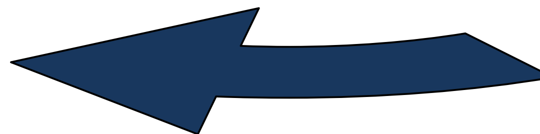
Local Authority



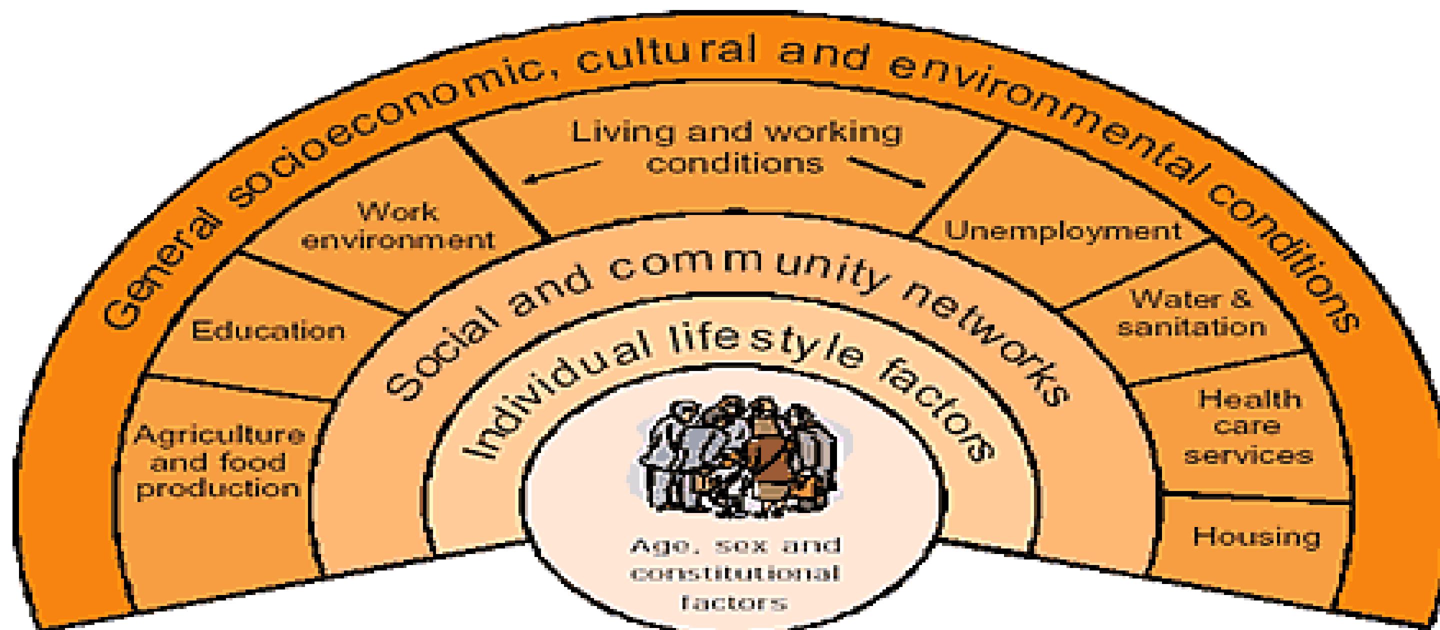


Primary Care Trust

JSNA & PH commissioner (jointly appointed)



Determinants of Health and Social Wellbeing



Source: Dahlgren G and Whitehead M, 1991.

Timeline

The two distinct characteristics of public health are that it deals with:

Preventative rather than curative aspects of health.

Population-level rather than individual-level health issues..

History of the 19th century

1834 - Poor law amendments - Poor houses & infirmaries

1842 – Edwin Chadwick- Local Authority/State intervention in health - 'Report on the Sanitary Conditions of the Labouring population of Great Britain'

1847 First Medical Officer of Health (MOH) - William Henry Duncan for Liverpool.

1848 John Simon was created MOH for City of London. 1848 Public Health Act created the General Board of Health and allowed authorities to create MOH posts without recourse to Parliament.

1850 onwards - Ladies Sanitary reform Association (early health visitors and environmental health officers)

1853 - Smallpox vaccination made compulsory

1839 - William Farr –statistics

1854 - John Snow linked water with cholera

1858 onwards- Joseph Bazalgette – built the sewers, provided clean drinking water

1880 - Education to age 10 made compulsory

1860 - Florence Nightingale sets up training school for nurses. Utilised William Farr's statistics to argue for improved hygiene. Also influenced the development of public health and district nursing in the community

1862 - Pasteur - demonstrates link between bacteria & disease

1867 - Lister - introduced antiseptic surgery. Surgical mortality reduce by two thirds

1875 - Public Health Act allowed local authorities to perform slum clearance

1876 - Koch identifies bacteria

1880 - Education to age 10 made compulsory

Timeline

History of the 20th century

1904 - Interdepartmental committee on physical deterioration

1911 - National Health Insurance Act + Census introducing social classes
1914-1918 WW1
1918 -Pandemic influenza outbreak

1919 - Ministry of Health established

1928 - Universal adult suffrage

1929 - Marriage act increased minimum age from 12 (girls) & 14 (boys) to 16

1932 - Sulphonamide (antibiotic) discovered

1939-1945 WW2

1941 - National Insurance Act - compensation for industrial diseases & injuries

1948 - National Health Service Act + National Assistance Act based on the Beveridge Report named the 5 giants: disease, ignorance, squalor, idleness and want. Focused government to attend to NHS, social security, housing, education & policy of full employment. The Welfare Sate

1952 - Polio vaccine

1960s - Benzodiazepines developed

1964 - Congenital anomalies reported nationally

1968 - Legalisation of abortion

1972 - Medical officers of health (MOH) cease to exist

1974 - Reorganisation of NHS

198O s - Various reports on inequalities in health

1990 - National Health Service and community Care Act national health – focus on GP based primary health teams

1988 &1998 - Acheson Reports into Public health

Timeline

History of the 21st Century

2002,2007,2008 Wanless Report making a financial argument for public health

2003 WHO The Solid Facts: Social Determinants of Health Wilkinson R and Marmot, M Eds

2007 Commissioning framework for Health and Well being. World class Commissioning: competencies. Department of Health,

2010 Marmot M Fair society, healthy lives. Strategic review of health inequalities in England post-2010

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