Public Health Review

Evidence Analysis – Short Report

The Scottish Government
Riaghaltas na h-Alba

Public Health Review

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This report summarises findings from an analysis of research literature carried out to inform the public health review group. It highlights a range of approaches to public health leadership, partnership working, governance and workforce infrastructure, and describes the key messages and learning points relevant to the Scottish context.

E.Curnock, July 2015

1 Summary of key findings

1.1 Public Health Capacity and Infrastructure

Robust public health infrastructure is required to fulfill essential public health functions such as surviellance, health protection, disease prevention and health promotion (World Health Organization, 2012). Whilst public health priorities may change in light of emergent challenges and changing contexts, it is is important to ensure the resource required to address enduring public health challenges is maintained and developed, for example provision of clean water, immuisations against communicable diseases and screening for chronic disease (Hanlon et al., 2011). Box one summarises an example of a simple framework to assess public health capacity (Aluttis et al., 2014). Such frameworks may be used for benchmarking and prioritisation of strategies to strengthen public health infrastructure and improve capacity.

Box 1: Dimensions of Public Health Capacity (Aluttis et al., 2014)

Dimension	Description
Organisational structures	The infrastructural ability of a system to contribute to goals of public health
Resources	The allocation and provision of human and financial resources necessary to carry out public health activities
Partnerships	Collaboration between organisations for effective public health practice
Workforce	Qualified human resources with sufficient skills and knowledge; availability of training options
Knowledge development	The knowledge base that provides information on the health of the population and that supports evidence-based public health policy and interventions at all levels
Leadership and governance	The ability and willingness of governments to improve public health by developing and implementing effective public health policies and by expressing qualities in leaderships and strategic thinking
Country specific context	The political context and other characteristics of a country that may have an influence on public health policies and capacity building efforts

1.2 Leadership

Emergent public health challenges (such as an ageing population, socioeconomic inequalities and the globalised sociocultural context) require new approaches to public health leadership (Beaglehole & Bonita, 2004; Czabanowska et al., 2014; Hanlon, 2012). In addition, the number of potential stakeholders with a public health agenda is 'wider than ever' (associated with increased recognition of the social determinants of health) and the nature of public health practice has shifted (Czabanowska et al., 2014; Davies et al., 2014; Koh, 2009). Box two summarises some of these leadership functions, both in relation to the public health workforce and the wider agenda of improving population health. It is recommended the review group identify the leadership features required for the current Scottish context and use these to benchmark Scotland's leadership performance.

Box 2: Features of leadership

Specialist and practitioner public health workforce

- Shaping, organising, networking, connecting, advocacy, gathering disparate groups together with a shared focus on a specific outcome (Day, Shickle, & Smith, 2014; Koh, 2009; Mackenbach & McKee, 2013)

- Identification of opportunities within seemingly 'chaotic' constantly changing environments with uncertain outcomes, and an ability to employ systems-thinking (Czabanowska et al., 2014; Hunter, 2009; Koh, 2009)

- Enthusiasm, vision and credibility underpinned by a commitment to social justice (Czabanowska et al., 2014; Griffiths & Hunter, 2007; Koh, 2009; Rechel & McKee, 2014)

- Collaborative, flexible leadership as a function of group aims or values (as opposed to authoritarian or technocratic models) situated in a relational community rather than attached to individuals or specific roles (Brownson et al., 2012; Czabanowska et al., 2014; Howieson, Sugden, & Walsh, 2013; Koh, 2009; Rayner, 2007)

Wider leadership to improve population health

- 'Leadership without authority' embedded within multi-sector alliances; galvanising civil society through traditional and social media; building bridges with academia and practitioners; national bodies who can serve as a convener of diverse organizations; encouraging the cultural shift toward active citizenship; participation in emergent public fora that nurture 'public interest leadership' (Davies et al., 2014; Drehobl, Stover, & Koo, 2014; Howieson et al., 2013; Lachance & Oxendine, 2015; Mackenbach & McKee, 2013).

- Influence through political astuteness and persuasion (Hunter, 2009; Koh , 2015; Mackenbach & McKee, 2013; Rayner, 2007; Rechel & McKee, 2014)

- Environments of innovation, creativity, imagination and continuous learning (Czabanowska et al., 2014; Rayner, 2007)

1.3 Partnerships

An extensive literature describes factors that facilitate or provide challenges to successful partnerships; these are summarized in box 3 at the end of this report. Some factors must be held in tension with others, and their individual relevance will vary by context and purpose of the partnership.

Reviews of evaluations of emblematic multi-agency public health partnerships (for example, Health Action Zones) find limited evidence of health impacts, reflecting the challenge of robust outcome evaluation of partnership working but also a lack of long-term sustainability and insufficient resources for implementation (Carlisle, 2010; Hayes et al., 2012; Smith et al., 2009; Spinks et al., 2009). Local government is a helpful context for the coordination of joint strategies and advocacy for macro-level sustainable change within a multi-sector 'settings' approach such as Healthy Cities, Healthy Workplace, Healthy Schools or Safe Communities initiatives (Dooris, 2013). An important role of the specialist public health function within wider partnerships is to counter pressure to shift attention away from the preventative agenda towards high-profile downstream issues, by locating health issues within an evidence-based ecological public health framework (underpinned by the epidemiology of the determinants and distribution of disease) and by articulating the evidence and ethical basis for potential interventions (Allin et al., 2004; Boydell & Rugkasa, 2007; Mackenbach & McKee, 2013; Taylor-Robinson et al., 2012).

Recent policy in Scotland seeks to strengthen partnership working both across public sector bodies and with communities, for example, the

Christie commission, the Community Empowerment Bill, and Health and Social Care integration. This is a helpful cultural and policy environment which aligns with the public health agenda.

1.4 National Policy

Reviewing health policies across Europe (including tobacco, alcohol, food child health, mental health, screening, and air pollution) McKee and Mackenbach identify why some countries have been able to enact effective national policies whereas others have not (Mackenbach & McKee, 2013). Factors identified include the availability of resources (including funding for a skilled workforce, functioning IT systems and data intelligence), the values held by their citizens, the cultural heterogeneity of the population, the quality of democracy and the effectiveness of government (a high quality civil service independent from political pressures, effective systems of policy formulation and implementation, and the credibility of the government's commitment to implementation) (Mackenbach & McKee, 2013). Investment of resource and political space for strong public health associations and professional groups that conduct advocacy work can also be important, particularly where corporate interests seek to undermine government actions (Beaglehole & Bonita, 2004; Mackenbach & McKee, 2013; Leppo et al., 2013).

Health determinants may be seen as the mediators between policies and health outcomes (Ståhl et al., 2006). Health in All Policies (HiAP) is a cross-sector approach that systematically takes into account the health implications of decisions across public policies in order to improve population health and reduce inequalities and plays an important role in the European Health 2020 policy framework (Leppo et al., 2013; McQueen, 2014). Conditions which support this approach include a supportive political context with legal backing, development of policy proposals across sectors with an ability to seize policy-making

opportunities, processes for intersectoral communication and implementation, resources (such as joint budgeting or delegated financing), and the technical skills and governance structures to implement policy decisions and evaluate their impacts on health and its determinants (Leppo et al., 2013; McQueen, 2014; Ståhl et al., 2006; Wismar et al., 2012).

Whether policies are developed and implemented collaboratively by the relevant policy sectors is a key challenge and includes engaging with non-institutional settings. This requires the need to consider more deeply what the 'think global act local' mantra means in specific contexts and may require a willingness to drop explicitly health language for that of wellbeing and sustainable development in recognition of the interconnectedness between human health, ecosystem health and public health (Dooris, 2013; Hendriks et al., 2014).

1.5 Governance and accountability

Evidence on the relative merits of different governance structures and relationships of accountability is mixed; there is a dynamic balance between national and local infrastructure for public health that changes over time and varies between countries according to their political context, structures, social attitudes and history of participative decision-making (Allin et al., 2004; Brownson et al., 2012; Jakubowski & Saltman, 2013). International country case studies presented in the full report (including England, France and Sweden) each demonstrate the tendency to counterbalance devolved responsibilities with national accountability and direction. The benefits of nationally-led, centralised, public health infrastructure include: the capacity to employ strategic approaches to addressing health issues with global roots with clear alignment between vision, strategy and objectives; the ability to address inequalities of access and resource when implementing and coordinating actions; and stronger infrastructure such as health intelligence, and IT resources. The benefits of centralization must be considered in tension with the benefits of power being devolved to localised regions, which include: more democratic decision-making with greater engagement and access to the population; locally responsive strategies with opportunities for experimentation; and the ability to utilise local drivers for implementation. However, localised governance may be susceptible to inefficiencies of scale, exacerbation of inequalities and is susceptible to individual interest agendas (Allin et al., 2004; Jakubowski & Saltman, 2013; Rayner, 2007).

As there is no apparent direct relationship to better population health outcomes and the balance between local and national governance for

public health, each country seeks to find the balance between these that best fits its culture, politics and values. There will always be a shifting dynamic balance between local and national, and therefore there is no single 'right' solution to this, but the mechanism for the connection between the two is important.

2   Conclusions

The evidence review highlights the absence of any 'menu' of features as the basis for a highly effective public heath function. This report describes the key messages and learning points from conceptual frameworks and theories relating to public health leadership, partnership working, governance and workforce infrastructure relevant to the Scottish context, but there is not strong evidence linking particular approaches to better outcomes. Rather, the effectiveness of the public health system is dependent not only on the skills, leadership, cohesion and adaptability within the various components and levels of that system, but also on the wider political, cultural and resourcing context in which the public health system operates.   The review has elucidated a number of factors that should be considered by those seeking to strengthen the Public Health function in Scotland. Among these are:

- The importance of maintaining and developing the resource and infrastructure required for public health resilience and capacity.
- The need to be clear about the 'leadership ask' in relation to the specialist public health function and to the wider challenge of improving the public's health in view of emergent priorities
- The importance of describing and reinforcing the specific public health contribution to partnerships
- The need for sustained resourcing to secure a sufficient intensity and reach of interventions through partnership working, including tailoring for people with greatest need.
- The need to consider how the 'Health in All Policies' concept can be supported in the Scottish context with appropriate integration of governance

- The achievement of a balance between centralised and local public health activity, with cohesion and accountability between these levels

Table 3: Task and People focused facilitators of partnership working, categorized in relation to Implementing (I) or Sustaining (S) phase

Task focused facilitators of Partnership Working	**People** focused facilitators of Partnership Working
Consideration given to alternative approaches to achieving outcomes; explicit consideration of the degree of involvement of each group to maximise resources, and agreement of pre-determined exit strategy (I) (Carlisle, 2010; Graham, Sibbald, & Patel, 2015; O'Mara-Eves et al., 2015)	Senior representation and senior engagement (I) (Boydell & Rugkasa, 2007; Stern & Green, 2005)
Clear success criteria / goals / aims / purpose (I) (Boydell & Rugkasa, 2007; Graham et al., 2015; Hunter & Perkins, 2012; Shaw, Ashcroft, & Petchey, 2006; Taylor-Robinson et al., 2012)	Participation of 'boundary spanners' – individuals who bridge organisations ('across'), connect with the policy agenda ('upward'), and with communities ('downward'), partners with local or 'insider' status, boundary spanning mechanisms. (I) (Carlisle, 2010; Eilbert & Lafronza, 2005; Oliver, 2013; Powell, Thurston, & Bloyce, 2014; Rugkasa, Shortt, & Boydell, 2007; Stern & Green, 2005; Taylor-Robinson et al., 2012)

Transparent frameworks and fair conduct for decision-making (I) (Marks, 2007; Shaw et al., 2006; R. Stern & Green, 2008; Taylor-Robinson et al., 2012)	Where there is community involvement: community and front-line workers are primary drivers (engagement is empowering rather than consumerist), not just for 'representation' (I) (Carlisle, 2010; Carr, Clarke, Molyneux, & Jones, 2006; Eilbert & Lafronza, 2005; Marks, 2007; Stern & Green, 2005)
Clear accountability structures and governance requirements which are similar across organizations or an ability to adapt to alternative structures; organisational performance management systems that include collaboration within criteria of each partner (I) (Boydell & Rugkasa, 2007; Carr et al., 2006; Hunter & Perkins, 2012; Marks, 2007; Powell et al., 2014; Stern & Green, 2005)	Collaborative leadership, rather than 'control and command' (S) (Carr et al., 2006; Ferlie, Fitzgerald, & Addicott, 2010 ; Hunter & Perkins, 2012)
Sufficient funding, infrastructure and resources, willingness to share information and resources; joint appointments (I) (Carlisle, 2010; Ferlie et al., 2010; Hunter & Perkins, 2012; Marks, 2007; O'Mara-Eves et al., 2015; Stern & Green, 2005; Taylor-Robinson et al., 2012)	Appropriate communication, shared language, responsiveness (S) (Carr et al., 2006; Shaw et al., 2006; Taylor-Robinson et al., 2012)

Connections and 'joined up thinking' between local and national agendas and between different national agendas, as well as policy stability (I) (Carr et al., 2006; Hunter & Perkins, 2012; MacGregor & Thickett, 2011; Shaw et al., 2006)	Time and space to develop trust and goodwill, and enable 'emergence' and 'evolution' of activities, capacity to work through conflict, protection from top-down restructuring (S) (Boydell & Rugkasa, 2007; Carlisle, 2010; Carr et al., 2006; Hunter & Perkins, 2012; MacGregor & Thickett, 2011; Marks, 2007; McMurray, 2007; Shaw et al., 2006)
Shared geographical boundaries with an approach to planning organized at a similar level (I) (Carlisle, 2010; Marks, 2007; Taylor-Robinson et al., 2012)	Job security, organisational stability and low turnover of staff; previous history of working together (S) (Carr et al., 2006; Hunter & Perkins, 2012; Marks, 2007; Powell et al., 2014; Taylor-Robinson et al., 2012)
Permission to experiment to solve problems, ability for local 'customisation' and an ability to frame problems and solutions differently from training and professional customs may suggest (S) (Ferlie et al., 2010; Hunter & Perkins, 2012; Pate, Fischbacher, & Mackinnon, 2010)	Shared values and priorities, built on an evidence base that spans sectors, support for 'off-line' development spaces where different perspectives can be discussed (I) (Carlisle, 2010; Eilbert & Lafronza, 2005; Ferlie et al., 2010; Stern & Green, 2005; Taylor-Robinson et al., 2012)

Commitment to outcome evaluation with published results, shared perceptions of 'good evidence', access to high quality data, and capacity to track multiple inputs and outputs over a long period, adaptive system to enable feedback from learning, continuum of outcome achievement (short and long-term) (S) (Carr et al., 2006; Eilbert & Lafronza, 2005; Graham et al., 2015; Hunter & Perkins, 2012; Powell et al., 2014; Taylor-Robinson et al., 2012)	Secure professional and organizational identities set within the context of strong identity for the partnership itself and the removal of unnecessary organizational symbols that emphasise cultural differences (S) (Ferlie et al., 2010; Pate et al., 2010)

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