Action for Better Public Health

Key Points

Major public health gains were achieved in the twentieth century. For example, infant mortality rates fell from 150 per 1000 in 1900 to well under 10 today. The health of people in all social classes is better than ever before. But concerns remain about persistent inequalities, and the impact of life style related problems such as those associated with poor diets, physical inactivity and smoking.

Improving knowledge without other supportive or regulatory interventions is most likely to benefit richer people. A major challenge for today is to provide support for health behaviour change that respects peoples’ freedom and helps improve the health of less advantaged groups.

Trying to ‘nanny’ older children and young adults can be counter-productive. But there is robust evidence that most working age and older adults want to live healthily, and respond positively to appropriate health messages. This is especially so when these are combined with initiatives that make healthy behaviour convenient and enjoyable.

Stopping smoking coupled with other changes, like taking moderate exercise and eating an extra serving of fruit or vegetables, might add 10 years life expectancy.

Health focused partnerships between public and private sector organisations can help promote fuller public engagement in health improvement, through using all society’s resources in more co-ordinated and complementary ways.

Pharmaceutical service providers can, along with other retailers and service organisations, contribute to public health improvement by enabling customers to have fuller information about health related issues and supporting health promoting behaviours. They can also facilitate more effective medicines use, to protect individuals, families and communities.
INTRODUCTION

Fundamental improvements in public health have been achieved since the end of the Victorian era. At the beginning of the twentieth century, average life expectancy in Britain was under fifty years. Infant mortality was about 150 per 1,000. Amongst the poorer sections of the population over 200 infants in every 1,000 born alive in 1900 died in their first year of life. Today, by contrast, average life expectancy in Britain for men and women together is close to eighty years. Even in the least advantaged groups the infant mortality rate is now down to about 10 per 1,000.

This progress has been the result of environmental and allied improvements, together with advances in medicine and health care. Of the approximately ten years of average life expectancy gained since the creation of the NHS in the late 1940s, about half has been derived from factors such as better food standards and collective protection from hazards like infections and accidents. The other five additional life years have stemmed from better medicines and enhanced surgical techniques employed in individual care (Bunker 2002).

Yet significant public health problems remain. Tobacco use is still the largest single cause of avoidable harm to the population, and particularly to less advantaged groups in the community. For example, while only 15 per cent of women in the most affluent quarter of the population smoke during pregnancy, this proportion is twice as high in the poorest quarter. Growing rates of obesity and diabetes represent another major challenge. Alcohol and illicit drug taking also cause appreciable levels of death and disability, as do various forms of mental illness. Even in fields such as heart disease, where mortality has fallen markedly since the 1950s, the figures for chronic ill health and long-term impairment are rising, along with extended survival.

The continuing existence of significant inequalities in health between people in different social classes provides an indicator of the scale of population health improvements yet to be universally gained. Assuming that the environmental, social and economic advances made in the previous century can be sustained, a key issue for the future – as the 2004 White Paper Choosing Health: Making Healthy Choices Easier emphasised – relates to the extent to which citizens will elect to use their wealth in ways that will help to reduce further not only the risk of an early death, but also chronic illness in later life.

Against this background this brief analysis explores opportunities for public health improvement in the coming century, and the challenges of building effective partnerships for better health between public and private service providers in the health sector and the wider economy. It examines data relating to the extent and nature of modern public health problems, and evidence on the extent to which affordable health promotion and allied interventions can successfully help individuals, families and communities gain better future health.

This School of Pharmacy and Boots paper goes on to outline ways that stakeholder organisations active in pharmacy are adapting in order to address effectively public health gain related goals, individually and in co-operation with other partners. Barriers that will have to be overcome to permit sustained change are also identified. Examples of innovative practice and public health promotion being pioneered in Boots pharmacies are provided in the Boxes complementing the main text. (See, for instance, Boxes 1 and 2.) However, important developments are presently taking place throughout pharmacy, and in other fields more removed from traditional health care. This deserves clear acknowledgement. Building progressively more effective partnerships for better public health will require a mutually supportive recognition of the differing resources and skills that all actors can contribute to achieving greater well-being and extended longevity for the whole population.

THE PUBLIC’S HEALTH IN THE TWENTY FIRST CENTURY

Figure 1 details the main changes observed in patterns of death among men and women as Britain passed through the demographic (population structure) and epidemiological (disease occurrence) transitions of the last 100 years. Apart from discontinuities associated with the global influenza pandemic at the end of the first world war, and the subsequent decline in cardiovascular deaths linked to rationing during the 1940s, the picture is one of relatively steady development.

Death rates from infectious illnesses fell during the early twentieth century, in large part because of better housing and nutrition. This led to reduced infection rates and stronger immune responses, individually and at a population level. The ‘lifestyle choice’ of having smaller families also permitted (along with better education for women) progressively improved infant and childcare during this period.

Cardiovascular (including coronary heart disease and stroke) death rates climbed continuously between the time when Boots first became established as a national retailer in the 1870s, through to the 1950s. This was in part because the population had increased access to tobacco and fatty foods during this period. Such goods are typically consumed in increasing quantities in communities that are in the process of becoming wealthy. Populations remaining very

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**Box 1. Small steps to large gains**

In January 2006, to coincide with the adoption of New Year resolutions, Boots launched the ‘Change One Thing’ campaign. Like the subsequent ‘Small Change, Big Difference’ campaign led by the Department of Health, this was designed to help motivate and provide support to people seeking to protect their health. It was in part based on evidence indicating that achieving relatively easy incremental changes in areas such as eating and exercise can open the way to important gains in life expectancy. The Change One Thing campaign focused on goals such as stopping smoking, losing weight, eating well, getting fit, becoming less stressed and looking good. Starter packs were available for supporting each type of resolution. Information was provided on-line and through leaflets. Support was also available through chat rooms, text messages and from Boots pharmacists in person. Almost half of Boots customers felt that the campaign was personally relevant to them.
poor cannot afford them, while those accustomed to wealth and education in time turn to less hazardous choices.

Since the middle of the twentieth century age standardized cardiovascular disease death rates have declined, while the equivalent cancer mortality rates for men and women combined have stayed roughly constant. However, because the population has (principally because of smaller family sizes) aged, the absolute number of cancer deaths has risen. Within the gross cancer mortality recorded various trends have taken place. These included a marked fall in the rate of stomach cancers associated with food refrigeration, and the impact of first rising and then falling rates of cigarette smoking on lung cancer incidence.

Figure 2 Expected length of further life at aged 50 and 65(UK)

By the start of this century life expectancy at birth for women had reached 81 years, and for men 76 years. These figures contrast with averages of 49 years for women and 45 years for men in 1901. As Figure 2 shows, it is predicted on the basis of established trends that by 2020 life expectancy for women will be 84 years, and for men 79 years.

Box 2. Individual membership, collective benefits

Following the Change One Thing campaign, Boots launched in April 2006 the Boots Health Club. This enables individuals who elect to join to identify areas of health of special interest to them. They can choose to receive mailings and e mails on topics like heart health, stopping smoking, children’s health, weight loss, vitamins and diet supplements, women’s health and pain relief and allergies. Customers are encouraged to ask health experts for additional advice as and when it is needed. In addition, the Boots Health Club has its own website (www.boots.com/checkout) and links with Boots’ prescription collection service. There are monthly ‘in store’ healthcare events for Health Club members (and other customers). Illustrative topics include asthma and hay fever management. To date, over a million people have joined the Boots Health Club.

The core public health questions such estimated figures raise include:

- can existing health improvement trends really be continued? Relevant challenges in this context include the possibility that negative aspects of increasing affluence, such as physical inactivity and obesity, will stop or reverse further progress. An alternative possibility is that declines in Britain’s

Box 3. Better access to prescribed and self selected treatment

Boots launched a ‘Midnight Pharmacy’ initiative in April 2006. This is aimed at ensuring that the company plays a key role in late night pharmaceutical care provision throughout the UK. It is planned that by December 2006 there will be 60 Boots pharmacies trading till midnight. The end-point target is that by the end of 2007 about 95 per cent of the population (that is, 19 out of every 20 potential customers) will be within a 30 minute drive to a Boots Midnight Pharmacy.

It is also important to note that the proportion of people classed as being relatively affluent has increased significantly in recent decades, while the percentage classed as least advantaged has declined. This helps to explain why, despite concerns that class related health inequalities in the UK. The fact that more advantaged people have in the main now stopped smoking is a key reason why some facets of health inequalities have increased in recent decades.

The answers to these and other related complex questions cannot be pursued in depth here. But the following points are worth particular emphasis:

1. Reducing health inequalities is an important goal. But it should not be pursued at the cost of neglecting opportunities for improving overall population health, or distorting perceptions of the fundamental causes of illness

It is a disturbing fact that life expectancy in some localities in this country is between five and ten years less than it is in other more advantaged areas. However, the pioneering public health researcher Sir Geoffrey Rose argued that it is a paradox of ill-health prevention (as opposed to disease treatment) that the most substantive public health gains are normally to be expected from interventions that change the behaviour of the entire public, rather than just individuals at very high risk of harm.

2. Greater public engagement in health protection and promotion is essential

In his 2004 report Securing the Health of the Whole Population, Sir Derek Wanless observed that limiting the cost of health services while at the same time maximising their productivity will in future be in large part dependent on fostering ‘full engagement’ of members of the public. This is not to say that the great majority of people are not already concerned about health issues, or that
they fail to take a responsible approach to health care. But it does suggest that if more people can be supported in ways that raise their self-efficacy in relation to health matters (that is, their confidence in dealing with illnesses and/or their prevention – Bandura 1986, 1994) and so permit them to take more effective action to care for themselves, then better outcomes will result.

The concept of improving service user self-efficacy underpins the Expert Patient Programme for supporting self-management of chronic conditions (Department of Health, 2001). A key challenge for professionals such as community pharmacists relates to the extent to which they can develop new ways of practicing that contribute at a population level to promoting enhanced self care (Boxes 3 and 4). This includes enabling people to manage their use of both prescribed and self-purchased pharmaceuticals well. Community pharmacists are potentially well positioned to move away from traditional, paternalistic, approaches towards establishing more equal and productive partnerships with health service users.

In Scotland there has for some time been a strong emphasis on encouraging the provision of public health related interventions via community pharmacies. Such thinking is also reflected in recent Department of Health policy documents such as Choosing Health Through Pharmacy. Modern approaches to health improvement encourage not only members of the public but also health care practitioners and managers in both public and private organisations to become more responsibly engaged in public health relevant service delivery and community development.

Box 4. Facilitating appropriate medicines use

For selected medicine groups, such as those for asthma treatment, Boots provides a special health information service. This offers targeted information about the condition and the medications used to treat it. This is printed off and provided during the dispensing process. Customers needing repeat prescriptions receive new information monthly.

Recent research suggests that even limited changes in physical activity and diet could lead to significant health gains, and help further improve both longevity and freedom from disabling illness. For example, Khaw and her colleagues (2001) looked at the relationship between vitamin C levels and death rates in a population of some 20,000 middle aged and older men and women living in East Anglia. Relatively small increases in fruit and vegetable consumption (equivalent to one circa 50 gm serving a day) were associated with a 20 per cent reduction in all cause mortality rates. In a subsequent study, these investigators also examined the relationship between physical activity and observed mortality rates (Khaw et al 2006). They concluded that even moderate levels of activity (0.5 hrs of recreational activity a day for people with a sedentary, sitting, job) are associated with a significantly (circa 10 to 20 per cent) reduced risk of both all cause mortality and cardiovascular disease incidence.

Such observational findings may be questioned for various reasons. But from a psychological perspective they offer reassurance that incremental health behaviour changes are achievable. They are also broadly consistent with a number of other study findings. A recent Cochrane Review on the impact of dietary advice (Brunner et al 2005) found that many health promotion programmes have increased fruit and vegetable consumption in adults by over one serving a day. These researchers calculated, on the basis of observed cholesterol and blood pressure reductions, that such modest life style adjustments can realistically be expected (assuming that behavioural changes are maintained) to cut stroke and coronary heart disease incidence rates by some 10 per cent. It has been estimated that successful smoking cessation, combined with dietary improvements such an additional daily serving of fruit and a shift from inactivity to moderate activity, could in some instances increase life expectancy by eleven years (Boseley 2006). That would be equivalent to closing the entire longevity gap between Britain’s most and least advantaged groups.

INVESTING IN PUBLIC HEALTH PROGRAMMES THAT WORK AND ARE WELCOMED BY CONSUMERS

In the past large public health campaigns aimed at multiple life style improvements have often had a very limited visible impact. This may have led some policy makers to doubt the value of all forms of health promotion. Unwanted ‘nannying’ messages have often proved unpopular (Mechanic 1999), and been regarded by the public as manipulative and intrusive. Politicians may have feared that investing in health promotion could alienate voters. Doctors and others health service leaders may also have believed that ‘public health’ interventions lack robust scientific evidence, and that spending on them might threaten the funding of acute care. And retailers and manufactures may have thought they would lose customers as a result of supporting unpopular ‘healthy living’ programmes.

Yet today there is growing evidence that well designed health promotion interventions are effective in changing health behaviours (Taylor et al 2006). When appropriately conducted they should enhance rather than undermine both approval ratings and economic performance. From an ethical perspective it can be argued powerfully that the role of public health interventions should be to inform and educate people about the health consequences of their actions, and to empower people to make choices that people feel are right for them, rather than to impose choices on them (Kessel 2006). But this does not obviate the need for health leadership in society, especially in situations where vulnerable people’s short term inclinations may carry with them a very high risk of unwanted future consequences.

Box 5. Making effective weight loss support more convenient

Eighty selected Boots pharmacies in England and Wales are in the process of introducing a new weight loss programme. Participants must be adults with a body mass index of 30 or more, or with a BMI of 28 plus additional risk factors. They have a consultation with a pharmacist. The examination offered includes blood pressure and blood glucose monitoring, and the setting of weight loss targets. The programme includes the provision of weight loss medication, and is designed to facilitate safe and effective treatment. Customers’ doctors are kept informed of their involvement and progress.

Advice and support is offered to service users through a helpline providing access to health professionals, and information and guidance on nutrition and increasing physical activity. This programme was originally piloted in Manchester, where the average weight loss achieved was 6.5 per cent at 3 months and 13.4 per cent after 9 months. 1, 000 customers have joined the Boots Weight Loss Programme to date. Examples of feedback from them include: ‘I have noticed my breathing is much easier if I have to run for a bus or walk upstairs, now I have lost some weight’ and ‘The doctor is happy I am losing weight. My blood pressure is much more controlled’.
Recent advances in public health management and health change techniques should open the way to more effective health improvement strategies. The latter often involve forming strengthened partnerships across the entire health and social care sector, and more broadly. Recent government efforts to involve major stakeholders such as Boots, the British Heart Foundation, Cancer UK, Sainsbury’s and Unilever more closely in promoting health behaviour change reflect this understanding.

Examples of useful insights into the age related and other factors influencing the adoption of health protecting lifestyles include:

- **infants and children** are highly dependent on the environment provided for them by their parents and their schools, and the examples set for them by the adults in their lives. Isolated special lessons on ‘health and healthy living’ are unlikely to be of great practical value. But healthy environments, providing on a normal daily basis good food, positive eating values and habits and enjoyable exercise opportunities from an early age are beneficial. Experience with programmes such as Head Start in the US (the equivalent of Britain’s Sure Start) indicates that parents and their families living in less advantaged settings can benefit from receiving information on and support for healthy eating and other issues. Community pharmacies are often conveniently positioned to support busy women caring for young families;

- **young adults**, by contrast, normally seek independence and may reject parental and ‘main stream’ advice associated with others having age-related authority over them. Conventional approaches to health promotion in schools or other settings can therefore be counter-productive, albeit that more radical criticisms of health endangering social conditions may be effective in influencing young adults’ attitudes.

Although it is sometimes suggested that health promotion programmes cannot have unwanted side effects, this is not the case. There is some evidence that on occasions they increase levels of smoking or other forms of drug use in youth and young adults. Similarly, there is evidence that ‘safe driving’ lessons for young males may increase accident rates by raising their interest in driving while having no effect on their response to risks (Cochrane Injuries Group, Driver Education Reviewers 2001). Another hazard to avoid in the context of both children and young adults is stigmatising obesity, and precipitating eating disorders in young men and women;

- **working age adults** are normally busy. Their behaviour is often particularly likely to be determined by convenience factors, and the practical viability of taking up health related options such as programmes designed to facilitate weight loss (Box 5) or smoking cessation (Box 6). These may offer longer life in the future, but require time to be invested in the present.

Examples of the latter include smoking bans, road safety and pollution laws, and changes in the salt and saturated fat content of foods offered in settings such as workplace canteens and products purchased in the high street. People with more free time, money and security are more likely to benefit from improvements in their health related knowledge, without other accompanying support factors (Gepkin and Gunning-Schepers 1996); and

- **older adults** nearing or in the decade after retirement tend to be more immediately aware of the gains they have to make from avoiding or slowing the onset of illnesses and disabilities than are younger individuals and groups. Their health related behaviour may therefore be more consistently motivated towards achieving health goals than that of younger adults. However, older adults – like everyone else – are also likely to favour more convenient and enjoyable choices. There is evidence, for example, that patterns of exercise incorporated into home life and personally preferred recreational activities are significantly more likely to be sustained than are those requiring attendances at special centres. One implication of this is that ‘walking to the shops’ for food or medicines (and perhaps some social contact) may in many ways be better for health than using home delivery services.

**Box 6. Smoking cessation**

During the four month ‘Change One Thing’ campaign Boots helped over 500,000 customers to try to stop smoking. The company has unique experience in the field of smoking cessation (including in the use of computer based cessation support systems, based on the work of Prochaska and Di Clinite) and is the nation’s largest supplier of self purchased nicotine replacement therapies. See also ‘Modernising Self Care’, published by Boots in 2002.

Other relevant observations include:

- **the more targeted towards specific ends and tailored to the concerns of particular groups** health promotion interventions are, the more likely they are to have significant effect sizes. Individual and community goal setting, and feeding back on behaviour change achievements, also enhance effectiveness. Such observations apply to people in all social groups, and the more shared values and expectations can be formed the greater the likelihood that more equal patterns of health behaviour and outcome will evolve (Box 7);

- **mass media advertising** alone is relatively ineffective in initiating new, complex, behaviours. However, it can be much more effective in raising the consumption of given products, whether they are health harming like cigarettes or health improving like wholesome bread or fruits. The appropriate branding and mass marketing of healthy product ranges could thus have an important part to play in promoting further health gains. In circumstances where additional information and support programmes are also in place, commercial and other advertising can also have useful role in reminding people about their established health improvement intentions/resolutions;

- **medicines use** can effectively support behaviour change, as well as having direct biomedical effects. This is well illustrated in the case of nicotine replacement therapy use, which doubles the likelihood of cessation in any setting. As further and effective new medicines (and also ‘neutraceuticals’ – health promoting food products) become available to address ‘life style’ related risks and conditions such as hypercholesterolaemia, obesity and type 2 diabetes, this fact may have important implications for both public health improvement and pharmacy; and

- **doctors** are more likely than other health professionals to change smoking and by implication other health behaviours through brief opportunistic interventions. However, there is also good evidence that **pharmacists and nurses** can support smoking cessation and other health behaviour interventions when these have been anticipated or requested by customers or health service users. As expectations of pharmacists as prescribers and health care providers rise, so too may their effectiveness as *ad hoc* health promoters.

**Box 7. Community inclusion in stores and health halls**

Successful retailers respect and seek to enhance the status and well-being of all their customers. In improving their services for those who choose to use them, companies such as Boots can serve all sections of the community. In Scotland and other parts of the UK Boots is pioneering a new ‘health hall’ concept. This is aimed at helping customers live better with long term conditions where necessary, and to take a pro-active approach to maintaining good health and vitality whenever possible. Staff in health consultant roles help customers find the best ways to meet their particular personal and family needs. Each health hall will also have private consultation facilities.

It is sometimes argued that poorer people cannot afford to eat healthily, or adopt other healthy habits. In certain respects such
concerns are clearly valid. (For instance, children with no access to safe and pleasant play areas are unable to exercise the same choices as those living in better environments.) Yet over-simplified explanations of the social status related factors underpinning inequalities in health can be misleading. For example, not all healthy eating choices are more costly or less convenient than the unhealthy alternatives.

In inclusive retailing and pharmaceutical care environments life style aspirations are shared, and consumers living in a wide range of situations enjoy common access to advice and support. Organisations ranging from community pharmacies to supermarkets can – with informed planning – serve to extend consumer choice, while at the same time contributing to social integration and reducing experienced social inequalities.

ENABLING PEOPLE TO ENJOY BETTER HEALTH

In the immediate future reducing further rates of tobacco smoking remains an obvious public health priority. Elimination of the smoking habit is an ideal goal. But in practical terms reducing levels of smoking in adults throughout the population to the low level today observed in the most educated and affluent social groups would be a reasonable goal for all stakeholders in better health to work towards.

Many other important public health improvement opportunities exist. For instance, further lowering hypertension rates in the population, through both lifestyle changes and a more extensive use of available medicines, could accelerate stroke and allied cardiovascular disease rate falls. The data shown in Figure 3 suggest there are still significant opportunities for new types of intervention in this context. These could be of special value to groups such as people of African and Afro-Caribbean origin at high risk from raised blood pressure.

Related possibilities exist in fields such as the accurate identification and effective control of raised cholesterol levels, and the diagnosis of type 2 diabetes. The latter is a particular threat to the South Asian community in Britain, although raised rates of obesity and diabetes present a risk to all sections of society. One of the reasons why Americans in middle age are significantly less healthy than those in Britain is because diabetes prevalence is twice as high in America (Banks 2006). The social status and stress related factors underpinning such differences may be complicated, and not as yet fully understood. Nevertheless, in the UK pharmacists working in many settings are seeking to expand their role in the prevention of known diabetes risk factors, and to demonstrate the potential viability of new service models at both the individual care and population protection levels.

Other options for new service developments exist in the area of sexually transmitted diseases, such as chlamydial infection (see above). As Figure 4 shows, the diagnosed incidence of this condition has risen rapidly in young women in their late teens and early twenties since the start of the 1990s. Parallel trends have also been identified in men in the early 20s. The Department of Health has already commissioned a new service in this area in London (Box 8).

Access to care based on this model is currently being nationally extended on a local NHS and private funding basis. Here again, similar initiatives could in future be offered in other areas.

Box 8 Screening for chlamydial infections

Boots currently runs a chlamydia screening programme in 216 stores London, funded via a contract with the Department of Health. People aged from 16 to 24 years can visit a pharmacy and obtain a free chlamydia testing kit. Various modes of result delivery are offered. Uptake monitoring shows phone text use at 50 per cent, phone calls at 30 per cent and communication by letter at 20 per cent. Currently around 8 per cent of tests are positive. When this is the case the customer receives free treatment for themselves and their partner. To date 19, 000 test kits have been issued.

BARRIERS TO OVERCOME

Many other options for translating the vision of enhanced public health promotion contained in documents such as Choosing Health: Making Healthy Choices Easier and Choosing Health Through Pharmacy into reality exist. They range from the provision of family planning services and dietary advice through to extending mental health care support, and pharmacy based services for people with alcohol and illicit drug use related problems. There are also important opportunities to offer innovative, and convenient, care for people with long term conditions such as asthma and arthritis, and also for individuals with acute disorders requiring symptomatic or short term treatment, like tooth abscesses or respiratory infections.

The more community pharmacists offer such services the more they will relieve the workloads of other NHS service providers,
and also be able to make population level health improvement contributions. However, the extent of the barriers to be overcome during progress to these goals should not be under-estimated. Challenges include:

RIGIDITIES WITHIN PHARMACY ITSELF
It is understandable that new ways of working and new approaches to business may appear threatening to people who have well established practices. Managers and professionals at all levels of community and hospital pharmacy need to work together to obviate unnecessary fears, and communicate awareness of their extending abilities to other stakeholders.

LOW PUBLIC AND POLITICAL EXPECTATIONS
Unduly low public expectations can inhibit change, in public health as well as in pharmaceutical care and other service contexts. It is therefore important that public views on health and health care are clearly and carefully understood. When they are inadequately informed targeted efforts can be made to correct misperceptions. When in fact public opinion is more enlightened than might be assumed, robust understandings of the reality of community preferences could permit progress towards improved public health to be achieved more rapidly than would otherwise be the case. The acceptance of smoking bans in public places provides an illustration relevant to this point.

The extent to which pharmacy based practitioners will in future be able to contribute to health promotion and illness treatment will depend to a significant degree on the beliefs of the public, and the extent to which other health professionals are confident of their abilities and expertise.

RELATIONSHIPS WITH GENERAL MEDICAL PRACTICE, AND NHS RESOURCES
In the UK the development of community pharmacy’s public health and allied role will depend in part on effective collaboration with general practitioners, and on the financial support of PCTs and other commissioning bodies. Promoting closer working between pharmacists, GPs and other primary care professionals should be seen as an important priority that can be pursued in a variety ways, including new forms of premises sharing (Box 9).

Corporate and other service provider stakeholders in better public health ought, on appropriate occasions, to be prepared to act in the public’s interests without new financial incentives being introduced. But in the long term failures to invest locally in enhanced pharmacy services will result in health gain opportunities being lost. Similarly, if the financial arrangements underpinning pharmacy and general medical service provision lack incentives for more constructive collaboration, the emergence of new patterns of inter-professional partnership may be blocked.

CARE RECORD SHARING
The introduction of universally available electronic care records should in future provide an important bridge between the provision of personal medical care and that of customer and community oriented services in pharmaceutical care settings. Despite perhaps inevitable problems, the NHS is making progress towards establishing such a system in a world-leading manner. But there is a danger that professionals working in community pharmacies may not gain adequate access to the care record system. This is said to be because of concerns about information security, coupled with what sometimes seem to be ill-informed beliefs that independently sited community pharmacies will not in future have a useful role to play in health improvement and health care delivery.

At worst, the technical dynamics of attempts to modernise NHS ICT based systems may serve to undermine government health policies aimed at increasing the flexibility and plurality of publicly funded and other health care delivery. Service user inability to permit the service providers of their choice to see or contribute adequately to their records would inhibit both choice and competition. Hopefully policy makers will understand the gravity of this risk, and take timely action to obviate it.

MODERNISING ATTITUDES TOWARDS PHARMACEUTICALS AS PUBLIC HEALTH PROMOTERS
In the past medicines have been more or less universally regarded as instruments of personal medical care, while vaccines have been seen – because of their ability to prevent rather than cure disease at a ‘herd’ (population) level – as agents of public health improvement. But this divide is becoming outdated. It will be increasingly redundant as more medicines with protective as opposed to curative properties are introduced. Failures to perceive this could impede the development of innovative approaches to the safe supply of pharmaceutical and pharmaceutically derived products with health promoting effects (comparable to, say, the elements of a Mediterranean diet) as consumer selected goods, rather than as professionally ‘owned’ treatments for individuals labelled as being ill or ‘abnormal’.

Box 9. Realising the promise of premises sharing
In the later half of 2006 a Boots store in Poole will be providing convenient access to free-of-charge NHS medical and allied services to the public. In conjunction with the local PCT, rooms will be available for walk in services such as out of hours GP care and also nurse prescriber facilities. It is hoped that the first phase of the project will include diagnostic services provision, orthopaedic care, sexual health screening, podiatry, smoking cessation, child health services and immunisation supply. If this is successful a second phase could include extended out of hours service provision and the establishment of a chronic condition management unit.

CONCLUSION
When Queen Victoria was alive, public health interventions were primarily aimed at goals such as improving sanitation and water supplies, and stopping grossly harmful practices like food adulteration with toxic substances. They were in essence based, even in an age of economic laissez-faire, on the belief that protecting the public from major environmental hazards is such a priority that governments and their agents have a duty to intervene as necessary to curtail individual freedoms and regulate commercial practices.

In the first half of the twentieth century the battle against threats such infectious disease was in the UK continued by interventions like those aimed at supporting mothers and improving childcare. It was at the end of this historical phase that the NHS was created, in part to ensure universal access to curative medicines such as antibiotics. Subsequently, in Britain’s second Elizabethan era, ‘public health’ has been more focused on problems associated with increasing wealth. These have included a high consumption of tobacco and usually high quality (but too often fatty and/or salty) foods, coupled with reduced physical activity levels. Hence the attention of individuals and organisations seeking to improve the public’s health has shifted towards providing treatment provisions on the one hand, and changing personal lifestyles and modifying the impacts of relative as opposed to absolute inequalities on the other (Wilkinson 2006).

The challenges engendered as a result of this new focus are demanding new types of state, corporate and individual response. These involve balancing due respect for individual and market freedoms with the need for appropriate public leadership, aimed
at ensuring that existing health gains are preserved and, when and where possible, new ones are attained. The strategic approach required can be described as seeking effective prevention and early treatment whenever possible and publicly acceptable, combined with later stage disease treatment or palliation whenever necessary.

Seen from this perspective, debates about whether or not modern Britain needs a health promoting service as opposed to an ‘old fashioned’ sickness treatment service are arguably outdated. Rather, a more integrated approach to primary and secondary illness prevention and treatment needs to be developed, which addresses risk reduction and early diagnosis but does not lose sight of the legitimate needs of people with established disease. For such a delivery system to work well voluntary commitment will need to be combined with appropriate regulatory intervention.

Individuals, charities, companies and the state should work together to identify common goals, and use their combined resources to achieve them.

Pharmaceutical service providers are important stakeholders in better public health. As professional and business enterprises they have a clear interest in helping to implement approaches based on a comprehensive understanding of the determinates of health, from the biomedical to the psychological and the social. Pharmacy’s own survival in the twenty first century will depend on building new capacities to deliver services relevant to changing public health needs. More importantly from a public health perspective, success in achieving this will save not only individual lives. It will also help build a stronger and collectively more prosperous Britain, that can continue to become a progressively better place for all its citizens to live and work in.

REFERENCES


© This paper is published by the School of Pharmacy, University of London, July 2006, in partnership with Boots. It was written by Dr Jenny Newbould and Professor David Taylor. They thank Peter Gibson, Tracey Thornley and Natasha Campling for their help and advice during its preparation.