Public health research in the UK: in response to McCarthy et al.

Sirs,

We read with interest ‘Public health research in the UK: a report with a European perspective’ by McCarthy et al. published in June 2014. We are conscious that, since the study was undertaken in 2010, the public health research landscape in the UK has developed considerably. A number of programmes were set up in 2009 which now have strong portfolios of public health research. All parts of the National Institute for Health Research (NIHR) support research in public health to provide significant opportunities for researchers and evidence for practitioners and decision-makers (www.nihr.ac.uk/publichealth). Public health research is particularly funded by the NIHR through the Public Health Research programme, focusing on interventions outside of health care, and the School for Public Health Research. The Health Technology Assessment programme evaluates NHS interventions, while Programme Grants for Applied Research supports NHS research delivering findings with early practical application. While the remit varies by programme, covering England or the UK, the application of research findings could extend across Europe. Research for public health is also supported by other Department of Health funding schemes, such as the Policy Research Programme and other funding bodies; for example, a recent option for early-phase intervention research is the Medical Research Council’s Public Health Intervention Development scheme. NIHR outputs are captured in a suite of five peer-reviewed, open access journals for anyone to use (http://www.journalslibrary.nihr.ac.uk/). We welcome contributions to identify research needs, deliver research to answer key questions and bring new evidence back into practice to strengthen public health research in the UK for the future.

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Mobile health: is it really a great advance?

The emergence of affordable mobile phones has allowed many developing countries that were far from the development of infrastructure such as fixed-line telephone and postal services to effectively leap frog these steps in development. This has been greeted with great excitement by much of the public health community, many of whom view mobile phone services as a panacea for suboptimal utilization of health services.

At first glance, the excitement is justified. In various parts of the world, clinical trials have demonstrated improved attendance at clinic appointments, improved compliance with treatment regimens, and improved communication with remote healthcare workers.1

However, our practical experience in Timor-Leste advises caution.

Timor-Leste is a young country, having regained its independence with the withdrawal of Indonesia after a 1999 referendum. Prior to the departure of Indonesia, development was poor, and this was compounded by the fact that as the occupying forces left 70% of buildings destroyed, along with the telephone system.2 Timor-Leste is now building infrastructure at a rapid rate, largely thanks to oil and gas revenues. However, there is yet to be a comprehensive fixed-line telephone system or postal service.

In recent years, mobile phone up-take in Timor-Leste has been enthusiastic with the arrival of two carriers in addition to the previous monopoly market leader. However, there is a significant variation in this take up, largely related to relatively high prices by global comparisons. Latest estimates are that 90% of households in Dili have a mobile phone, and only 25% in the enclave of Oecussi. 16% of the population does not have any access to media (radio, television, newspapers, internet or mobile phone).3 The purchase of mobile phone SIM cards in Timor-Leste is simple, with SIM cards freely available from vendors on the street and many shops. At times mobile phone providers provide incentives to purchase a new SIM by offering a higher value of credit than the purchase price.

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

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

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

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References

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Public health coming home

Dear Sir,

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

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

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

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

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