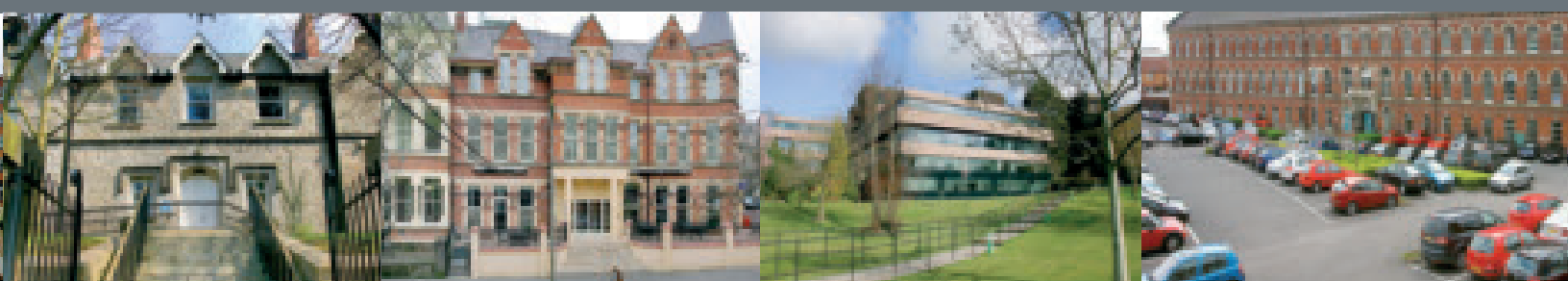
Four decades of public health

Northern Ireland's health boards
1973–2009



The Ormeau Baths building, headquarters of the Health Promotion Agency, 1990-2009.

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Preface

The history of public health in Northern Ireland project was funded by the Public Health Trust. The initiative was commissioned to mark the dissolution of Northern Ireland's four health boards in 2009. It was conducted at the University of Ulster at the Centre for the History of Medicine in Ireland.

The project collected an oral history from public health professionals from four decades to create a repository of experiences in public health. This oral record and documentary sources form the basis for a brief, reader-friendly narrative history of public health beginning with the formation of the boards in 1973 and ending with their dissolution in 2009. The written history is based on a variety of sources. It incorporates oral testimony and also uses the boards' annual reports, Chief Medical Officers' reports, Director of Public Health reports, regional strategies and programme-specific literature.

Beginning in 2008, interviews were conducted with 37 public health professionals, representative of a broad spectrum of disciplines including medicine, environmental health, nursing and health promotion. People were invited to give interviews and the initial list was expanded as each interviewee suggested someone who might be willing to contribute. All interviews were based on the same set of questions. However, these were not rigidly applied and instead became themes addressed in the course of interviews. It was found that interviewees often talked beyond the remit of the questions and the process and the interviews were all the better for it. Three questions were asked of everyone. These were: 'Has devolution made your job harder or easier?' 'Is it time for the dissolution of the boards?' 'What was the most significant development in public health over the period?'

This study examines the history of public health in Northern Ireland from 1973 to 2009. It takes a broad chronological approach, which examines the developments in public health for each decade beginning with the formation of Northern Ireland's four health boards in 1973, through the subsequent decades, and ending with devolution and the dissolution of the boards in 2009.

Acknowledgements

I would like to take this opportunity to gratefully acknowledge all those who have assisted in the completion of this history, especially the Public Health Trust for commissioning the project. I would like to thank those who have commented and offered suggestions on the manuscript: David Stewart, Janet Little, Paul Darragh and Mary Black. I also owe a debt of gratitude to all those who kindly took part in the interviewing process.

I would like to thank Professor Greta Jones for her invaluable guidance and endless patience. And to my colleagues at the Centre for the History of Medicine in Ireland at the University of Ulster, Susan Kelly, Leanne McCormick and Andrew Sneddon. Thanks also to the staff at Queen's University Medical Library, the University of Ulster Library and Maureen Hamilton in the Reference Centre, Eastern Health and Social Services Board. Thank you to Kate Hasson for transcribing and to Fiona McGarry at the Irish News. Thanks are also due to my wife, Clare, for all her help and support.

John Privilege

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Introduction

For much of its existence, Northern Ireland has been unique. Between 1922 and 1974 it was the only autonomous region of the United Kingdom, having its own governing executive and constituent assembly. Between 1974 and 1998 Northern Ireland was governed from Westminster through the medium of a secretariat which included a Secretary of State and a number of junior ministers responsible for the administration of services. Devolution once again returned following the signing of the Good Friday Agreement in 1998.

Northern Ireland has also been unique in that from 1969 and throughout much of the period considered here it has been wracked by political and sectarian violence. The Troubles undoubtedly affected the health of the population in ways other than death and injury. One of the interviewees, for example, talked about the post-traumatic stress of an entire community. The impact of the Troubles on healthcare and health professionals has been considered elsewhere.[1] It must be said, however, that although health was mostly a neutral topic amid so much that was contested, the Troubles placed considerable strain on those charged with delivering the service. Aside from the risk to life and limb, there was also severe disruption to travel because of violence and civil unrest. Moreover, professionals faced the challenge of how to remain outside the political and sectarian tensions dividing society.

The public health system in Northern Ireland grew out of developments in the nineteenth century and broadly followed the British model. In certain respects it lagged behind Britain, and in others, like the Northern Ireland Tuberculosis Authority, it surpassed them. The National Health Services Act (NI) of 1948 made provision for a comprehensive health service in Northern Ireland along the same lines as that being established in England, Scotland and Wales. However, because of Northern Ireland's local administration, provision had to be made for the subtle differences between the system here and the rest of the United Kingdom. For example, in Britain the Minister for Health and the Secretary of State were empowered to provide services under their own authority. In Northern Ireland, both the Ministry of Health and local government were not empowered to provide services but needed to procure them from a number of statutory bodies.[2]

Thus, the administration of healthcare fell to a system of eight health authorities. Two urban authorities were augmented by six county health bodies. The administration of health services was headed by a County Medical Officer whose management team included an administrative officer, a County Dental Officer, a County Public Health Inspector and a Director of Nursing. These positions were replicated at a district level. County Armagh, for example, had three district administrations, Northern, Eastern and Western. Each area had a team including a District Medical Officer and a District Public Health Inspector. Hospitals were administered by the Northern Ireland Hospitals Authority, which was assisted by 28 management committees. General practitioners, dentists, pharmacists and other health professionals came under the authority of the General Health Services Board.

In 1973 this system of administration was dissolved. Health and social services would be delivered by four new Health Boards. The county health and administrative structures had been in operation for many years but it had 'never been claimed to be the best way of running a health service'. Indeed, in *A guide to the new structures* published in 1972 it was argued that that the system of healthcare in Northern Ireland had only come about as a result of historical development and negotiation and compromise at its birth.[3] On the eve of restructuring, the population of Northern Ireland was 1,536,065, more than half of which was under the age of 30.[4] The birth rate was low in comparison to the early 1960s and would decline for most of the decade. Life expectancy at birth for men was 68 years and 74 years for women.[5] The average weekly wage across all industries was £31.59 for men and £14.72 for women. Unemployment was at 9% for men and 5% for women but was increasing sharply.[6]

01

The new health boards, 1973–74

What now serves as a hotel in Belfast's university area was once the offices of the former EHSSB before it moved to new accommodation in the city centre in 1987.

The year of 1973 saw the radical restructuring of public administration in Northern Ireland. The county health system was dissolved and four new health boards were created to administer health and social services. Environmental health moved to the newly reorganised district councils.

Seismic changes

On 1 October 1973 health and social services in Northern Ireland underwent the most radical series of reforms since the foundation of the NHS in 1948. The administration of not only health but local government was transformed as were almost all of the agencies involved. Northern Ireland's 66 rural, urban and district councils became 26. Many of the responsibilities previously undertaken by local councils – housing, roads, water and sewerage – became the purview of new statutory bodies like the Northern Ireland Housing Executive and the Department of the Environment.

The final report by Dr Seamus Maguire, Armagh's last County Medical Officer, offers a useful snapshot of the shape of public health on the eve of the changes. The total population of the county area was estimated in 1972 to be 136,000. There were 2,876 live births that year and the largest single recorded cause of death for adults was ischaemic heart disease. There were 779 cases of measles notified, 41 cases of scarlet fever and 29 cases of tuberculosis.[7] The health authority had a concerted and well organised programme of immunisation against measles, rubella, diphtheria, whooping cough and polio.

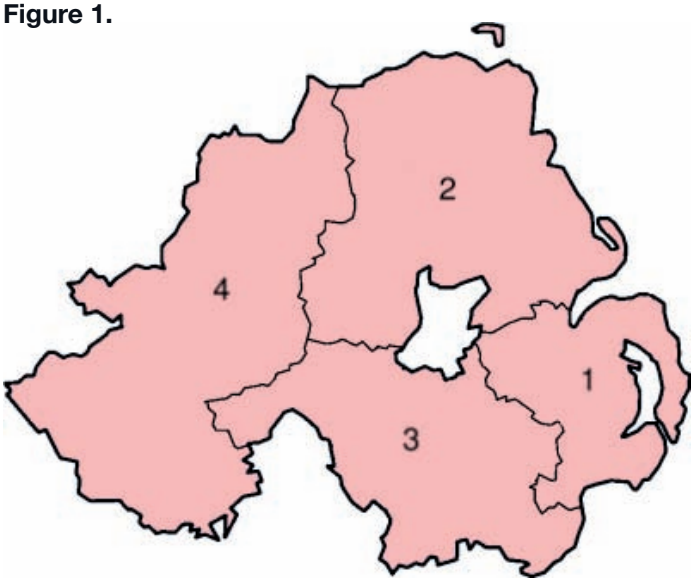
Dr Maguire also noted in his report that there had been 32 deaths that year from road traffic accidents. This was distressingly high and the number of such incidents was increasing.[8] There were 76,744 health visits carried out over the course of the year of which 55,294 were to children in the 0–5 month age group. In total 20,188 children attended child welfare clinics and family planning advice was dispensed by a health visitor in Daisy Hill Hospital.[9]

Alongside the medical professionals under the county health system public health inspectors monitored housing conditions, though the creation of the Northern Ireland Housing Executive had created some confusion.[10] There were 754 samples of public water taken, 138 of which were unsatisfactory. Health inspectors examined swimming baths, sewerage and sewage disposal as well as carrying out food hygiene inspections of abattoirs and creameries. Air quality was also monitored along with noise pollution. Health education, especially on hygiene in food production and preparation was also carried out under the auspices of the County Public Health Inspector.

Health restructuring

The radical restructuring of local administration in Northern Ireland was first suggested in a parliamentary Green Paper published in 1969. A review body reported in June 1970 and in 1972 the shape of the new structure was outlined in a report by management consultants Booz, Allen and Hamilton. The 'black book' provided a detailed account of the new arrangements including management structures and job roles. In his introduction to the report the Permanent Secretary, Norman Dugdale, recognised that despite almost four years of inquiry and reports the current timetable for implementation had afforded little opportunity for consultation. There was no alternative, however, as the changes in Northern Ireland provided a template and something of a pilot for similar changes in England and Wales. The date for implementation had therefore been set for 1 April 1973.[11]

Figure 1.



The four health boards:
1. Eastern Board; 2. Northern Board;
3. Southern Board; 4. Western Board.

It was certainly the case that senior health staff had had little time to prepare for restructuring. Dr James McKenna, then working for the Northern Ireland Hospitals Authority, recalled that he and his colleagues had 'only a number of preparatory teach- ins… two one-week things in Newcastle where people sort of prepared their thoughts'.[12] The rationale behind the restructuring was declared as being 'the improvement of the provision of health and social services to the community in Northern Ireland through establishing an integrated approach to the delivery of hospital and specialist services, local authority health and welfare services'.[13] The changes, it was hoped, would provide a more rational and comprehensive structure in which to decide priorities, develop policies and 'work together toward a common goal of meeting the total needs of individuals, families and communities for health social services'.[14]

The Northern Ireland Hospitals Authority, the General Health Services Board and all existing local and county health committees and authorities would cease to exist under the new structure. Instead, health in Northern Ireland would be administered by four new health and social services boards. The boundaries of the new entities would be based around the newly drawn council districts (Figure 1). Each would have a minimum population of 200,000 and contain a medium-sized hospital, divisional offices of existing health and welfare authorities and a number of health centres, residential homes, hostels and day centres.[15] The Northern Board would encompass the councils of Moyle, Antrim, Ballymoney, Ballymena, Carrickfergus, Coleraine, Larne, Cookstown and Newtownabbey. The Southern Board area included Craigavon, Armagh, Banbridge, Dungannon and Newry and Mourne. The Western Board area was made up of Londonderry, Fermanagh, Limavady, Omagh and Strabane.

The boundaries of the Eastern Board were problematic. The inclusion of North Down, Ards, Down and Lisburn was straightforward enough. Difficulties arose over where to put the areas of Belfast and Castlereagh. It was thought, as outlined by Booz, Allen and Hamilton, that to include the large population of the greater Belfast area might imbalance the board structure. The role of the four Belfast area hospitals was both local and province-wide. Further problems, such as the lack of defined catchment areas for GP surgeries, meant that consideration was given to establishing a separate board for Belfast and Castlereagh.[16] In the end, both were included in the Eastern Board area which had a population of 696,000. The board employed 17,632 staff and was allocated a provisional budget of £40 million. The Northern Board employed 5, 368 staff serving a population of 245,000 with a budget of just under £10 million. The population of the Southern Board was 258,000 served by 3,627 staff with a provisional budget allocated at £10 million. The Western Board had the smallest population with 229,000 people served by 4, 272 staff. The budget here was set at just under £11.5 million.[17]

The restructuring occurred at an inauspicious time. Relations between trade unions and Edward Heath's Conservative Government had been rapidly deteriorating and the United Kingdom was experiencing a period of increasingly bitter industrial relations. High fuel prices caused by an oil embargo contributed to a growing energy crisis which saw frequent power cuts. Inflation was high, unemployment was rising and nationwide financial problems threatened the funding of the health service reforms.[18] In Northern Ireland, the changes proceeded amidst a climate of violence and civil unrest. There was also general uncertainty over the political future of the Northern Ireland Government.

Even given such universal concerns, the lack of comment on these radical changes in local administration in the press is surprising. The Derry Journal, however, was prepared to give the new arrangements the benefit of the doubt. The changes, an editorial argued on 2 October 1973, held out the prospect of greater economy and accountability. 'What misgivings there are', the journal went on, 'concern the concentration of so much of the local government powers in the regional boards in part nominated by central government and only in part by the district councils'.[19]

The civil unrest that was convulsing Northern Ireland actually had minimal impact on the implementation of the board scheme. Public health professionals carried out their duties despite severe travel disruption caused by street violence and bombings. And, indeed, through the fuel shortages and road blocks during the Ulster Workers' Council strike in 1974.[20] In his final report, Seamus Maguire commended staff to the County Health Committee. 'Despite the civil unrest', he said, 'it is a pleasure to record the efficient manner in which staff have reacted to the increasing work [from the restructuring] throughout the year'.[21] For health service staff, perhaps more disruption was caused by the reforms themselves than by events in the wider community. The uncertainty over structures, over the future of jobs and the nature of the changes themselves caused many health workers to retire or leave the service altogether. 'It is an upheaval', James McKenna recalled, 'for anybody to be told that you're going to be out of a job on 1 of October next. There will be jobs but you have to apply for them'.[22] The result was that the reforms proceeded amid a sometimes chronic shortage of staff. This was one of the reasons why implementation was delayed from 1 April to 1 October 1973.[23]

The management structure of the new boards was based on a system of teams and committees. Overall, the Ministry of Health and Social Services decided priorities and standards as well as financing the service. It would delegate to the boards the framing and delivery of services within their respective areas. The health boards were administered by an area executive team which consisted of a Chief Administrative Medical Officer (CAMO), a Chief Administrative Nursing Officer, a Director of Social Services and a Chief Administrative Officer. The Area Medical Advisory Committee was represented by a hospital consultant and a GP as well as the Area Pharmaceutical Officer. The team was expected to operate on a collegiate basis. At district level the structure included district administrative medical officers (DAMOs) and district nursing officers and so on. In contrast to subsequent developments in England social services remained part of an integrated health structure. Environmental health, however, was split off and placed within the new local councils.

It was hoped that the emphasis on team management would encourage a collective responsibility for the provision of services. As the G*uide to the new structure* explained 'working as a team does not come naturally to everyone and new methods may need to be learnt. Given time, the team approach should pay dividends in better and more complete decision-making'.[24] Despite the sweeping nature of the changes, the architects of the restructuring believed that only senior staff would feel the brunt of any impact. The nurse on the ward or the hospital porter or the home-help would notice little change having a new employer. Patients and the public, too, would also see no sudden change 'although in time the new structure will provide opportunities for more effective working-together by professionals and a better all-round service for the community'.[25]

It was the case, however, that there was a general difficulty in filling the gaps left by staff leaving before restructuring came into effect. The team approach was also problematic at the outset. James McKenna, who was appointed CAMO in the Northern Board, proceeded without any assistant CAMOs and with DAMO posts unfilled. Moreover, relationships in the new team structures had to be forged from scratch as often individuals were working together for the first time.[26]

Across the four boards, reorganisation presented similar problems. The difficulties in bedding in the new management structure were increased by the staff shortages. The situation in the Eastern Board was compounded by the sudden death of its first CAMO, John Andress, on 6 June 1974. In his first report, his successor, James Taggart, noted that 'the delay in the promulgation of a satisfactory career structure for clinical medical officers has resulted in considerable frustration'.[27] In the Southern Board, Seamus Maguire reported that the stresses of reorganisation had been worsened by the current economic crisis, which had severe ramifications for funding. Costs were being controlled by limiting recruitment.[28] In a frank assessment of some of the uncertainties in the Western Board, the CAMO there, N. E. Gordon said that reorganisation had proved a traumatic experience. 'All staff', he wrote, 'found that their posts no longer existed after 30 September 1973 and found themselves thrust into the position of being either transferred or applying for a post in the re-organised structure'.[29] Northern Board CAMO James McKenna expressed similar sentiments. 'Before the end of the year', his report stated, 'staff personnel problems became sources of irritation. It was very hard to justify the anomalies that existed. The same grade of staff doing the same type of work under the same conditions now had different conditions of work from the same employer'.[30] The anomalies had come about because the old health authorities that now constituted the board had operated autonomously with little synchronising of working practices.

For public health and community medicine, the new structures were a radical departure. In future, the CAMO took on responsibilities for the whole range of hospital management in addition to the traditional public health remit of the Medical Officers of Health based in the local community. Described as the most radical part of the reforms, each board would undertake programmes of care in its area. These were to be designed at area level and administered at district level. As well as commissioning teams for infrastructure, the programmes included group preventative care which, as its name suggested, focused on care that was not individual in character but directed towards a group. This encompassed screening, immunisation and health education. There was also a health and social care programme which covered mental health, care of the elderly, the homeless and unmarried mothers. It was hoped that there might also be liaison programmes and committees with local education and housing agencies.[31]

Results

An idea of how well the new structure had bedded in was given by a series of studies undertaken by the Department of Business Studies at Queen's University. The researchers conducted interviews in 1974 and again in 1975–6 with senior health officers in several board districts. These included Limavady, Londonderry, Strabane and South Belfast. The results showed that the optimism of those who framed the new structure was not quite justified. Officers felt that financial constraints arising from the deteriorating economy was hampering their performance. Many stated that their healthcare objectives had been met despite a lack of money. It was not only financial juggling that preoccupied senior managers. Staff shortages persisted into 1976.[32]

Responses were not all negative, however. There was high job satisfaction expressed regarding the participation in planning of services, influencing the development of training, preventative services and increased contact with other professionals. There was general agreement about the objectives of programmes of care – the identification of needs, assessment of resources and the setting of priorities to meet those needs.[33] In spite of this optimism, at the time of printing, the Queen's report noted that there were no actual programmes of care in operation in any of the areas surveyed, though working groups had been established.

Overall, half of the officers questioned felt that patients had benefited or would benefit from the reorganisation in the future. A quarter felt there was no evidence of any benefit yet and a quarter saw no benefit at all. Those who felt that patients had benefited believed integration would achieve a more cohesive and better coordinated service. Patients would also benefit from a more even distribution of finances across Northern Ireland. Those who saw little positive in the new structure believed the service had become more remote and impersonal from the patient. The financial injection that the health service in Northern Ireland received during restructuring was considered to be more beneficial to the patients than the restructuring itself.[34]

It was against this backdrop of upheaval and uncertainty that public health had to evolve and adapt. It was not only the structures of the health service that had changed utterly. The relationship between community medicine and environmental health had also changed as the latter diverged from the health umbrella. Public health doctors nationally formed the discipline called community medicine. The medical staff were transferred to the boards under CAMOs. Environmental health staff remained with the local authority as did the legal enforcement arrangements. As we shall see, close working relationships continued between public health doctors and environmental health staff to ensure the continued efficient running of the health protection services.

Another change occurred in 1973 which was every bit as 'seismic' as the creation of the four health boards. At the same time as re-organisation, the Faculty of Community Medicine was created through the cooperation of the Royal College of Physicians of London, Edinburgh and Glasgow. A pattern was established whereby trainees in community medicine were sent to Edinburgh or the London School of Hygiene and Tropical Medicine for a year to study for a master's degree. James McKenna viewed the faculty as of vital importance to the development of public health. Of equal importance, however, was the calibre of the trainees. 'We got good people', he recalls, 'and that was the most significant thing – to get the right people'.[35]

02

New departures, 1973–79

The former headquarters of SHSSB, Tower Hill in Armagh, was once the city's workhouse and then a hospital. Today it provides offices for the regional Health and Social Care Board established in 2009.

Community medicine and environmental health adapted to the new structures in Northern Ireland to deliver the public health service. The health boards initiated health education programmes and new approaches on public health emerged in the wider world.

The role of community medicine

Assessing the future of community and preventative medicine in 1971, Britain's Chief Medical Officer and one of the architects behind the development of the NHS, Sir George Godber, dismissed the 'Jeremiahs' who declared that the role for public health was diminishing in the decade ahead.[36] 'There has never been a time', he said, 'when there was so great an opportunity for the specialist in community medicine to promote the health of the people through better organised medical care'.[37] He spoke of the importance of immunisation programmes. Protecting against measles had prevented between 500,000 and one million cases and over one hundred deaths. Virtually all of the 300,000 cases the previous year could have been prevented. On the subject of prevention there was, he said, persuasive though not conclusive evidence that screening for cervical cancer could lead to a reduction in cases.

The principal cause of death among adults in Britain was diseases of lifestyle. The challenge for community medicine was to identify the factors contributing to these afflictions – smoking, obesity and inactivity. 'The relationships of early death to these factors', Godber said, 'must surely be clarified in the 1970s and real chances for prevention may emerge'. It was important, therefore, that opportunities for intervention should be taken. Godber argued that education on health and healthcare was vital. People might be persuaded to do things for themselves and their own long-term benefit or to refrain from harmful lifestyles.[38] Above all, Godber concluded that community medicine and preventative medicine needed to cooperate with other professionals and agencies to successfully fulfil its function.

But in the aftermath of re-organisation, as Jones and Pickstone point out, the role for community medicine was poorly defined. Community physicians were expected to fulfil multiple roles – specialist, manager and adviser. Community medicine, they argued, was more an occupational category than a novel public health approach.[39] Certainly, reorganisation had made the kind of relationships envisaged by Godber difficult. Not only was there a whole new management structure but environmental health and community medicine were now in separate bodies. For community physicians the new boards were a bewildering affair. Fionnulla Watters (then Fleming) remembers how, as Assistant Chief Medical Officer (ACAMO) in the Southern Board, she was coping with responsibilities that were entirely new, like hospital administration. New relationships had to be forged and trust built up across the board area.

At times community physicians had to feel their way 'to begin to make an impact on where we needed to be'.[40] John Watson who was appointed ACAMO at the Eastern Board in 1978 recalls that the emphasis was more on hospital administration. 'The other aspects of public health', he said, 'such as preventative and infectious diseases did not feature probably as highly as they do now'.[41]

Environmental health

For environmental health, restructuring offered new opportunities. Morris McAllister, then a public health inspector, recalled it was generally felt that they were now 'masters of their own fate' following re-organisation.[42] Even so, the challenges facing environmental health were immense. Some idea of the scale of the responsibilities it faced was provided by the Association of Public Health Inspectors' (APHI) report for 1972. Overseeing and monitoring of food production was a huge undertaking with 139,222 cattle slaughtered for human consumption along with 220,416 sheep and pigs and 383,000 poultry; 295 tonnes of unsound meat was seized or surrendered. There were 4,253 inspections of property carried out as well as 1,792 formal and 1,768 informal samples of food taken for chemical analysis. Overall, public health inspectors carried out 14,494 visits in 1972.[43]

The APHI had argued that the 'expertise of public health inspectors in dealing with unfit and substandard houses and associated environmental health problems must not be overlooked' but by the end of 1973 the uncertainties regarding the position of public health inspectors amid the new structures had largely been resolved.[44] In respect of housing, public health inspectors remained the principal enforcement officers on housing conditions. In 1974, inspectors carried out 25,000 surveys on behalf of the Housing Executive.[45] Conditions proved particularly problematic across Northern Ireland. Brian Hanna who was a public health inspector with the Belfast City Council, recalls that almost a quarter of all houses in Belfast alone were unfit for human habitation with high rates of poor quality homes in deprived wards like the Lower Falls, Shankill and parts of East Belfast.[46]

Close links and working relationships between the various professionals engaged in public health were maintained. This was more to do with the efforts of individuals, as no formal structure for cooperation existed other than the requirement for CAMOs to act as medical advisers to local councils. Morris McAllister recalls that the strong connections between professionals were possible because most of the personnel remained in post after re-organisation. This, however, became more difficult as the decade progressed and personnel changed.[47] The necessity for this close working relationship was emphasised in James Taggart's first report at the Eastern Board. Cooperation was essential between professionals on infectious diseases, pollution and port health. 'The establishment of this close personal relationship is especially important', he wrote, 'in the handling of medical confidential information such as notification of disease, control of carriers and the disinfestation of persons'.[48] Two examples of the success of this relationship occurred in 1975. An outbreak of typhoid fever was controlled quickly and the source found to be an employee in a Belfast retail outlet. There was also a serious outbreak of food poisoning at an unnamed institution in which 'the speed and effectiveness of containment was due to the close cooperation between medical officers, health inspectors and laboratory services'.[49]

Health visiting and health education

Although beset by difficulties, the bleak assessment of public health in England presented by Jones and Pickstone in the 1970s is not wholly applicable to Northern Ireland. Health visits by community nurses, for example, continued almost uninterrupted by the structural changes. The importance of these visits was acknowledged by Seamus Maguire in his annual report for 1976. Health visitors were often the first, and sometimes the only, point of contact between the health service and families.[50] Such visits provided an opportunity for assessing not just individuals but families and communities.

They did not only deal with child and maternal health but housing conditions, drug and alcohol abuse.[51] Health visiting was exercised across the four boards. In the Southern Board there were a total of 125,507 home visits in 1974. This increased to 150,769 the following year.[52] There were 110,426 visits in the Western Board in 1977, an increase of 10% on the previous year.[53]

One of the major functions carried out by health visitors in this period was health education. Even as community physicians were distracted to a large extent by the aftermath of reorganisation and its associated problems, there was a general commitment to engagement with the wider community on health issues. This was reflected in the prominence given over to what was termed 'diseases of modern civilisation'. These were identified as cardiovascular disease, mental illness, drug dependence and respiratory difficulties caused by poor air quality. Through educating on health it was hoped 'to encourage the behaviour necessary to maintain normal good health, to impart information about illness and disease…to promote judicious use of the Health Service and to supply help and rehabilitation to those undergoing illness'.[54]

By the mid 1970s three out of the four boards had appointed permanent health education officers who provided information, advice and guidance on a range of health issues from smoking cessation to family planning to board staff, voluntary groups and individuals. Year-on-year increases in the demand for this service meant movement to permanent premises, new staff and the provision of training. In 1975, the importance of health education for prevention and community medicine was outlined the Northern Board's annual report. 'The board has not been unaware of the need to stimulate the community to help itself and to give encouragement and assistance to voluntary organisations… to encourage greater awareness amongst board staff of the community dimension and its value in promoting not only a better service but a healthier society'.[55]

The need for intervention, for education regarding diseases of lifestyle was starkly illustrated in the meticulously gathered statistics published in the boards' annual reports. Year after year heart disease was cited as the most frequent cause of death among both men and women across Northern Ireland. In 1976 in the Northern Board, for example, there were 1,091 deaths attributed to heart disease. This was almost twice the number of deaths caused by all forms of cancer.[56] Alarmingly, the mortality rate climbed as the decade progressed. In 1979 the Southern Board reported that its coronary wards remained under severe pressure throughout the year due to overcrowding.[57] Small wonder, then, that health education concentrated on smoking cessation, obesity and exercise. These programmes complimented and incorporated government initiatives like 'Prevention and health: everybody's business' from 1976 and 'Look after yourself' from 1978.

Infectious disease and rationalisation

The 1970s saw a sustained effort on immunisation by community physicians and health workers. There were immunisation programmes against diphtheria, tetanus, measles, rubella, whooping cough, polio and smallpox. A typical year, 1975, saw the Eastern Board carry out 6,049 immunisations against diphtheria, 5,433 against whooping cough and 6,084 against polio.[58] The Southern Board carried out a total of 45,987 immunisations that year.[59] In the Western Board there were 9,051 immunisations against diphtheria and 9,008 against tetanus.[60]

Crucially, however, as well as monitoring the numbers of immunisations carried out, community physicians and health workers were concerned about the number of children who were not being immunised. In 1978, N. E. Gordon recorded that in the Western Board area some 29% of one year-olds were not immunised against diphtheria, 55% not immunised against whooping cough and 37% had not been given inoculation against polio.[61] The task of redressing this shortfall fell to health education workers and health visitors. In the Southern Board, for example, health workers and community physicians had to try and overcome widespread suspicion against the whooping cough vaccine.[62]

The gaps in immunisation uptake led to episodic, though regular, epidemics of measles as well as widespread occurrences of whooping cough. Throughout the decade infectious diseases proved a sustained threat for community and environmental health. In 1975 the Eastern Board, public health staff responded to 59 cases of dysentery, 538 cases of gastroenteritis, 330 cases of infectious hepatitis and a surprising total of 131 cases of pulmonary tuberculosis.[63] In the same year, the Southern Board dealt with 12 cases of non-paralytic polio, eight of them in Craigavon.[64] This resulted in a major mobilisation by health care staff with 41,978 booster doses of vaccine being administered. In 1977 two cases of paralytic polio were diagnosed in North and West Belfast and this gave rise to great anxiety within that community. Again a major response was mounted by Board and Community staff. Dr James Taggart then CAMO concluded that it was only this prompt intervention that prevented the onward spread of this disease.[65]

For community medicine the reorganisation meant a protracted period of rationalisation of hospital services. All four boards inherited a collection of small community hospitals, local maternity units and health centres from the amalgamation of the old health authorities. The boards conducted hospital planning exercises which had a major impact on the shape of future hospital services. The rationalisation process was time consuming and not without controversy. In the Western Board, for example, the Commissioning Group noted that 'there was a massive response representative of the majority of the community and this clearly indicated that our local hospitals occupied a unique place in the hearts and minds of the communities which they serve'.[66]

It appeared as if the Western Board experienced particular problems following the establishment of the new structures. On the subject of community initiatives the board declared, rather cryptically, in 1975 that its 'contribution to the field of community work is dependent to a considerable extent upon the future of this work in the province as a whole'.[67] By 1978, however, several programmes had been initiated. There were study groups on health centres, on smoking and on alcohol abuse.

A renewed commitment to community initiatives was evident in N. E. Gordon's assertion that 'there is much as yet un-mobilised or untapped potential for self-help in communities so that if ways can be found through encouragement, training and social action, the communities themselves might make a significant contribution, far greater than they appear on the surface, to the promotion of social welfare'.[68]

Alma Ata and the *Baird report*

It is fair to say that 1978 proved something of a watershed year for public health. At an international conference on primary healthcare held in September in Alma Ata in the old Soviet Union the World Health Organization redefined the parameters of and aspirations for public health. The conference declaration expressed the need for urgent action by governments and health workers to protect and promote the health of all the people of the world. It reaffirmed that health, defined as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, was a fundamental human right". Alma Ata identified the gross inequalities that existed in health not just between the developed and developing world but within borders as well.

Moreover, the declaration insisted that people should have the right and the duty to participate individually and collectively in the planning and implementation of healthcare. The participation of communities in this process and in their own health provision was also emphasised. The declaration called for the maximum of community and individual self-reliance and participation in the planning, organisation, operation and control of primary healthcare.[69] These ideas influence public health professionals in Northern Ireland who sought to implement the philosophy and the approaches from Alma Ata at a local level.

Alma Ata created a change of ethos for public health, where the emphasis was hencefourth laid on programmes to realise the idea of health as part of the totality of wellbeing. It also signals the involvement of local communities in determining their own health and their healthcare. One of the first initiatives in Northern Ireland in the wake of the Alma Ata conference involved infant mortality. In December 1978 an inquiry into maternal and child healthcare was established under Dr T. T. Baird. The rationale was simple. 'A greater proportion of children in Northern Ireland are dying before the age of one year than in Great Britain and most economically developed countries'.[70] The inquiry set out to examine the root causes behind the statistics and also to suggest changes in health and social policy to provide redress.

As well as having the highest infant mortality rate in the UK, Northern Ireland also had the slowest rate of decline. The report concluded that the rate of mortality was determined by social, economic and environmental factors in addition to medical factors. The highest mortality rates were among the lowest earning sections of the community. It pointed out that the disparity in wealth between sections of society in Northern Ireland had not changed significantly since 1911. Generally, living standards were much lower here than in England, Scotland and Wales. In 1977/8, for example, 44% of people had a gross weekly wage which was £20 less than the weekly average in Britain.[71] Environmental factors, too, were taken into consideration. Half of all infant deaths were due to infection which was directly attributed to poor housing conditions.[72] Whilst the report emphasised that change needed to be tackled through social policies that alleviated poverty in the community at large, it also stressed the importance of specific health related intervention. The suggestion was made, for example, that allowances might be raised for expectant mothers in 'at risk' groups. In the meantime, selective action could and should be undertaken in the community to improve provision for certain women during pregnancy, for needy families and for young children.[73] The report from the Baird inquiry typified the commitment in public health to the totality of wellbeing and to targeted interventions which became established by the end of the decade.

James McKenna has argued that there was a much greater commitment to community medicine and prevention in Northern Ireland than in England. If true, an important element in maintaining this ethos was the role played by the School of Social and Preventative Medicine at Queen's University which was headed by Professor John Pemberton. Staff were appointed, for the most part, jointly between the university and the Eastern Board. Medical students received teaching in epidemiology, the social determinants of health, health protection and the management of health resources.[74]

It has been argued that the creation of the four health boards and the wholesale organisational change in Northern Ireland and the structural changes in England after 1973 distracted public health officers. There is also some truth in the assertion by Jones and Pickstone that community medicine drifted closer to hospital medicine and health service administration. Public health efforts continued, however, on disease, hygiene, housing and health education with a high degree of cooperation which persisted despite the disruption of re-organisation. The Alma Ata conference provided renewed focus for community physicians and environmental health staff to health and wellbeing.

03

Years of change, 1980 – 90

The regeneration of Belfast city centre provided new offices for the EHSSB in Linenhall Street in 1987 and this building continues to host the Health and Social Care Board and the Public Health Agency.

During this time there were significant developments in public health. The problems of inequalities in health were raised in the *Black report* and new approaches emerged in its aftermath. Public health efforts continued against a backdrop of further restructuring and poor economic conditions. Meanwhile, new programmes and initiatives were adopted from the wider world.

The *Black report* and *Inequalities in health*

In Britain, a stark illustration of the kind of gap in health experience defined at Alma Ata was provided in 1981 with the publication of *Inequalities in health*. The report was delivered from a working group chaired by Sir Douglas Black, former president of the Royal College of Physicians. The group's brief was to assemble available information about the differences in health status among social classes and the factors that might contribute to these. The report found that the gap between social classes in the year 1976 was as wide as it had been a generation previously and was, in some cases, widening. It is worth noting that the report also identified problems in quantifying this gap in healthcare. Health statistics often related to rates of mortality and morbidity and not 'positive health'. Expressions of vigour, wellbeing and engagement with the environment or the community were hard to measure.[75] There were also problems with using the Office of Population Census and Surveys' (OPCS) professional classifications. Half of the population of Britain, for example, fell into social class III.

Nevertheless, what became known as the *Black report* made alarming reading for public health. It concluded that 30 years of the welfare state and the NHS had achieved little in reducing social inequalities in health. The extent of the problem was illustrated by the fact that if the mortality rate of Class I had applied to Classes IV and V in 1970–2, the lives of 74,000 people aged under 75e would have been saved. The problem was imbedded in society and could only be tackled by social provisions that go far beyond the benefits provided by the Health and Personal Social Services. *Inequalities in health* made 37 recommendations including an increase in social benefits, especially for children. It urged that greater resources be allocated for health education and preventative measures and that these should be targeted towards socially deprived groups. It also called for the development of District action plans and for government sponsorship of health education.[76]

Further administrative changes

In many ways, the early 1980s were years of crisis for public health. There remained a chronic shortage of staff in the Northern Ireland boards and more organisational restructuring loomed. Across the discipline of public health in the United Kingdom there persisted a feeling of uncertainty and disconnection.[77] Health Service reforms were driven by the findings of a Royal Commission on the NHS which reported in 1979 and formed the basis of health policy under Margaret Thatcher's government. *Patients first* envisaged a simplification of the health authority management structure. In Northern Ireland, this resulted in the removal of the district administration structure in the boards. The upheaval was keenly felt among community physicians across the UK. Around 20% of all the community physicians who had entered the system in England during the previous decade had taken early retirement by 1982.[78]

In Northern Ireland, restructuring removed both DAMOs and district nursing management.[79] District executive teams were replaced by units of management. In the Western Board, N. E. Gordon declared that the changes would be remembered by those directly involved in the Health Service as a year of unprecedented change.[80] Along with the management structures new protocols for scrutiny and accountability were implemented. All of which were undertaken amid swingeing cuts to spending on the health service.

The government-ordered efficiency savings had a direct impact on aspects of the public health function in all the boards. The fiscal problems, for example, resulted in a shortage of health visitors. The Northern Board was 30 short of national recommendations at a time when community nursing was under increasing pressure.[81] This increased demand was attributed to the social deprivation caused by the high levels of unemployment.[82] Contacts by health visitors remained the initial, and sometimes the only links between families and health professionals. These visits also provided an opportunity to assess the health and wellbeing of whole families. Given the high unemployment rates, male family members were quite often at home. In addition, the close-knit nature of Northern Ireland's society meant that older members of the extended family frequently only lived a few doors away. Health visitors were seldom seen as interfering and this acceptance considerably eased the process of building networks of care around needy families.[83]

In spite of the upheaval from restructuring and the dire financial situation the relationships established within public health were maintained. Seamus Maguire noted with satisfaction and gratitude the close cooperation between community physicians and environmental health officers.[84] Efforts continued on immunisation, to reach those sections of the community with a low uptake of vaccination. Bill McConnell, then working in the Southern Board, recalls the dismay he felt at the gap in immunisation, together with the relative disinterest of the general public and some health professionals towards tackling measles. This required the coordinated efforts of community physicians and health education officers to redress.[85]

In his final report to the Eastern Board in 1981, James Taggart noted an upsurge in infectious diseases. Rates for measles, whooping cough, dysentery and infectious hepatitis were all on the rise. The following year James McKenna, the new CAMO, recorded the re-emergence of diseases which had been considered to be under control. There were for example 60 cases of tuberculosis in the board area. However, by far the most worrying outbreak occurred in West Belfast when a two year-old boy contracted paralytic poliomyelitis. Amid an atmosphere of panic among the general population and something of a media frenzy, special clinics were established to provide booster doses of polio vaccine in the Belfast area.[87] While measles was a preventable condition there was a difficulty in persuading both the public and even some professionals that it was a sufficiently serious condition to warrant its eradication. [88]

The Moyard Health Profile

The Alma Ata declaration of 1978 highlighted the need for community participation. The *Black report*, as well as demonstrating the existence of chronic inequalities in health, also recommended a comprehensive research strategy to include variables like social conditions, behavioural factors and the impact of social policies. In the early 1980s a small group of health professionals identified an opportunity to address both these ideas.

The state of health in areas of West Belfast was a cause of great concern. Year by year, West Belfast topped the figures on measles, infectious hepatitis and dysentery. The uptake of immunisation in North and West Belfast was 41% for tetanus, diphtheria and polio compared with 81% in North Down.[89] The outbreak of polio in 1982 demonstrated the problem created by the low immunisation rates.

The chance to intervene arose when the Moyard Housing Association requested the demolition of a block of maisonettes in the area. A small housing estate consisting of 165 homes in West Belfast, Moyard had a history of problems caused by poor sanitation. There had been a series of outbreaks of gastroenteritis on the estate. Local people blamed a leaking sewer which allowed sewage to seep on to the street. In June 1983 the Moyard Health Profile Group was established, with the support of senior board staff, to initiate contact with the residents of the estate. This was a unique approach. The group comprised, among others, a community physician, a health education officer, a community worker, social worker and a nursing officer.[91] The Profile Group set out to identify the hazards to health in Moyard and to improve the environmental influences on the health of the community. It was hoped that the learning from this approach would result in a model which could be applied to other areas with significant health problems.[92]

The community at first reacted to the initiative with suspicion. The Moyard final report admitted 'local people were sick of talking to…professionals who, although sympathetic, always went away and were never seen again'.[93] Matters came to a head in January 1984 when community representatives attached to the group rejected the questionnaire drafted by the professionals on the Profile Group. Mary Black recalls the community representatives felt 'if you started asking those questions they would be in to take the children off us'.[94]

The involvement of lay members of the group in drafting a subsequent health questionnaire in many ways handed ownership of the process to the community. It also improved relationships and built trust. For the health professionals involved in the project, Moyard was an important educational process. 'It is easy to talk about damp and cold and sickness', the final report states, 'but to experience the cold of the maisonettes, to see the damp in the bedrooms and the bathrooms gave a new meaning and significance to the concept of poverty'.[95]

The findings of the Profile Group were published in 1985 and provided a remarkable snapshot of the health and wellbeing of the people of Moyard. In all, 701 people lived on the estate, half of whom were under 16. There were few recreational facilities in the area like play areas. No GPs operated in Moyard and often the only contact local people had with health workers was through health visitors. The incidence of low birth-weight was almost twice the board average. Only 31% of children were immunised against whooping cough, 15% against polio. Almost half the children on the estate, some 49%, experienced persistent chest infection. Half of all women had never had a cervical smear.[96] There was an enormous gap between the perceptions of need among local people and the perceptions among health workers and other professionals.

The report did accentuate some positives. Environmental health officers maintained close working relationships with Northern Ireland Housing Executive officers in the area. There was a general feeling among these officers, however, that they remained reactive rather than proactive in meeting some of the formidable problems of Moyard. Along with the difficulties posed by raw sewage, 74% of maisonettes were affected by damp and cold. Mice were reported in 45% of households.[97] The profile group recommended a named environmental health officer for Moyard who would maintain regular contact both with local community representatives and officers of other statutory agencies.[98]

Overall, the goal of the profile group was to transform people from passive recipients of healthcare and services into protagonists for good health. Lay participation, however, was not uniformly accepted and the profile group experienced resistance in certain quarters to local people becoming involved in the health decision-making process. Although the group had been commissioned by the board it was viewed with suspicion by local management and as a result local field workers from Health and Social Services were unable to be involved. This meant problems for the Profile Group in getting access to child healthcare records, for example, and also finding accommodation.[99] The support of the Profile Group at a high level within the board was a useful lever for local action but this diminished over time.

Moyard may have been developed 'as these initiatives sometimes are, as an act of desperation in order to solve problems which defeated conventional services operating in conventional ways' but it left a significant legacy.[100] The project did provide a template for future action and the lessons learned would be applied to other projects in the future as the Eastern Board maintained a commitment to community action. Its strategic plan for 1988–90 incorporated a programme to encourage the lay health workers and lay health groups and their interests in health issues. A fund of £100,000 was allocated for such projects.[101]

The Moyard Health Profile was widely distributed and presented as a case study provided a focus for discussion of the concept of multi-sectoral cooperation and lay participation in health. For the residents of Moyard, the Profile Group provided the opportunity for ownership of the decisions not only about their own health but also about services to meet needs in their own area. It also gave them confidence when dealing with statutory and health agencies.[102] The result was a general improvement in facilities in the area and the Profile Group was expanded locally to become the Whiterock Health and Social Services Group.[103]

The Moyard project showed the extent to which public health in Northern Ireland was prepared to embrace the changing ethos and new ideas from the wider world and implement them at a local level. It incorporated many of the ideas of Alma Ata and the recommendations of Sir Douglas Black's *Health inequalities*. A range of staff drawn from Public Health, Health Education, governmental health and lay health workers began to adopt new ways of working on community health problems.

Environmental health in the 1980s

We have already seen how environmental health found its place amongst the new statutory agencies in Northern Ireland. The Environmental Health Association (EHA) (formerly APHI) report for 1980 recorded efforts on food hygiene and on port health. The report also marked the improving air quality due to the success of Smoke Control Orders. Industrial pollution was not the problem it had once been, however, Northern Ireland's continued reliance on solid fuels for home heating resulted in significant degrees of pollution.[104] Belfast, for example, had the worst air quality in the United Kingdom – a combination of coal burning and geographical position.[105] By 1982, the centenary year of the Institution of Environmental Health Officers, there were 92 Smoke Control Orders in effect across Northern Ireland covering some 73,000 homes.[106]

As the decade progressed food safety issues became increasingly important. Northern Ireland witnessed a significant increase in the incidence of unfit meat, while outbreaks of food poisoning reached an all-time high. There were problems too, for environmental health officers (EHOs) along the border with the Irish Republic. A large proportion of Irish food exports to the UK entered this way and there was concern among officers that they lacked sufficient powers to deal with unfit meat.[107]

The growing legislative role for the European Economic Community also proved problematic and the relationship between UK environmental health and the EEC was an uneasy one. Throughout the early years of the decade the EHA complained constantly that there was no environmental health representation on EEC consultation groups. Although tasked with enforcing European legislation and standards, they had no voice in drafting them.[108] The Institute of Environmental Health Officers had the persistant feeling that as far as Europe was concerned they remained misunderstood and undervalued.

Nevertheless, environmental health was very much a part of the changing face of public health. The driving force was, once again, the World Health Organization. For some time there had been an awareness that only a multi-sectoral approach could achieve progress toward the kind of totality of wellbeing envisaged in Alma Ata. The potential for the environment to contribute to health was one of the driving factors behind the WHO's 'Healthy cities' programme. The initiative was launched at a conference in Lisbon in 1986 as part of the organisation's 'Health for all' agenda. The intention was to bring together a partnership between the public, private and voluntary sectors to focus on urban health and to tackle health related problems in a broad way.[109] 'Health for all' set 38 targets to improve the health and wellbeing of all but also to specifically target disadvantaged groups. It was based around healthy public polices, a multi-sectoral approach and community participation.[110] It was also an attempt to move medicine away from a medical view of health towards a social one and shift cultures away from 'victim-blaming' to healthy public policies. The ethos was to address the broader social determinants of health, by putting health on the agenda of all sectors, with an agreed city health plan which would tackle inequalities.

The importance of a positive urban environment was clear. By the year 2000 it was estimated that 75% of Europeans and the majority of the world's population would live in cities.[111] There was also growing awareness of the link between high urban populations and the eco-crisis – global warming and ozone depletion – facing the planet. 'Healthy cities' envisaged a network wherein urban centres could cooperate on health, exchange information and encourage mutual support. The participation of Belfast, however, was by no means a certainty. The two key partners in ensuring that the city was accepted into 'Healthy cities' were the Eastern Health and Social Services Board and Belfast City Council. A delegation comprising health education officers, community physicians and environmental health officers faced a battle to secure a place. There was incredulity among some WHO officials at the Düsseldorf 'Healthy cities' conference that somewhere like Belfast could or would want to participate in the programme. It was pointed out, however, that cities from troubled regions like Tel Aviv had been included. This argument was accepted and Belfast was included in the project in 1987.[112]

The importance for health of the urban environment was confirmed at a WHO environmental health conference in 1988. The conference shared a vision of ecological cities that retained the principle of minimum intrusion into the natural state while aiming for the maximum amount of variety in physical, social and economic structure. It also adhered to the idea of a closed system that used as much renewable energy and recycling as possible.[113] The idea of the urban environment as a positive force for health was much more than a rediscovery of the sanitary approach to public health. It was more than clean air, good housing and water. 'Healthy cities' offered the opportunity to implement city plans for health which were action-based and which included environmental action to encourage individual and community health in a multi-agency, collaborative and community approach.

The rise of health promotion

An important component of almost every WHO strategy was the entitlement of individuals and communities to information about their health. As with almost all aspects of public health in the 1980s there were changes in how this was delivered. As the decade progressed all four boards in Northern Ireland stressed the importance of health education in address the health needs of the community. Health education departments received more funding and staff levels increased. In 1982 the Health Education Forum for Northern Ireland carried out initiatives on smoking cessation and immunisation.[114] In the Eastern Board, education was deemed essential in promoting good health and preventing diseases. However, it also recognised that more could be achieved 'by changes in socio-economic conditions and the environment than by individual behaviour'. In recognition of this, the appointment of a community health education officer 'gave reality to the aspiration of a community development approach to health'.[115]

The boards and their health education departments recognised that the work must move beyond the individual and their understanding and should recognise the wider impacts on health. To a large extent, education in public health involved giving individuals messages on health and a better understanding of how their bodies functioned and what could be done to protect them. What was happening, however, was a rediscovery 'of the idea that this was about society and how society responds and how individuals take part in that process'.[116]

In 1984 the World Health Organization issued a discussion document on health promotion, which it defined as enabling people to increase control over and to improve their health. It asserted that health was a resource for everyday life and not an objective of living. Health was 'a positive concept emphasising social and personal resources as well as physical capacity'. It involved the whole community being handed control of and responsibility for their own health. Health promotion directed action towards the determinants of health as part of a cross-disciplinary approach. It concluded that, as a concept, health promotion was positive, dynamic and empowering which made it rhetorically useful and political attractive.[117]

The increasing significance of health promotion was not without controversy. In 1984, John Watson, Northern Board CAMO, noted that the words 'health promotion' had 'become quite emotive in the past year in parts of the UK following reorganisation where it is seen as something different from health education and necessitating separate structures and funding. Fortunately, no such schism exists here'.[118] WHO's commitment to the philosophy of health promotion was reiterated in 1986 at a conference in Ottawa, Canada. The conference reaffirmed the Alma Ata declaration on wellbeing and declared that in order to reach such a state the individual or group must be able to identify and realise their aspirations, to satisfy needs and to change or cope with the environment. Political, economic, social, cultural, environmental and behavioural factors can all favour health. Health promotion aimed at reducing health inequalities by delivering control of health to individuals and communities.[119]

In 1985 the Northern Ireland Health and Social Services Council identified some of the problems experienced by health education. 'Sometimes health education', the council reported, 'is perceived as a panacea that will solve the problems resulting from the conflict between finite resources and the escalating demands made on the Health Service because it is assumed that prevention ought to be cheaper than cure'.[120] In suggesting an overall strategy, the council recommended a multi-disciplinary approach, including health promotion teams established in every board. Health promotion should be given a high priority in Health Service planning and the necessary resources.[121]

It was not the case that 'traditional' health education was abandoned altogether. Information and educational efforts continued in schools and through local education and library boards and in advice distributed by health visitors. However, health promotion also became incorporated into the public health strategies of all the boards. In the Eastern Board's strategic plan for 1988–90, for example, it was noted that there was widespread agreement that an independent health promotion organisation should be set up in Northern Ireland to assist the boards in planning and evaluating health promotion programmes.[122] Subsequently, in 1988, the Northern Ireland Health Promotion Unit came into existence.

Health promotion represented much of the ethos in what would become known as the 'new public health' that developed over the course of the 1980s, and it became an integral part of the fight against an old enemy. In spite of the efforts of the previous decades, heart disease remained the largest single cause of death across Northern Ireland. In Belfast alone, 25% of all deaths in the under-65 age group were caused by cardiovascular disease.[123] Necessity is often the mother of invention and the epidemic proportions reached by heart disease had led to a degree of innovation and no shortage of expertise in the treatment of cardiac arrest. The creation of the Cardiac Ambulance and the inception of the Northern Ireland Coronary Prevention Group were just two of the medical responses to the rise in heart disease.

It remained, however, a challenge for public health. In 1985 the World Health Organization's Target 9 of the 'Health for all' initiative aimed at reducing by 15% mortality from cardiovascular disease in the under-65 age group in Europe by 2000. To that end, the boards established the 'Change of heart' programme, which targeted the known behavioural factors that contributed to heart disease – smoking, diet and lack of exercise. This passed to the Health Promotion Unit in 1988. Another vital component in the battle against heart disease had been established much earlier, again under the auspices of the World Health Organization. In 1983 the Belfast MONICA Project was set up under Alun Evans to monitor trends and determinants in cardiovascular disease. The ten-year programme was initiated to track the sometimes wildly differing trends and mortality rates of heart disease around the world. All coronary heart disease events and, in some cases, stroke events, were registered using standard protocols.[124]

The project had a target population of 224,000 across Belfast, Castlereagh, North Down and Ards. In 1983-4, 2,361 people were studied to establish levels of risk. In 1986-7, a second survey involving 5,230 people was carried out. The programme looked at factors like smoking, diet, obesity and cholesterol levels. But other factors emerged. One of the findings published in 1990 found that even amongst non-smokers tobacco posed a hazard to health as a large proportion of young people were exposed to other peoples' smoke for long periods each day.[125] MONICA was also charged with evaluating the 'Change of heart' programme over its lifetime.

The Acheson report

In January 1988 a committee headed by the Chief Medical Officer for England, Sir Donald Acheson, delivered a highly critical report on the state of public health in England. It was an inquiry prompted by the re-emergence of high risk communicable diseases and fatal outbreaks of salmonella at Stanley Royd Hospital in 1984 and legionnaire's disease in Wakefield. Events seemed to confirm that, at least in England, public health had 'taken its eye off the ball'.[126]

The Acheson inquiry set out to improve the surveillance of the health of the population centrally and locally, to encourage polices that promote and maintain health and to ensure that the means were available to evaluate existing health services.[127] The report found that public health had been badly affected by the reforms of the early 1980s. There was also a lack of coordinated information on which to base policy decisions about the health of the population. There was a lack of emphasis on the promotion of health and healthy living. Confusion, existed about the precise role and responsibilities of public health doctors in relation to variety of issues, including communicable disease control. Poor communication existed between agencies and there was a weakness in the capacity of health authorities to evaluate the outcomes of their own activities. Shortages of staff with the appropriate training persisted and doubts were expressed concerning the credibility of some of the staff in situ.[128]

It must be said that the picture painted by Acheson was not representative of public health in Northern Ireland. Nevertheless, the effect of the report was beneficial. Among Acheson's recommendations was the creation in all health authorities of the post of Director of Public Health (DPH). He or she would have the obligation to produce an annual report on the health of the population. Regular contact between the directors of public health and chief environmental health officers was advised to improve communication and collaboration between agencies. The role of health promotion was emphasised, as was the control of infectious diseases in the creation of the new post of Consultant in Communicable Disease Control.[129] Acheson had offered a bottle of champagne to anyone on the inquiry team who could come up with a better name but none was forthcoming. Rod Griffiths, former President of the Faculty of Public Health, believed that with their creation 'the future of health protection was secured'.[130]

In Northern Ireland, James McKenna left the Eastern Board to take up the post of Chief Medical Officer. In an important development he instituted the publication of a report at the end of 1988 that gave a concise overview of the health of the population. The first reports of the new DPHs in the post-Acheson era were a radical departure from what had gone before. These glossy, eye-catching and reader friendly publications centred around providing a detailed picture of the current health state of the population. The new directors were free to take a thematic approach, which captured much of the philosophy of public health as well as reflecting current trends and initiatives. In *Public health matters* for the Eastern Board, the new DPH, Gabriel Scally declared that public health meant the health of the public. The board had no right of ownership over the health of the people living under its care. The individual was inherently responsible for his or her own health but it was the duty of the board to furnish the appropriate knowledge, skills and services to help them achieve this.[131] The importance of a healthy environment was also stressed. The Eastern Board retained a commitment to multi-sectoral community development initiatives like health profiling. The report highlighted the Blackstaff Health Profile, a similar initiative to that carried out in Moyard, underway in the Village area of South Belfast. The report noted a small decline in deaths from ischaemic heart disease but immunisation had a way to go if the board was to meet the WHO target of 90% uptake by 1990.[132] The effort to meet these targets, in many ways, set the future agenda for public health in the Eastern Board. Other initiatives, like the GP Miniscript bulletins on infectious diseases or the 'Picture of health' survey marking Belfast's centenary were also undertaken in the immediate aftermath of Acheson.

The Chief Medical Officer and the new DPHs agreed that although the structure of the new annual reports may be different they would all include sets of tables based on the same approach to data collection and analysis to allow comparisons to be made across Northern Ireland. Thus, the core tables remained a key part of the DPH reports – *Public health matters* in the Eastern Board, the *Report of the director of public health* in the Northern Board, *Health accounts* in the Western and *Aspects of/Towards Better Health* in the Southern Board. In the Southern Board, Seamus Maguire delivered *Aspects of health*, his final report. Its main theme was the link between economic and social deprivation and ill-health, especially unemployment.[133] Heart disease remained the largest cause of death amongst the under-65 age group. Like all the boards, the priorities for the coming year were influenced to a large extent by WHO targets and approaches. In 1989, the new Director, Paula Kilbane, published *Towards better health*. The report outlined the ways in which the Southern Board had responded to the targets set the previous year. It noted the successful application of Smoke Control Orders and improving air quality in places like Newry. And the success of closer links forged with the Northern Ireland Housing Executive.[134] On immunisation, the report remarked upon the significant increase in the uptake rate following the introduction of the MMR vaccine. The boards uptake was already higher than the WHO target at 92% while 98% of all secondary schoolgirls had been immunised against rubella.[135] The number one priority for the coming year would be the effort to achieve the 'Health for all' target of a 15% reduction in heart disease related deaths.

New diseases and new initiatives

The emergence of health promotion as a weapon in the public health arsenal was timely. The 1980s saw the emergence of some new and menacing infectious diseases. In 1988 Seamus Maguire remarked that HIV/AIDS had the potential to reach epidemic proportions in Northern Ireland despite the adoption of a comprehensive containment strategy.[136] In the absence of any vaccine or even effective treatment the public health response was characterised by health education, promotion and screening. In November 1988 the number of people estimated to be HIV positive in Northern Ireland was 49. Of these, ten had developed AIDS and there had been four deaths.[137] The following year, *Aspects of health* put the total number of Northern Ireland cases of HIV at 61 with 12 cases of AIDS, nine of whom had died.[138]

However, the actual number of cases of HIV was reckoned to be much higher. The problem was that gathering statistics was made difficult by the fact that little was actually known about sexual behaviour in Northern Ireland in this period.[139] Nevertheless, by 1986–7 a comprehensive strategy had been developed as the nature of the disease and the ways in which it was transmitted and who the at-risk groups were became better understood. The boards and the newly created Health Promotion Unit responded with education and awareness programmes for multi-disciplinary training groups. Policies on prevention and control of infection were also implemented. But this was not without controversy. The idea of sexual health and sex education was and remains an emotive issue in Northern Ireland and attempts to engage with the community, especially young adults sometimes met with intense opposition.[140] Moreover, alongside programmes on the health management of HIV/AIDS it was also necessary to implement policies to combat prejudice and discrimination against the diseases and its victims.[141]

By contrast, there was much less controversy over the implementation of two screening programmes for breast and cervical cancer. The adoption by the government of the recommendations of a working group on screening chaired by Sir Patrick Forrest in July 1985 provided the impetus for the project. The new systems were a massive undertaking. In the Eastern Board, which would pilot the scheme, some 50,000 women aged 50–64 who were registered with a GP would be invited for mammography. The scheme would start in 1989, which had been designated European Year of Cancer.

Screening for cervical cancer had been available through family planning clinics for almost 30 years but in 1988 a call/recall system was put in place that would target 180,000 women aged 20–64. Starting in the east, the service would roll out across Northern Ireland in the coming year.[142] There were 145 deaths in the Eastern Board area from breast cancer in 1989. Fewer women died from cervical cancer but almost 90% of the 18 who died had never had a smear. It was felt that a large proportion of these deaths were preventable. Unusually perhaps, the screening programmes experienced no difficulty in getting the necessary funding. They were also welcomed and applauded by women's groups and trade unions. The initial uptake was put at around 70% of those invited but the figure tended to mask areas of low uptake in traditionally problematic areas like North and West Belfast.

The 1980s were a period of intense change for virtually all aspects of public health. The decade provided a complex series of challenges, including more reorganisation, the emergence of new diseases like HIV/AIDS and legionnaire's disease, and a shifting philosophy and ethos for public health practice. Northern Ireland did not experience the crisis in confidence in the discipline in the same way England did. By 1988, public health had become used to adopting the targets and reacting to the agenda set by the World Health Organization. Across the boards, progress had been made on immunisation, community participation and the identification of risk factors regarding heart disease. The *Acheson report* galvanised public health in Northern Ireland and provided an opportunity to refocus and reset agendas to meet the challenges set by WHO and those to follow in the next decade.

04

New agencies, new challenges 1990–99

The Castle Buildings complex, within the Stormont Estate, today hosts the Department of Health, Social Services and Public Safety.

The 1990s began with more reorganisation in the Health Service. New agencies were established to augment the public health effort and a Labour government came to power.

Internal market

As in previous decades the early years of the 1990s were a period of radical reform for the Health Service. The Tory government's 'Health of the nation' proposals of 1991 envisaged the establishment of an internal market within the NHS. For Northern Ireland, this meant that the four boards would purchase services from a range of health providers such as GPs and hospitals. The reforms also meant the setting of new targets, not in terms of hospitals beds but based on the achievement of a reduction in deaths from common diseases such as heart disease and cancer. Other target areas included mental illness, accident and injury and maternal and child healthcare.[143] There was also a new contract and enhanced role for GPs, which changed their relationship with the board. Now, as well as diagnosing and treating illness, family doctors were charged with preventing illness and the promotion of health. Practices that achieved targets, like 90% immunisation uptake, were to be given additional remuneration.[144]

The meeting of new targets and the commissioning of services meant better information on the health needs in their respective areas was needed by public health departments in the boards. As John Watson noted in his report in 1990 the DPH annual reports were of crucial importance in this process. 'While maintaining their status as independent commentaries on the health of local residents', he wrote, 'future reports are likely to become valuable instruments of change by assisting the boards to discharge their new responsibilities'.[145]

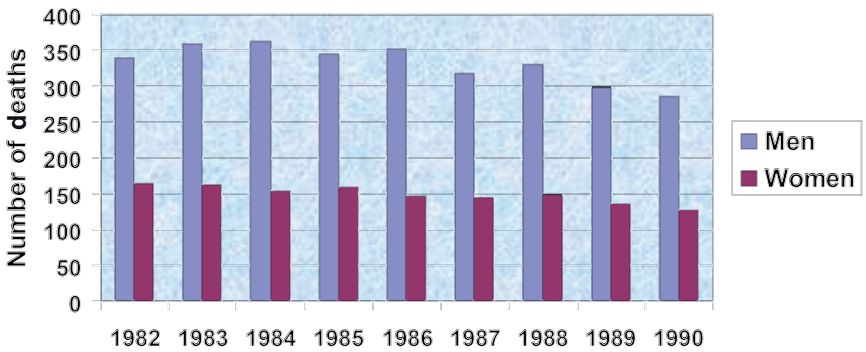
In the opinion of James McKenna, Northern Ireland's CMO, the boards were already ahead of their counterparts in Britain in being able to assess the health needs of their populations and in obtaining the services to meet them.[146] Since coming to office in 1979, the Conservative government had set a series of five-year plans for healthcare in Northern Ireland's regional strategy. The 1987–92 regional strategy incorporated many of the WHO's 'Health for all' targets. The CMO's report offers a useful overall snapshot of the health of the Northern Ireland population. For example, the new screening service for breast and cervical cancer was being rolled out across the board areas. Between January and December 1990 there had been 132,000 smear tests carried out. Over 18,000 women had been invited to attend for breast screening but the uptake, only 10,400, was disappointing.[147] The new decade also saw diseases added to the list for those requiring notification – cryptosporidiosis, legionnella, malaria, meningococcal septicaemia and chicken pox. Food safety concerns had led to the formation of a committee on the microbiological safety of food under Sir Mark Richmond.[148]

In terms of the targets set in 'Health for all', public health in Northern Ireland achieved notable success: 95% of two-year olds had been immunised against diphtheria, polio and tetanus; 91% had been immunised against measles. However, the uptake rate on whooping cough was only 84%. James McKenna noted that the introduction of the MMR vaccine in 1988 had contributed to the high uptake rates realised by the immunisation campaign. The success in meeting most, if not all of the 90% by 1990 targets was noted at board level. In the Northern Board, John Watson recorded that the board had not only met but exceeded the target set on measles. The uptake rate on whooping cough remained 'tantalisingly close' at 89.5% but was a vast improvement on the 43% rate of 1981. A new computerised child health system had played a part in the success of the campaign in flagging non-attendees to GPs and health visitors.[149] The popularity of the MMR vaccine was also noted by Paula Kilbane in the Southern Board. The uptake was currently around 93%, though the rate for whooping cough was lower, leading to 82 notified cases.[150] However, in his report to the Western Board, Bill McConnell reflected on the fact the same diseases were causing the greatest rate of death at the beginning of the 1990s as they had at the time of his first report. There were 12.5% more deaths in the Western area than in North and East from heart disease. The higher rate therefore required setting higher targets for reduction.[151]

The success in meeting immunisation targets was also noted by Gabriel Scally in the Eastern Board. However, non-communicable diseases continued to present a considerable burden, especially cancer and heart disease. Since 1980, death rates from ischaemic heart disease (IHD) had fallen significantly, across Northern Ireland.

There were other concerns. Teenage pregnancies were on the rise. In 1990, over 21% of children born in the board area were to unmarried mothers.[152] HIV/AIDS represented a persistent threat. In 1990, there had been 22 cases of AIDS in the Eastern Board, 19 of whom had died. There were 76 cases of HIV, mostly among homosexual and bi-sexual men but there was evidence of increasing numbers of infection amongst heterosexuals. The most effective measures against the disease remained prevention and protection.[153] The board remained committed to community development. For example, it continued to support the Blackstaff Health Profile in South Belfast. The intention was for maximum community involvement in a multi-agency approach.

Figure 2.



Standardised deaths from IHD for men and women in Northern Ireland 1982–90. (Source: CMO report 1999)

Overall, public health medicine was committed in the new decade to the goals set by WHO, the regional strategy and those targets set by individual directors of public health. The broad intention was to reduce inequalities in health, to add years to life and health to life by reducing disease and disability. The reforms in the NHS required the boards to identify the needs of the people they served and to commission the services appropriate to those needs. Health promotion was an integral part of the public health approach. As the regional strategy pointed out 'if real gains are to be made in the health of the population it will be necessary for the Department and the boards not only to continue to promote a healthy lifestyle but to equip people with the skills and opportunity which encourage them'.[154] The boards could set an example in this by ensuring that all premises have appropriate health promotion policies on smoking, diet, alcohol and occupational hazards. As purchasers they should ensure that every service agreement has a health promotion and education element.

A health promotion agency

The importance of health promotion to public health in Northern Ireland was illustrated in 1990 with the launch of the Health Promotion Agency for Northern Ireland (HPA). Under the executive directorship of Jane Wilde the Agency was charged with advising the Department of Health on health promotion matters, sponsoring research and evaluation and preparing and publishing material relative to health promotion. The regional strategy for 1992-7 called for coordinated regional health promotion programmes and the setting of targets for reducing the preventable major causes of disease and disability. Key to this approach was the encouragement and support of a healthier lifestyle and the development of a safe and healthy environment.[155] This was in marked contrast to the health education approach which was 'almost like teaching people about good health and public health and then hoping that, having learned something, people would naturally then choose better health'.[156]

The Health Promotion Agency would act in cooperation and take 'concordant action' with the agencies concerned to help people acquire the necessary information and skills to improve their health.[157] The Third International Conference on Health Promotion held in Sundsvall, Sweden in June 1991 reaffirmed the importance of the social and economic dimension to health. It also emphasised empowering people in terms of their own health and the role for community involvement in healthcare. The agency began what was to become a long-standing relationship with the World Health Organization, leading the way for the acceptance of Northern Ireland into the CINDI (Countrywide integrated non-communicable diseases interventions) programme. This fitted neatly into the priorities set for the new agency in the regional strategy, which called for action to reduce heart disease and cancer by targeting tobacco, nutrition and high blood pressure.

In its first few years partnerships were forged with a variety of organisations, including the University of Ulster, Belfast Institute of Further and Higher Education and the Ulster Cancer Foundation. As well as continuing the 'Change of heart' programme, the Health Promotion Agency participated in 'Europe against cancer' and began initiatives on family planning, and drugs and alcohol programmes aimed at young people. A key component of the health promotion effort was raising awareness through the media. Television advertising along with newspapers, radio and leafleting campaigns were all utilised in promoting a healthy lifestyle.

In 1996 Jane Wilde left the agency to head the Institute of Public Health in Ireland, and was succeeded as executive director by Brian Gaffney. In the mid-1990s there was a fundamental review carried out by Rabbi Julie Neuberger, which looked at the health promotion function in Northern Ireland. One of the recommendations was for the agency to move to a more contractual relationship with the Department of Health. There was also a subtle shift in the agency's approach. Reflecting trends in the wider world, health promotion put less emphasis on ill-health being caused by individual lifestyle. In the latter half of the decade, health promotion moved towards a broad approach which, along with addressing lifestyle, looked at how the social, economic and physical environment affected health. Accordingly, the agency worked closely with WHO initiatives like 'Healthy cities' with the aim of creating a more enabling environment.[158]

The environment – changing agendas

By the 1990s there was an increasingly clear division in the functions of environmental health. Those services provided to local authorities – inspection, disease control and food safety – all continued in Northern Ireland's 26 councils. However, there was a growing emphasis on the effect of the broader environment on the health of the population.[159] A flavour of some of the services provided by environmental health officers can be gleaned from the reports delivered to Belfast City Council by Brian Hanna, then Director of Environmental Health. In the report for April 1992 to March 1993, for example, EHOs investigated two cases of dysentery, 34 instances of campylobacter, 21 cases of salmonella and 63 cases of food poisoning. A total of 1,634 ships were inspected in port.[160] A vast improvement in housing conditions in Northern Ireland was noted. In 1974 almost a quarter of all homes in Belfast were adjudged to be unfit for human habitation. This had dropped to 7.4% by 1987. Although the number was deemed to be still too high, the changes reflected how, in certain areas, there was a reduction in the need for intervention by EHOs. Other areas of activity, like food control, consumer protection and safety and pollution control, were rapidly expanding. The traditional role of the environmental health officer had changed. Where previously this had been ostensibly a matter of inspection and enforcement, EHOs were now involved in education on health and in health promotion.[161] Environmental health was now a key component of the 'Healthy cities' project in Belfast and could only expand its 'influence for positive change'.[162]

As with public health medicine, the ethos of environmental health as a discipline continued to evolve in the 1990s as it absorbed the agenda abroad in the wider world. In 1992 the Earth Summit held in Rio de Janeiro, called in response to global climate change, outlined what needed to be done to ensure that social, economic and environmental issues were placed at the heart of all development on the planet. What became known as Local Agenda 21 outlined a set of principles to help local authorities achieve a consensus for local communities and imposed statutory obligations on waste, the control of contaminated land and open access to environmental information.[163]

The adoption of the world agenda at local level was symptomatic of the way in which the discipline of environmental health was changing. EHOs remained 'feet on the street', investigating and enforcing in local authorities. But they also increasingly worked as part of the multi-sectoral approach to wellbeing in the community. In 1996 a commission on environmental health was set up by the Chartered Institute under the chairmanship of Dr Barbara McGibbon to examine how the discipline in the United Kingdom could develop in the future. In *Agendas for change* the commission reported that in England a gap had developed between environmental health and public health medicine and that this drift needed to be reversed. The environment had become an important determinant of health. Environmental health could not ignore the inequalities in environment and health associated with the widening gap between rich and poor, which was now greater than at any time since the 1930s.[164] The report recognised that people could only be healthy in a healthy environment and that in the modern era they did not 'merely expect that the environment should not damage their health they increasingly expect that social and environmental policies should promote their health'.[165]

For the future, as far as environmental health was concerned, prevention was better than cure. Success in reducing environmental inequalities depended on collaboration and partnership. The discipline needed to be aware of the impact that poverty had on peoples' environment. Civic participation and engagement on the environment was crucial. Such an approach could help address diseases of lifestyle in perhaps the same way environmental health tackled communicable disease.[166] The report concluded with a new framework for environmental health, a framework that promoted sustainability and required new powers and action at a local level as 'it is the totality of living conditions in an area that influence health and wellbeing'. *Agendas for change* also called for the urgent reintegration of environmental health and public health medicine.[167]

There is little evidence, however, of the kind of schism mentioned in the report occurring in Northern Ireland. Traditionally, the relationships between public health professionals were close and sustained. In 1990, for example, a sizeable portion of John Watson's report as Northern Board DPH was given over to Sam Knox, Deputy Chief Environmental Health Officer for the northern councils group. His report noted local initiatives on hygiene, waste management, litter control and noise abatement. But it also reflected some of the wider environmental health issues. The report talked of the hierarchy of environmental health concerns – global concerns like climate change, international issues like acid rain and local concerns on water and air pollution.[168]

The kind of multi-sectoral approach envisaged in *Agendas for change* was already well under way in Northern Ireland in the Belfast 'Healthy cities' project. The 'Healthy cities' annual report of Patrick Kinder in 1996 outlined the range of activities carried out under the initiative. There was a focus on reducing inequalities of health opportunities and on strengthening the capacity of the individual and community to take action to improve health. A key aspect of this approach was improving the physical and social environments that support health. This included a healthy building award, the encouragement of tobacco-free zones and a city health plan that recognised 'health is the outcome of a range of social economic and individual decisions made by human beings in many walks of life'.[169] Moreover, there was close cooperation between environmental health officers and the Laganside Corporation in the regeneration of the riverside area of Belfast. This collaboration produced tangible changes for the better in the local environment and an improvement in the living experience for the local community. For example, the building of the Lagan Weir enabled control of water levels and eliminated the often overpowering smell from mudflats at low tide.[170]

Assessment and commissioning

In his report for 1992–3 (delayed to incorporate census figures for 1991) Northern Ireland's CMO, James McKenna described 'Healthy cities' as a major vehicle for achieving 'Health for all' targets. The theme of his report was successful collaboration and the health of Northern Ireland in a wider European context. Participation in the CINDI project was seen as a great opportunity and the report also mentioned the success of the MONICA project which was collaborating with Toulouse to further assess the risk factors for heart attack and stroke. The French city had a population similar to that of Belfast in the at-risk age group. However, people in this group in Belfast were four times more likely to have a heart attack.[171] Food safety had been increasingly on the public agenda during the year with over 200 cases of salmonella. The year of 1993 also saw the introduction of GP fund-holding and the Chief Medical Officer was keen to let nothing affect the close relationship between GPs and public health staff, as family doctors were uniquely placed to assess the needs of their patients.[172]

Across all of the boards the increased level of inquiry, surveillance and reporting demanded by the health reforms was maintained. This was as essential for the commissioning process as it was for determining the health status of the population. In its regional strategy and in its reforms, the government called for locally sensitive commissioning. This meant responding to the expressed needs of the community. In the Western Board, for example, a declining birth rate meant the need to rationalise maternity services.

This process was not without controversy. As Bill McConnell, Director of Public Health, noted in his annual report 'it is clear that it may be difficult at times, although hopefully not impossible, to create debate about health changes without there being some feeling of winners and losers as a result'.[173] In the Southern Board the new Director of Public Health, Anne-Marie Telford, noted in her report that local communities, individuals and local representatives all contributed to the assessment of local needs. The new purchasing arrangements would allow input from such groups to be more formal and systematic.[174] In the Northern Board, a new pattern of acute hospital care was established with the opening of the Antrim Hospital. Further plans were underway for the development of the Causeway Hospital.[175]

In terms of the development of regional services, all four boards cooperated in the Regional Medical Services Consortium. Established in 1991 following the split between purchasers and providers, the consortium collaborated in and often led commissioning initiatives that shaped hospital services across Northern Ireland. Public health, for example, contributed to the review of renal services which saw the establishment of more locally based units in Omagh, Antrim, Altnagelvin and Daisy Hill hospitals. Access to, frequency and quality of dialysis were all improved as a result. Commissioning took up an increasingly large share of the public health function at the boards following the reforms of the early 1990s. A further example of this occurred in 1996 when a fundamental reorganisation of oncology care across Northern Ireland was undertaken following the publication of *Cancer services – investing for the future.*

The DPH reports offered a sophisticated picture of the health of the populations they served. Often, however, more information was needed. In 1994, the Western Board embarked upon a health and lifestyle survey. In spite of its comparatively small geographical size and size of population relative to Northern Ireland there were still significant variations in peoples' health experience. The population in the Western Area was 265,820. It remained one of the most disadvantaged regions of the United Kingdom with the highest standardised death rates for both women and men in Northern Ireland.[176] Overall, 26% of people had been unemployed for more than five years, while 32% of people fell into the classifications for manual professions. Interestingly, the survey also measured how people perceived their own health. In all 76% of those surveyed thought their health was good, 20% thought theirs was only fair; 40% of those unemployed felt their health was poor.[177] It was noted that there was an awareness among respondents of the factors contributing to heart attacks and other illnesses. However, there was a considerable gap between what people knew about healthy living and what they actually do.[178]

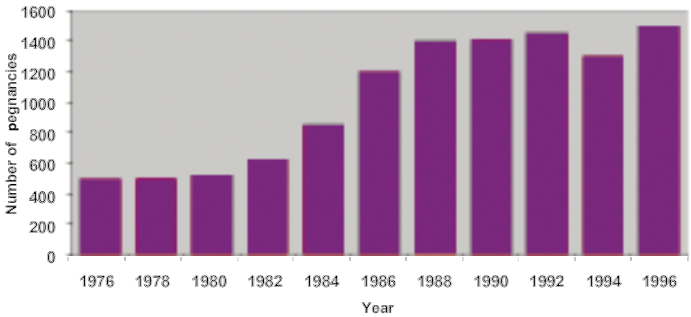
Regardless of the successes, there was a general feeling across the boards that more could be done. In the Eastern Board the departure of Gabriel Scally in 1993 led to a brief period of flux that saw both Philip Donaghy and Janet Little acting as DPH. *Public health matters* noted in 1994 that even though much had been achieved in identifying the needs and health status of the community, this knowledge needed to be broadened, particularly with regard to ethnic minorities. The report also recognised the importance of the environment in determining health. Those living on housing estates experienced greater levels of disadvantage, higher rates of long-term illness and poor mental wellbeing.[179]

Alongside the public health efforts of the boards there were also government-led initiatives on health. In 1993 a confidential enquiry into stillbirths and deaths in infancy was begun in England, Wales and Northern Ireland. Although overall infant mortality rates had declined steadily since the 1970s there were variations across the regions. The survey set out to establish which babies died and why this was so.

Sexual health and communicable diseases

Reproduction and sexual health became a growing public health concern by the middle of the decade in all areas (Figure 3). In the Northern Board there had been a reduction in teen pregnancies from 500 in 1989 to 400 in 1993. However, this figure was deemed to be still too high and family planning needed to target young people.[180]

Figure 3.



Pregnancies to unmarried teens in Northern Ireland, 1976–96. (Source: CMO annual report 1998)

To address the issues of teen pregnancies and what was perceived to be the inadequate provision of sexual advice to young people, the Eastern Board facilitated the establishment of a Brook Advisory Centre in Belfast in 1992. For 40 years Brook had provided free and confidential sexual information to the under-25 age group in Britain.[181]

From the outset, the move proved controversial. Northern Ireland, as it has already been noted, remains a difficult place in which to discuss sex and sexual health. Brook faced bitter and vocal opposition from religious groups and political parties like the Democratic Unionist Party. It was alleged, quite wrongly, that the centre arranged abortions in England for women from Northern Ireland. Brook, and members of the board were accused of 'destroying the moral fibre of Northern Ireland' in dispensing advice on sexual health to young people. A judicial review of the decision by the board to fund Brook was forced by legal action taken by two GPs. This was successfully resisted and eventually Brook secured the support of Belfast City Council.[182] Despite continuing opposition from religious groups the Brook Advisory Centre operated for the remainder of the decade. However, the issue of sexual advice remains contentious.

The biggest killer in every area remained non-communicable disease. In the Western Board area between 1992-3 over 2,000 potential life years were lost to heart disease.[183] This was despite a downward trend in cases of ischaemic heart disease. And yet, it was infectious disease that captured the headlines and the imagination of the public by the mid 1990s. The emergence of new diseases associated with food – BSE in cattle and the human variant CJD – caused something of a climate of fear. Late in 1996 an outbreak of E.coli 0157 centred in Wishaw in Scotland led to 496 cases, 20 people dying as a result. Subsequently, a panel of experts led by Sir Hugh Pennington set new recommendations on food safety.

In Northern Ireland, the new Chief Medical Officer, Henrietta Campbell, commissioned a review of communicable disease arrangements. It was recommended that a new regional epidemiology unit be established to track infectious disease.

The subsequent Communicable Disease Surveillance Centre (CDSC) was affiliated with the Public Health Laboratory Service (PHLS), which operated similar units in England and Wales. The role of the CDSC was to provide assistance to other public health teams, directors of public health and the Chief Medical Officer in the surveillance and control of communicable disease.[184]

New Labour and health policy

Before the general election in 1997 the Conservative Health Minister for Northern Ireland, Malcom Moss, outlined another five-year strategy. *Health and wellbeing into the next millennium* again set targets for public health based on 'Health for all'. It was intended to cut the death rate from heart disease in the 35–64 age group by 40% by 2000. A 30% reduction in deaths in the 65–74 age group was also proposed. Stroke deaths were to be cut by 40%. The idea was to provide something tangible to aim for and the means of measuring progress.[185] Targets were also set on cervical and breast cancer. Health promotion was an integral part of the government's intended approach.

At the general election, however, Labour swept to victory in a landslide. The new government presented its vision of public health for Northern Ireland in *Well into 2000 – a positive agenda for health* published in 1997. It was an attempt to set new goals for improving the overall health of the nation and recognised the impact that poverty, poor housing, unemployment and a polluted environment have on people's health. The new Northern Ireland Secretary, Mo Mowlam, stated that despite improvements and success in the social and healthcare system 'the fact remains that the incidence of some illnesses and diseases is still unacceptably high in Northern Ireland'. The new government's approach to public health involved integrated action, better information, health promotion, fairness and participation.[186]

The declared aim was for all government policies to make their full contribution to improving people's health and targeting public money towards addressing social need. There were proposals for improving arrangements on food safety and banning tobacco advertising. Northern Ireland's Labour Health Minister, Tony Worthington, assumed personal control of the government's inter-departmental group on public health because it was recognised that 'education, housing, transport, social services and all our departments can act to prevent accidents and ill-health'.[187]

It was a hopeful health manifesto full of the language of social inclusion, partnerships and participation aimed at healthy public policies. The emphasis was on tackling health inequalities through community development and participation. Local communities would be supported to identify their own health needs and concerns. The role of the health authority would be to help people devise and implement solutions.[188] It was intended that all commissioning and, indeed, health policies, should be preceded by a health impact assessment. The effect and the needs of the environment would also be taken into consideration. Smoking would be specifically targeted as a major cause of ill-health. The idea was to help and support people in their efforts to stop, to create smoke-free environments and promote non-smoking as the norm.[189]

The government's public health agenda received further direction from the publication in November 1998 of a report on health inequalities by a commission chaired by Sir Donald Acheson. The report focused not on the role of the NHS but on the social and economic determinants of health. These would require a multi-agency and governmental response. The report of what was an independent inquiry was met with a much more welcoming response by the government than that given to the *Black report* in 1980.[190]

In many ways, however, the multi-sectoral approach to public health was already very much in evidence in Northern Ireland. In 1995, for example, the new DPH at the Eastern Board, David Stewart, made tackling health inequalities a priority. These needed to be addressed at an individual level and at a community level by improving access to essential facilities and encouraging macroeconomic and cultural change.[191] The commitment to community development was maintained. The Blackstaff Health Profile project in South Belfast was joined by initiatives on the Ballybeen estate in East Belfast. Similar efforts were underway in housing estates in West Belfast.[192]

By the end of the 1990s all the boards had embarked upon major surveys on lifestyles and health perception. In 1998, the Eastern Board assessed the health status in several areas in Belfast including Duncairn, Short Strand and New Lodge.[193] In its 1997 survey, the Northern Board found that a considerable proportion of the board area was at risk of experiencing inequalities in health. This was characterised by low income, unemployment, lack of educational qualifications and isolation.[194] The survey also recorded rising levels of obesity and the diminishing impact of antibiotics due to over-prescription. In the Northern Board, the uptake of cervical and breast screening was the highest in Northern Ireland but still below national recommendations. Looking forward to the new century, John Watson identified some of the coming challenges. AIDS remained a threat, as did E.coli. Moreover, some old diseases like TB were emerging in a medicine resistant form.[195]

The approach of New Labour meant something of a renaissance in public health in England.[196] However, much of the ethos and collaborative strategies were already underway in Northern Ireland. At the end of the twentieth century the public health endeavour had met with considerable and measurable success. People in Northern Ireland were now living longer and enjoying a better quality of life than at any other time.[197] Diseases like diphtheria had been all but eradicated and the incidence of measles was vastly reduced by the success of the boards' immunisation programmes. However, old problems persisted. Ischaemic heart disease was in decline but still a major threat to health. It was set to be overtaken by cancer as the biggest cause of death in Northern Ireland by 2003.[198]

At the beginning of the new millennium Northern Ireland's Chief Medical Officer, Henrietta Campbell warned that 'awareness needs to be raised about the relatively poor state of our population's health. The aim must be to raise our level of health to that of the best in Europe'.[199] In the coming years, public health in Northern Ireland would have to deal with the prospect of an ageing population, continue efforts to prevent disease and promote a healthy lifestyle. Health inequalities persisted.[200] The future remained far from certain. Funding was becoming available for new initiatives like health action zones but there were also sweeping reforms on the horizon. Moreover, public health would have to operate in the uncharted and very turbulent waters of peace and devolved government in Northern Ireland.

05

A new millennium

The headquarters of the former WHSSB at Gransha Park House, Londonderry, now a regional office of the Health and Social Care Board.

The twenty-first century brought devolved administration to Northern Ireland for the first time in 30 years. Public health faced the challenge of new diseases and new threats which continued to develop against a backdrop of further administrative and structural changes.

Investing for health

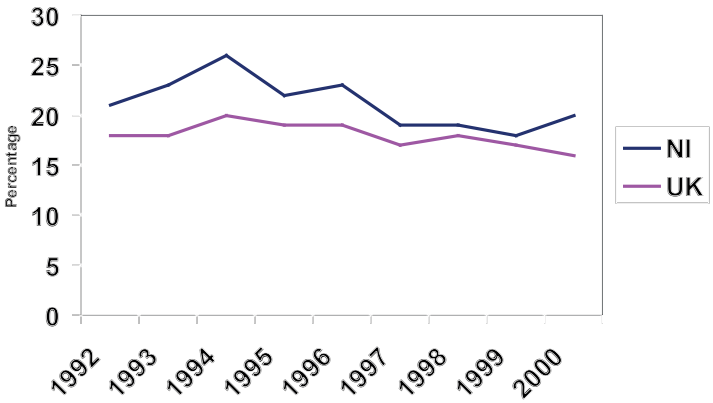
Following the signing of the Good Friday Agreement in April 1998 a power-sharing Executive and constituent Assembly were established to take over government functions from direct rule ministries in Northern Ireland. The settlement, however fragile, ostensibly brought to an end a civil conflict that had guttered and flared for over 30 years. The Assembly, like Northern Ireland society as a whole, remained politically, religiously and culturally divided, sometimes bitterly so. However, healthcare had remained a neutral issue, by and large, throughout the conflict and, post-settlement, provided an opportunity for unity for the new government.

In the Executive's first year the Department of Health was reconstituted as the Department of Health, Social Services and Public Safety (DHSSPS). The main responsibilities of the department were hospitals, GPs and community health, public health and the ambulance and fire services. The mission of the DHSSPS was to improve everyone's health by ensuring the provision of appropriate health and social services and to support a programme of health promotion and encourage the community to adopt activities and behaviour that will lead to better health and wellbeing.[201]

The Executive's 'Programme for Government' declared that 'a modern, successful society must include major improvements in health. We recognise that we have to work across departments to improve health and tackle inequalities'. It was also noted that a good environment was essential for good quality of life.[202] 'Investing for health' was launched as Northern Ireland's regional health strategy in 2002 under the auspices of the Office of First and Deputy First Minister.[203] It was a concerted attempt to focus on the social determinants of health, health inequalities and the health and wellbeing of communities and individuals. It was intended as a dynamic, long-term process of improvement to bring Northern Ireland's health standards up to those of the best in Europe. The Executive was committed to playing its part and to working with others to make health improvement a reality. A Ministerial Group on Public Health comprising representatives from every government department was established to carry this agenda forward at Executive level and lend it cross-departmental and cross-party support.

The philosophy behind 'Investing for health' was a simple one. 'If we invest even small amounts of time and money and effort now', the rationale went, 'we can make substantial future gains in health'. At the heart of the approach was the realisation that health and wellbeing was largely determined by the social, economic, physical and cultural environment. It sought to shift the emphasis away from the treatment of ill-health towards prevention by tackling the factors which adversely affect health and perpetuate health inequalities.[204] As Michael McBride, Northern Ireland's CMO has pointed out, where you live in Northern Ireland has always mattered, it's always mattered for the wrong reasons…because it determines [not only] how long you live 'but it also determines how long your children will live and that's fundamentally unacceptable – morally and ethically'.[205]

Figure 4.



Children in workless households. (Source: IfH 2002)

Massive improvements had been made in the health of the public in Northern Ireland in the last century. In 1900, life expectancy for men and women was 47 years. In 1999, it was 74.5 and 79.6 years respectively. Nevertheless, Northern Ireland remained top of international league tables on heart disease, cancer and teenage pregnancies. Many people remained in poor health throughout their lives. It also continued to have the highest percentage (Figure.4) of children in workless households in the United Kingdom.[206]

'Investing for health' set objectives and targets on health improvement based on a 7–10 year period. It planned to add three years to the life expectancy of men and two for women by 2010 and improve life expectancy among the most disadvantaged groups in the community. It aimed at reducing the number of people with a psychiatric disorder by 10% and lift 20,000 people out of fuel poverty. The strategy also set out to reduce death rates from accidents by a fifth and stop the increase in the level of obesity so that by 2010 the proportion of men and women who are obese would be less than 17% and 20% respectively.[207]

All boards would enter into partnership with a coalition of statutory, voluntary and community organisations to deliver 'Investing for health' at local level. Each would also draft a health and wellbeing improvement plan for their area. 'Investing for health' would operate in conjunction with government initiatives like 'Targeting social need' and urban and rural regeneration programmes. The strategy would use the example of and build upon existing initiatives like 'Health action zones', 'Healthy cities',' childcare partnerships and peace and reconciliation partnerships. 'What we are trying to do', Bill McConnell, Western DPH explained, 'is pick out big strategic issues where one organisation could not do anything about them but you can do much more if you are working together'.[208]

In the Northern Board, for example, the new 'Investing for health' partnership involved 38 partners including district councils, the Northern Ireland Housing Executive, environmental health along with a variety of local community and voluntary groups.[209] Of 180 electoral wards in the board's area, 33 were identified as disadvantaged and 21% of people were regarded as being vulnerable to rural isolation. The board also commissioned the Institute of Conflict Research to study the role of young people in community conflict and its effect on social wellbeing.[210] The board's five year plan identified health as a fundamental human right and it would proceed on the basis of social inclusion, local involvement, fairness, equal rights to services and information according to need. The plan set out to address community needs regarding wellbeing. Thus, for example, two initiatives addressed rural transport issues and personal debt.[211]

In the Eastern Board, the Health Improvement Plan targeted specific areas of need and worked alongside education and library boards and the Housing Executive. It was specifically designed to address the complex split between the board's rural areas and the urban sprawl of Belfast.[212] In the Southern Board the Health Improvement Plan was outlined in *Dare to dream – 2003 and beyond.* Each of the 39 partners, 19 from statutory agencies and 20 from social and community groups, began by designating a 'beacon project' that specifically addressed the aims and objectives of 'Investing for health'. In Armagh and Dungannon, for example, 26 initiatives were supported, including health checks for farming communities.[213] There were 30 participants in the Western partnership which would build on the example and the progress of the Western Health Action Zone and Derry 'Healthy cities'.[214]

'Investing for health' was robust enough and had sufficient support to survive the difficult early years and eventual collapse of the first Northern Ireland Assembly in 2002/3. In an update delivered by direct rule Health Minister Angela Smith in 2004, it was noted that all departments remained committed to the strategy through the Ministerial Group on Public Health. It was described as the main driver behind the implementation of the strategy and ensured that it stayed on the agenda of all government departments and public bodies. Targeting social need also continued with a neighbourhood renewal strategy aimed at the most deprived 10% of areas in Northern Ireland which would work alongside initiatives like 'Making Belfast work' and the 'Londonderry regeneration initiative'.[215]

Despite the political uncertainty caused by the suspension of the Northern Ireland Executive and Assembly, the commissioning process continued. In 2004, for example, the Chief Medical Officer, Henrietta Campbell, announced the creation of a Regional Cancer Services Framework to build on the significant progress achieved through the implementation of *Cancer services – investing for the future*. The aim was to provide a cohesive structure for the provision of a uniformly high standard of care for people of all ages with cancer. The steering group for the programme, which held its first meeting on 27 January, included the Directors of Public Health for the Western and Southern Boards, Bill McConnell and Anne Marie Telford.[216]

In 2005, the 'Investing for health' update was delivered by the new Secretary of State, Shaun Woodward. The priorities set out included tobacco, with a five-year strategy aimed at changing people's perceptions of tobacco use, offering help to people who wanted to stop smoking and programmes to prevent young people taking up the habit. Obesity was also a priority. It was vital to tackle the problem if any of the targets on life expectancy were to be met.[217]

As devolution continued to falter mid-decade, Angela Smith unveiled an ambitious 20-year regional strategy for health. Continuing the themes of 'Investing for health', the strategy was based on 'engagement with individuals and communities on health promotion and the development of a responsive and integrated service which will aim to treat people in communities rather than hospitals unless it is necessary'. 'A healthier future' outlined some of the challenges for public health in the coming years. For example, there would be 90,000 more people of pension age in Northern Ireland by 2025. The strategy also contained 30 initiatives on mental health, ten of which would tackle the upsurge in suicides across all areas and especially among young people.[218] 'A healthier future' also noted one of the most significant developments in the history of public health in Northern Ireland. In 2007 smoking would be banned in all enclosed workplaces, restaurants and bars.

New structures

The new decade brought more fundamental changes for health in Northern Ireland. In 2003, the Review of Public Administration concluded that the four Northern Ireland health boards would be dissolved and their functions assumed by new regional organisations. There would be a Regional Health and Social Care Board, a Patient and Client Council along with a Regional Support Agency. Most significantly, there would be a new Regional Agency for Public Health and Wellbeing.[219]

The rationale behind the review was to strengthen the ability of the Health Service to meet the challenges of implementing 'Investing for health' and address the priorities set out in the Executive's Programme for Government. It was intended that the creation of the new agency would strengthen the public health agenda at both local and regional level. Together with 'Investing for health', the overall approach would be to address the social determinants of health, health inequalities and continue to implement local solutions to local problems in a coordinated, multi-disciplinary fashion.[220]

The restoration of devolved government in 2007 meant that the reorganisation would proceed under a devolved minister. Michael McGimpsey, who replaced Barbre de Brún as Health Minister, said the proposed changes 'pave the way for a more cohesive and coordinated approach to health and social care and reflect my desire to see a service that is efficient and patient-centred with a focus on improving our overall health and wellbeing'.[221] The new Public Health Agency would work closely with the Health and Social Care Board and would have responsibility for health protection, health improvement and development as well as addressing existing public health issues. It would be governed by a chief executive with directors for public health, nursing and professions allied to medicine and operations. Assistant directors would be appointed for health protection, health and social wellbeing and service development and screening. The new agency was set to come into existence in April 2009.

New controversies and new diseases

In her annual report for 2000, Northern Ireland's Chief Medical Officer, Henrietta Campbell, noted that 'in many instances we were reminded that doctors were fallible and that the systems supporting them are, at times, weak and under-resourced and this can have tragic consequences'.[222] The early years of the new century were difficult for medical professionals, following a series of high profile controversies. It emerged that children who had died in the Alder Hey hospital in Liverpool had organs removed without parental consent. Harold Shipman, a GP, was found to have murdered his elderly patients for money. Other incidents, too, served to undermine trust in doctors and healthcare professionals.

In spite of this, and the widespread changes in the political framework, the basic work of public health continued. In 2000 infectious disease continued to be a major issue for health professionals. Hospitals came under pressure as the result of a particularly virulent outbreak of influenza A. This was despite the most successful vaccination campaign to date which saw an uptake level of 67%. Influenza again put pressure on hospitals in 2004 despite an uptake in flu vaccine of 73% among the over-65s. Moreover, the middle of the decade witnessed the emergence of a new and potentially more lethal strain in the form of Avian influenza. The spectre of a pandemic prompted the Chief Medical Officer to warn that such an outbreak could persist for up to five months, affect all age groups and cause a significant number of deaths.[223]

The effort to maintain levels of childhood immunisation was undermined somewhat by the high profile controversy over the MMR vaccine. Following an investigation by the Committee on the Safety of Medicine and the Joint Committee on Vaccines, MMR was declared safe. This was reiterated by subsequent findings of the World Health Organization and the Medical Research Council. The adverse media coverage of the controversy caused a dip in uptake levels, especially in England and the Republic of Ireland. In Dublin, an outbreak of measles led to two deaths.[224] In Northern Ireland, the efforts of a coalition of health professionals including health visitors, GPs and consultants in communicable disease control ensured that uptake fell nowhere near the level of 86% experienced in parts of England. Indeed, in the Southern Board the decline in uptake was minimal – from around 95% to 93%.[225] Infectious diseases, however, remained problematic and once again demonstrated their capacity to menace the health of the population.

The emergence of severe acute respiratory syndrome (SARS) also caused concern among health professionals along with a media panic. The disease, a variant corona virus, spread from its point of origin in Guangdong, China around the globe by air travel. Between March and July 2003 there were over 5,000 cases and 774 deaths. Learning from a serious outbreak in Toronto, Canada, and taking advice from WHO regarding the probability of a reoccurrence of the disease, a SARS taskforce was established.[226] The speed with which SARS spread through global air travel provided a salutary lesson for public health. 'We may live on an island', Brian Smyth at CDSC has pointed out, 'but we are by no means isolated'. On any given day there are 33 flights between Northern Ireland and international air hubs in England.[227]

However, it was not only the exotic that captured headlines in terms of infectious disease. Healthcare acquired infections at times dominated the health agenda with outbreaks of *C.difficile*, norovirus and methycillin-resistant *Staphylococcus aureus* (MRSA). None of these infections was entirely new. Indeed, MRSA was noted in health reports as far back as 1976. Nevertheless, the potential mortality of the illnesses and their high infectivity in hospitals made for sensational headlines and an outraged public. Questions regarding the cleanliness of hospitals were raised and the behaviour of hospital staff and other healthcare professionals came under intense scrutiny. In April 2004 the Department of Health Social Services and Public Safety introduced new control(s) assurance standards regarding the control of infection in hospitals.[228]

Health action zones

A key component of the public health strategy in the new century was the establishment of health action zones (HAZ). They were conceived as an attempt to directly address health inequalities and improve health and wellbeing in pockets of deprivation with a multi-disciplinary, community-led approach. The first was established in North and West Belfast in 1999. The philosophy was that in order to improve health and wellbeing and tackle inequalities in health it was essential to work with those who could actually influence the social determinants of health. It was also important to give a degree of ownership of the programme to the community by enabling local people to identify their own concerns and health needs.

The philosophy, if not the exact approach, is certainly recognisable from initiatives like the Moyard Health Profile and other community-based programmes. Modern health action zones, however, involve a much higher number of partners. Health professionals in Belfast, for example, were joined by officials from the Housing Executive, Education and Library Boards and Belfast City Council. It also benefited from existing collaborations like 'Healthy cities'. HAZs provided a framework in which to address not only traditional health concerns like the local environment, unemployment and lack of facilities but also some of the difficulties peculiar to Northern Ireland. In North and West Belfast, for example, the HAZ formulated a response to a feud among paramilitaries in the Lower Shankill which had led to the deaths of nine people and resulted in sudden and dramatic shifts in population. In the Ardoyne area 240 school children were denied access to their school through sectarian tensions. Both events played out within one square mile and are illustrative of some of the difficulties of developing a community approach in a divided society like Northern Ireland.[229]

By 2002 HAZs were established in all four board areas. The Northern Board's 'Northern neighbourhood project' focused on 14 urban and rural areas identified as experiencing particular need. Again, the programmes are community-led with an emphasis on lay participation in identifying the issues affecting health and wellbeing in the area. The board operates in conjunction with local councils, the Housing Executive, community groups and EHOs in addressing key themes of access to services, health promotion and educational improvement. Each neighbourhood has a community action plan covering services for young people, the needs of older people and environmental concerns. It has been essential for the success of this project and, indeed, all such initiatives that the community identifies the issues if people are to be equipped with the necessary knowledge and skills to prevent them getting ill and to address barriers to health both structurally and on an individual basis. Trust has proved a key factor in the progress of these schemes, especially in tackling the growing phenomenon of suicide.[230]

There are many similarities between the approach evident in 'Investing for health' and that of the health action zones. As John Watson noted in 2001 'the aim of the HAZ is to encourage the statutory, private, voluntary and community sectors to come together to identify need and implement agreed initiatives that will help reduce inequalities and improve long-term health and wellbeing'.[231] In 1999 a health action zone was established in the Armagh and Dungannon area of the Southern Board. Partnerships were set up among a variety of agencies to tackle issues identified by local people, among them the problem of rural isolation. In 2002, The Western Health Action Zone was established. It targeted urban areas under the Derry 'Healthy cities' programme but also looked to meet the needs of rural communities in the board area.[232] The inter-agency relationships established here would also form the basis of the 'Investing for health' partnerships in the area.[233]

Cross-border cooperation

Cross-border cooperation on health received renewed impetus following the Good Friday Agreement. 'Investing for health' offered the opportunity for mutually beneficial cross-border cooperation through the North-South Ministerial Council. Five areas were highlighted under 'Investing for health'. These were accident and emergency services, emergency planning, health promotion, cancer research and health technology.[234]

However, such cooperation on health was not new. In 1992, the Ballyconnell Agreement was signed by the Republic of Ireland's North Eastern and North Western Health Boards and Northern Ireland's Western and Southern Boards. The agreement created a new body, Cooperation and Working Together (CAWT) which had for its primary aim the improvement of the health and social wellbeing of their residents living along the border. The agreement was revised in 1998 following the signing of the Good Friday Agreement and again in 2002 following 'Investing for health'. Programmes undertaken by CAWT in border communities included health promotion, accident prevention and initiatives to curb smoking, acute services development, mental health and parenting projects.[235]

Cross-border cooperation was also a guiding principle of the Institute of Public Health in Ireland. The institute was established jointly by the departments of health in Northern Ireland and the Republic of Ireland. Under the directorship of Jane Wilde it had been providing public health intelligence on an all-Ireland basis since the 1990s. For example, it carried out a study of the cause of death for people under the age of 65 for the period 1988–1998. The institute provided statistical confirmation of the link between poverty and ill-health in Ireland. It found that those living in the poorest circumstances had much higher death rates for all causes. For cancer the rate was 100% higher and almost 200% higher for respiratory illnesses.[236]

In 2006, the institute proposed to strengthen the health intelligence apparatus by establishing a population health observatory in Ireland. Similar initiatives existed in France and in parts of the United Kingdom. The purpose of the observatories was to gather accurate and relevant information about health and disease. 'Investing for health' charged the institute with developing plans for a comparative monitoring of trends in health, determinants of health and health inequalities North and South, and also relative to other EU countries. Thus, it proposed the creation of the observatory to meet this challenge.[237] Leadership was also an important component of the 'Investing for health' strategy and the institute developed the 'Leadership for building a healthy society' initiative. The programme aimed at developing a network of leadership made up of professionals from different organisations and sectors from across the island of Ireland.

The environmental component

As with public health medicine, environmental health, as a discipline, found itself in a state of flux in the new century. It was not only a changing set of priorities or the movement away from traditional roles that had begun in the 1990s. The challenge for environmental health was to continue to develop amid the shifting sands of devolution, the creation of new agencies and the development of a new regional public health strategy.

The functions of environmental health did not become fragmented or diminished among new statutory agencies. In April 2000, for example, The Food Standards Agency was established in Northern Ireland. It was given the remit of consumer and public protection with regard to food and would offer advice to ministers and develop policy. It would, however, only audit the enforcement efforts carried out under local councils with regard to food hygiene. Environmental health officers would remain the primary investigators of food related disease outbreaks. Similarly, housing inspections would continue despite the dwindling number of unfit homes and the massive expansion in new housing development. In many cases the traditional enforcement role of environmental health persisted.

Nevertheless, there was a concerted effort to redefine the discipline to meet the challenges of the new century. In 2002 the Chartered Institute of Environmental Health and the Health Development Agency collaborated to produce a ten-year vision. *Environmental health 2012* argued that environmental health made a fundamental contribution to the maintenance and improvement of public health and in improving quality of life and wellbeing.[238] It also welcomed the shift in public health policy towards local action aimed at reducing health inequalities at a community level. It warned that the discipline could no longer afford to concentrate solely on the enforcement function because the equally important skill set on health improvement would be lost. This was essential as legislation and government initiatives now required local authorities to fully participate in strategic partnerships on health. Environmental health professionals would work closely with other partners in efforts to address health inequalities. For the future, the discipline would proceed under a number of key themes including improving quality of life, environmental sustainability and in an integrated approach to public health.[239]

As in the 1990s, there was concern in the profession over a growing separation between environmental health and public health medicine. Indeed, this was one of the findings of the *Hanna report* on environmental health in England in 2006. In Northern Ireland, however, the traditionally strong links between these two aspects of public health persisted. The wider relationship between the environment and the health and wellbeing of the public was acknowledged at government level and environmental health would play an integral part in the devolved administration's 'Investing for health' strategy.

The appointment of a Chief Environmental Health Officer for Northern Ireland (CEHO) in the restructured Department of Health, Social Services and Public Safety did much to maintain close cooperation. The role of the CEHO was to provide essential advice to the Department on a wide work area characterised by an ever-changing and eclectic group of issues. The post also provided an essential link between the Department and Northern Ireland's 26 district councils as well as the four group environmental health committees and Belfast.[240]

At a regional level, 'Investing for health' set key targets on the environment. For example, targets were set on air quality with reductions sought in major pollutants like benzene, carbon monoxide, lead, nitrogen and sulphur dioxide.[241] At local level, councils and environmental health officers were essential partners in delivering the 'Investing for health' agenda. Indeed, environmental health was already playing a key role in all of the existing health partnerships like 'Healthy cities' and the health action zones. 'Investing for health', in some respects, merely confirmed and enhanced a role which was already being successfully carried out. It was duly noted that many of the environmental functions undertaken by local councils had a direct bearing on health and on the social determinants of health.[242]

The report compiled by Brian Hanna for the Chartered Institute of Environmental Health in 2006 remarked on the positive developments in post-devolution Northern Ireland in terms of environmental health. It noted that in England 'many civil servants in many different departments of state have responsibility for some aspects of the service, none seem to have a brief for it as a whole'.[243] In Northern Ireland, by contrast, 'the recommendations and indeed the tacit acknowledgement of a clear role for environmental health practitioners within the future public health function… has been achieved by EHO advice and input into the process on a number of fronts'.[244] The new century may not have witnessed the transfer of the public health function to local government as envisaged by *Agendas for change* in 1996 but the link between public health medicine and environmental health remained undiminished by devolution. Indeed, in the multidisciplinary approach, regionally and locally, of 'Investing for health', that relationship has become inextricable.

Efforts, threats and challenges

In many respects the first decade of the twenty-first century has delivered a series of significant new challenges for public health, and not just in terms of disease and illness. The attacks on the World Trade Centre in New York on 11 September 2001 brought to the western world the phenomenon of indiscriminate suicide attacks aimed at mass casualties, destruction or disruption. In a country that had experienced a civil conflict for over 30 years, a certain amount of emergency and major incident preparedness could be expected. This has certainly been the case. However, as Henrietta Campbell pointed out in 2002, the spectre of suicide bombings represented a new and emerging public health threat. Especially when combined with the equally new phenomenon of bioterrorism as illustrated by the spate of attacks using anthrax spores in the United States. In Northern Ireland over 60 hoaxes involving white powder had been investigated.[245]

In the aftermath of September 11 and the anthrax scare the Department of Health Social Services and Public Safety moved to strengthen its capability to respond to major incidents. Antidotes to various chemicals were procured along with supplies of antibiotics and Hazmat equipment. Plans were drawn up for selective inoculation against smallpox. An emergency medical assistance and response team was established to provide a multi-disciplinary team to manage casualties and to augment the hospital response to large-scale disasters.[246] The civil contingencies movement had been growing since the 1990s amid fears regarding the potential for loss of life and mass disruption from terrorism. Indeed, the review of public health function called for nothing short of a regional approach to emergency preparedness linked in with wider UK and EU planning.[247]

The changing climate offered the prospect of flooding and other natural disasters. It also meant the possibility of new diseases spreading from warmer climates and threats to the food chain.[248] The fact that emergency planning had become part of the public health function was confirmed in the Civil Contingencies Act of 2004. A series of emergencies in the United Kingdom and elsewhere illustrated the need for a planned and coordinated response. The Civil Contingencies Act contained the emergency preparedness duties for local responders in Britain and the responsibilities set out in the Northern Ireland Civil Contingencies Framework. This approach has codified good practice and defined expectations on organisations in the public sector. The need for a coherent strategy has been made all the more urgent by the nature of modern society, which has become more interconnected than ever before. For example, most hospitals operate on a 'just in time' or an on-demand basis for food, medical supplies and fuel. The impact on this system of a shortage of delivery drivers due to influenza would be catastrophic.[249]

The new century also witnessed a major population shift in Northern Ireland both in terms of numbers and ethnicity. All the boards and allied agencies needed to adapt to an influx of workers and immigrants from diverse and disparate countries. In the Southern Board, for example, a rising birth rate was compounded by an influx of European and cross-border workers. There was a certain amount of additional pressure on resources. However, the arrivals from Portugal and Eastern Europe have in no way constituted a drain on resources. The experience of the Southern Board has been that the vast majority of immigrants to the area have been of working age and in comparatively good health. There have, however, been some concerns regarding communicable disease. Migrant workers have arrived in some instances from countries where illnesses like tuberculosis are prevalent and from countries without immunisation programmes.

The rate of immigration has increased year on year since 2000. In 2003 local social security offices in the Southern Board alone received almost 5,000 applications for National Insurance numbers; 60% of these came from just three countries – Portugal, Lithuania and Poland. Much has been done by the Southern Investing for Health Partnership including the South Tyrone Empowerment Programme which provides interpreters. Migrant support centres have also been established in towns like Dungannon and Portadown.[250]

For the Health Promotion Agency, the priority has been making information and health advice available in as many forms as necessary to meet the needs of the immigrant community. It has been found that new audiences need a specifically tailored message. Eastern Europeans, for example, have higher patterns of smoking and a lack of familiarity with smoke-free environments. It has been a delicate balancing act on the part of health professionals to foster inclusion and deliver messages on health to immigrants without encroaching on their culture or community.[251] Other efforts on inclusion and health have concentrated on settled communities like the Chinese and Indians, and also on Northern Ireland's Traveller community. These represent sections of Northern Ireland's society that may have particular needs or which may have been marginalised or cut off from mainstream health provision in the past.[252]

As in the three previous decades examined here public health has evolved and adapted through shifting priorities, changing governments and administrative structures. 'Investing for health' represents the embodiment at regional level of the kind of local cross-discipline, multi-sectoral approach that had begun in the 1980s. The positive effects, or otherwise, of the strategy remain to be seen. As Ian Carson, Acting Chief Medical Officer pointed out in 2005 'due to the nature of many of the 'Investing for health' targets significant progress may not be evident for a number of years in areas such as health inequalities, mental health and obesity'.[253]

In April 2009 the four Northern Ireland health boards ceased to exist. For over 30 years the boards shaped healthcare in Northern Ireland and their functions would now be assumed by regional bodies. Public health would become the responsibility of the regional Public Health Agency together with partners across the public, community, voluntary, private and government sectors.

06

Past, present and future

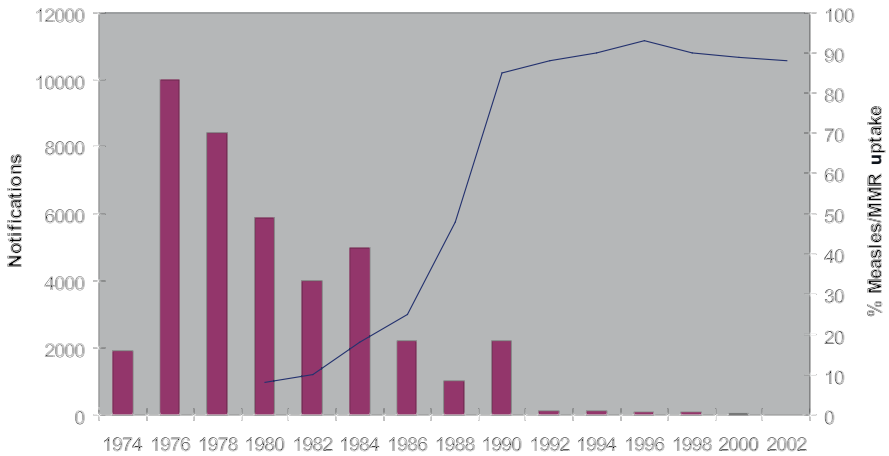
The clinical sciences building at the Royal Victoria Hospital, a centre that has played an important part in medical teaching in Northern Ireland.

Public health professionals reflect on four decades of the service.

Public health remains a discipline that is constantly evolving. This has been a consequence of striving to address a wide set of problems and adapt to changing government policies and administrative structures. It has also been receptive to ideas and approaches in the wider world, which is evident in the growing part played by the World Health Organization in setting the public health agenda. The 36 years since the foundation of the four health boards have seen some notable successes. Among them has been a complete change in attitudes towards childhood immunisation in Northern Ireland from having one of the lowest uptake rates to one of the highest in the United Kingdom. The development of the immunisation effort and its subsequent effect on outbreaks can be seen in Figure 5.

Public health efforts have contributed to a transformation in the quality of housing, in air quality, and through commissioning have established the pattern for much of Northern Ireland's acute services – hospitals, mental health and maternity units. In the early years of the new decade public health medicine had significant input into implementing the recommendations of the Campbell Review which led to a change in the delivery of oncology services. Like with renal services in the 1990s, this meant increased local access and improvements in quality.

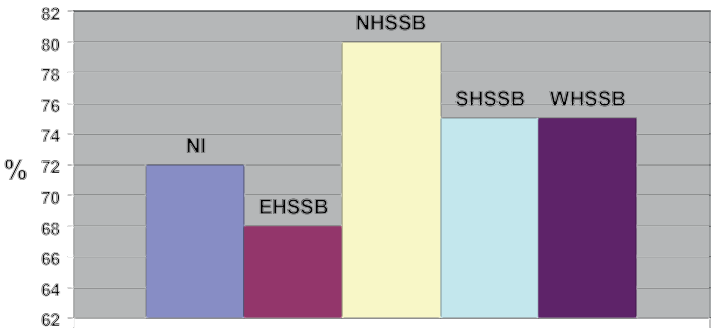
Figure 5.



Measles: notifications and vaccine uptake 1974–2003 Northern Ireland. (Source: CDSC)

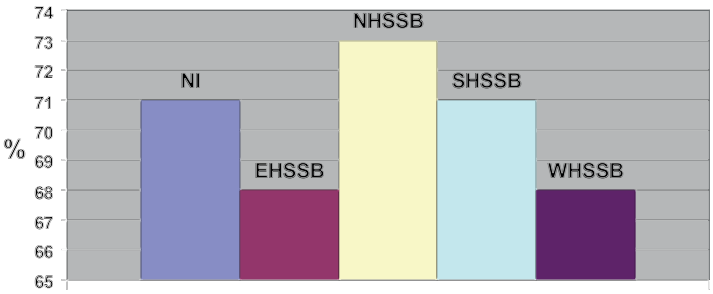
Services often taken for granted today, like screening for breast and cervical cancer, have had to be constructed and implemented from scratch. The uptake of screening for cervical and breast cancer has continued to cause concern despite the overall rate having risen for cervical screening from 65% in 1996 to just under 70% in 2001. Breast screening uptake remained steady at around 75%.[254] Uptake rates for Northern Ireland for both programmes for 2002/3 can be seen in Figure 6 and Figure 7.

Figure 6.



Breast screening uptake rates 2002/3. (Source: CMO report 2004)

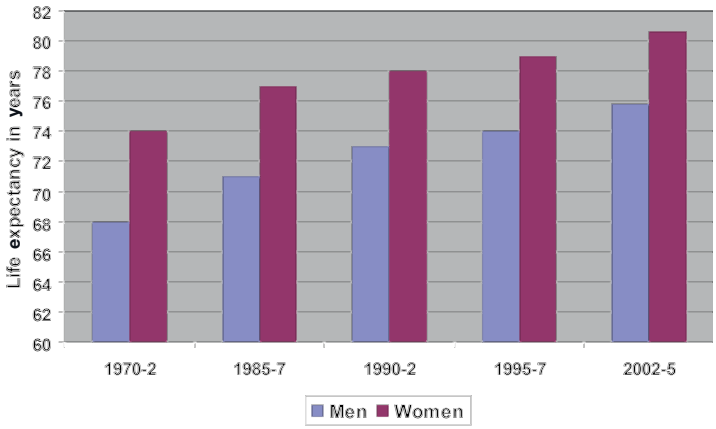
Figure 7.



Cervical screening uptake rates 2002/3. (Source: CMO Report 2004)

Other aspects have been more difficult to quantify but are equally illustrative of the potential for public health to make a difference in the lives of individuals and communities: the relationship, for example, between health visitors and several generations of the same family. Many of the targets set for Northern Ireland, both in regional strategies and by WHO were met. For example, the goal of 90% by 1990 on childhood immunisations was realised. Other targets have proved more elusive, especially on heart disease and teen pregnancies, despite consistently downward trends. Nevertheless, life expectancy for both men and women in Northern Ireland has increased steadily (Figure 8).

Figure 8.



Life expectancy in Northern Ireland 1970–2005. (Source: NISRA/CMO annual reports)

Devolution

Northern Ireland's devolved government remains new and unfamiliar territory. Thus, the eventual success of devolution in Northern Ireland has met with a variety of responses from public health professionals, especially when asked whether this had made their jobs easier or more difficult. Similarly, there were differing experiences regarding working with a locally elected health minister for the first time and with members of the new Assembly.

Devolution has offered the opportunity for the community in Northern Ireland to take ownership of its Health Service. Gabriel Scally has argued that the violence of the past 'held back for some considerable time discussion and debate about those key determinants [of health] because all of the political space, all of the media space…was taken up by the Troubles'.[255] The view that devolution offers an opportunity has been echoed by Michael McBride particularly the opportunity for discussion on issues like health and education. The post-devolution period has involved a degree of political maturation which is still ongoing. Democracy anywhere is a good thing and the Executive has placed public health high on its list of priorities. *Investing for health* is 'the best public health document in the English language'.[256]

At a local level, too, there have been positive experiences of devolution, particularly regarding the issue of ownership. Democracy has been very important to health and communities have begun to ask questions and to understand the links between health and regeneration. The political vacuum created when the Assembly collapsed after 2002 was very damaging.[257] Moreover, there have been links forged through initiatives like health action zones between communities previously separated by sectarian tension and violence.[258]

However, a recurring issue among some public health professionals was concern that a conflict exists between the ability of local politicians to make difficult decisions and their desire to be re-elected. It is the idea that politicians have a short-term agenda that only stretches as far as the next election. There was some degree of scepticism and indeed fatalism regarding the position of health post-devolution expressed during interviews. 'It used to be that our local politicians at all levels', one said, 'sat in the stands and criticised while we were down on the pitch playing. Now they are down on the pitch beside us but I think they still don't understand the game'.

It has not been the idea of devolution that has caused difficulties but rather its execution. In the first Assembly, for example, the Democratic Unionist Party inundated the Sinn Féin Health Minister Barbre de Brún's office with obstruction-causing requests for information. Now the DUP are full partners, working alongside Sinn Féin daily as both are now the majority parties in the Executive and Assembly. It was a complaint that because of the history between the parties here and their constituencies that a lot of questions are loaded from a party political view rather than for the good of the community.

Operating under a direct rule minister had its own problems. True, the decision-making process was much quicker, especially in relation to commissioning new hospitals and services.[259] However, direct rule ministers had always been disconnected to a greater or lesser extent from the community. They were unelected and unelectable in Northern Ireland and therefore not accountable to the local population. The result was dependence on the advice of civil servants and a certain remoteness from the consequences of ministerial decisions. For example, the last Conservative Health Minister, Malcom Moss ordered a 3% reduction in health spending. The only way to accomplish this was to remove 3% capacity from the system. The result was that waiting lists rose and board officers, and not the minister, were blamed in the local media.

Dissolution

There was general recognition and appreciation of the positive role played by the four health boards and their achievements. However, the consensus among public health professionals was that it was time for change. Some concerns were expressed. It was felt, for example, that the dissolution of the boards and the subsequent shedding of staff would rob the service of a reservoir of talent and experience. The creation of the Regional Public Health Agency has been broadly welcomed, though with some reservations.

The Agency, for example, offered the prospect of a unified approach but there also needed to be sensitivity to local implementation and local initiatives.[260] 'I would still feel in my heart', Brian Gaffney said, 'that even if we establish a Regional board there will have to be below that a local or more community-based approach that may well replicate the functions of the four boards'.[261] Gathering all of public health medicine under one roof was viewed as a good idea by Brian Smyth as it offered great opportunities for specialisation and for training.[262] For Philip Donaghy, the four boards had long outlived their usefulness and were producing unnecessary duplication of work that 'quite often in a small place like Northern Ireland, one or two people could do'.[263] The ending of the boards and the creation of the new agency offers, in the opinion of Gabriel Scally, the opportunity to produce a more effective and rational approach to doing things. 'I think the duty of public health', he said, 'must always be to seize every possible opportunity to improve the health of the population and to use whatever structures there are available to do so'.[264]

The future

The phenomenon of the media setting the popular health agenda now and, probably in the future, has put pressure on public health staff. Moreover, society now has access to unprecedented levels of information on health. In recent history, both have conspired to produce detrimental effects on the public health effort. The controversy over MMR, for example, tapped into a vein of popular suspicion or disquiet regarding modern medicine and reduced uptake levels. Admittedly, this affected England more than Northern Ireland but unsubstantiated health scares did put health professionals under unnecessary pressure.

Moreover, media-led campaigns surrounding the provision of drugs like Aricept for Alzheimer's or Herceptin for breast cancer have sometimes placed public health doctors in a difficult position. 'There are decisions you are being asked to make', Diane Corrigan has said, 'on the grounds of economics and cost-effectiveness weighed against very eloquently made cases by individuals who have horrible diseases and who believe very strongly that those cases could be improved a lot'.[265] Equally, a culture of blame has grown up in the media and in society when something goes wrong and this has been especially true with regard to health.[266]

The sound-byte approach of the media to health has also proved difficult. 'We tend to be light entertainment to the media', Philip Donaghy complained, 'most of the time stocking-fillers going on between the main meaty bits of the news'.[267] When addressing health issues, the tendency has been towards sensationalism and blame. Healthcare associated infections attract headlines like 'killer bug' and allegations of dirty hospitals and negligent staff.[268] It has been difficult to address complex matters like infectious disease and even macro issues like global warming without scaremongering and hyperbole. The challenge remains for public health professionals to harness the better aspects of the information age to deliver credible health information and informed debate.

Warnings regarding pandemic influenza have proved timely. Infectious diseases continue to be unpredictable and to menace the health of the population. As planning was being undertaken for Avian influenza, an outbreak of Swine flu originating in Mexico spread quickly across the globe via air travel. Other infections, too, will remain on the public health agenda. Sexually transmitted diseases continue to rise and healthcare acquired infections continue to make the headlines. As has been pointed out, pathogens will always ruthlessly seek out and exploit weaknesses in defences.[269]

The problem of getting the new Public Health Agency up and running figured prominently among the future challenges identified by public health professionals. This was especially true given the prospect of a future funding climate which is looking increasingly cash-starved. The view was also expressed that public health needed to 'grasp the nettle' of publicising itself and of convincing both politicians and the public of the benefit and necessity of investing money in the long term. Nigel McMahon viewed future public health challenges – climate change, the pace of modern life, the environment – as many and varied. 'I don't think I would single out one issue and say that's going to be the next big thing', he said, 'I see the challenge almost as the sheer complexity of it all'.[270]

A mixture of old and new concerns regarding behaviour and lifestyle will also make the public health agenda in the future. Teenage pregnancies, sexual health, smoking, drug and alcohol abuse will all figure prominently. Mental health, too, remains a concern, especially the rising levels of suicide among young people. In terms of lifestyle, John Watson stated 'the future of public health scares me because the ability of the individual to take responsibility for their own health seems to be diminishing and a huge example of that is the fact of the obesity issue'.[271]

Four decades of public health

Responses were also varied among public health staff when asked what they thought was the most significant development over the last 36 years. Several respondents nominated the smoking ban as having the potential to make the most difference in people's lives. Others mentioned the compulsory use of seatbelts and the success of the lay health worker or 'Investing for health'. Environmental health officers chose the successful enforcement of clean air legislation and the transformation in housing quality in Northern Ireland. James McKenna chose the establishment of the Health Promotion Agency as being an invaluable asset to the public health effort. Others chose something that remained outside the public health remit. Northern Ireland's Troubles had a tremendous impact on the health and wellbeing of the population that went beyond death and injury. The stresses and strains of four decades of political and sectarian violence could only take a massive toll on the mental health of the community.

Over four decades, public health in Northern Ireland has burgeoned to become a multi-faceted, multi-disciplinary approach to improving the health and wellbeing of individuals and the community. It has managed to evolve without jettisoning its traditional functions and priorities. The environment still matters in terms of clean air, water and good housing. Health protection continues with efforts to tackle infectious diseases. Over the years, however, new strategies and approaches have been added to the overall effort. Health education and health promotion have been joined by the rise of the community development approach to public health. Efforts at all levels have included a focus on directly addressing the social determinants of and inequalities in health. This approach is at the core of the regional strategy of 'Investing for health'.

07

Conclusion

The County Hall building in Ballymena has provided accommodation for a range of public services over many years. It currently hosts the Northern Offices of the Health and Social Care Board and Public Health Agency and was previously home to the former NHSSB.

The 36 years of public health under the board system in Northern Ireland saw a series of problems and achievements. The first problem has been adapting to massive upheavals in health and public administration in successive decades. The replacement of the county health system with the boards in 1973 was followed by structural changes and health service reforms in the 1980s and 1990s. Fundamental restructuring has occurred in recent years with dissolution and the creation of the Public Health Agency and other regional bodies to take over board functions. There is a degree of historical symmetry surrounding the establishment and dissolution of the four health boards. The language of change – integration, cohesion, effectiveness – rings familiar. Both reorganisations proceeded against a backdrop of economic uncertainty.

The changes to the administrative structures within which the public health service has been delivered have sometimes proved detrimental. Acheson found that the reorganisation of the service in the 1970s and 1980s had damaged the public health effort which was, in many respects, rejuvenated by subsequent reforms. There was also the challenge of responding to the findings of landmark reports such as Acheson, Black and Baird. Different governments imposed shifting priorities and funding levels. There was also the need to adopt and meet targets set by the World Health Organization.

A further problem has been adapting to the changing social conditions in which public health has been delivered. Improvements in healthcare, housing and the environment have produced a changing disease profile. As the threat to health from some diseases, like tuberculosis and diphtheria, have diminished others have arisen. Societal problems of poor diet, lack of exercise, smoking and drug and alcohol abuse continued to challenge. Sexual health was and remains a difficult issue for Northern Ireland.

In response, public health adopted a series of radical and innovative initiatives in Northern Ireland. This has included health profiling and community development programmes which began in the 1980s, evolving and spreading across all board areas by the 1990s. Health promotion has also been an important aspect of efforts to change individual and community behaviour. Of crucial importance, too, has been the close relationship between public health medicine and environmental health. This cross-disciplinary approach has been validated most recently at regional level by 'Investing for health'. This willingness to cooperate across disciplines and to embrace new developments from the wider world has been pivotal in the evolution of public health in Northern Ireland and the key to much of its success.

From 1973 to the present, life expectancy in Northern Ireland has increased year on year for both men and women. The incidence of ischaemic heart disease has declined. Societal attitudes towards immunisation are today unrecognisable from those in the early 1970s. Inoculations against other diseases like Hib and HPV have been added to the successful immunisation effort. Sanitation, air, water and food standards are the highest they have ever been and a watershed has been reached in efforts against both heart disease and cancer with the success of the ban on smoking in enclosed spaces in 2007. Perhaps the most significant development for public health has been in recognising good health as a fundamental human right. That health means more than the absence of illness. That only through a many-layered approach can the necessary steps be taken to effect changes in the totality of wellbeing at a societal level.

Public health is a discipline that can never stand still. Each decade throws up new challenges, old problems linger and priorities change. It involves the effort to protect the public, change individual and community behaviour, shape and maintain for the better the spaces they occupy and influence the direction of government. It remains sometimes an angry and outraged discipline that has enshrined good health not only as an unalienable human right but also as a measure of social justice.

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Paul Darragh	CPHM, Eastern Board	5 February 2009
Philip Donaghy	CPHM, Eastern Board	9 December 2008
Brid Farrell	CPHM, Southern Board	28 November 2008
Brian Gaffney	Chief Executive, HPA	18 November 2008
Pauline Ginnety	Health Education Officer (Moyard)	30 March 2009
Angela Greer	CCDC (retired), Eastern Board	25 March 2009
Maureen Griffith	Assistant Director, Nursing, Northern Board	29 January 2009
Brian Hanna	Chair, Local Government Commission	3 February 2009
Frank Kee	CPHM, Northern Board	20 December 2008
Margaret Kelly	Chief Nurse, Western Board	11 March 2009
Paula Kilbane	Chief Executive, Eastern Board	24 November 2008
Janet Little	DPH (Acting), Eastern Board	24 November 2008
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[220] Review of the public health function, pp. 6–8.
[221] Northern Ireland Executive briefing 2008
[222] Health of the public 2000, p. 1.
[223] Health of the public, 2004, p. 71.
[224] Health of the public, 2000, p. 61.
[225] Margaret Kelly, Mar. 2009. See also Building healthy futures 2000, p. 61.
[226] Ibid., p. 79.
[227] Brian Smyth, Jan. 2009.
[228] Health of the public, 2004, p. 75.
[229] Mary Black, Nov. 2008.
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[236] Health of the public, 2001, p. 22.
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[239] Ibid., p. 7-10.
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[243] Hanna report, p. 5.
[244] Ibid., pp. 6–7.
[245] Health of the public, 2002, p. 2.
[246] Ibid., p. 77.
[247] Review of the public health function, 2004, p. 12.
[248] Ibid., p. 43. See also Gary McFarlane Jan. 2009.
[249] Anne Wilson, Dec. 2008.
[250] Investing for health annual report, 2003, p. 26.
[251] Brian Gaffney, Nov. 2008.
[252] Maureen Griffith, Jan. 2009.
[253] Health of the public, 2005, p. 20.

Past, present and future
[254] Health of the public, 2001, p. 46.
[255] Gabriel Scally, Dec. 2008.
[256] Michael McBride, Feb. 2009.
[257] Mary Black, Nov. 2008
[258] Collette Rogers, Feb. 2009.
[259] John Watson, Nov. 2008. Also James McKenna, Oct. 2008.
[260] Mary Black, Nov. 2008.
[261] Brian Gaffney, Nov. 2008.
[262] Brian Smyth, Jan. 2009.
[263] Philip Donaghy, Dec. 2008.
[264] Gabriel Scally, Dec. 2008.
[265] Diane Corrigan, Jan. 2009.
[266] John Watson, Nov. 2008.
[267] Philip Donaghy, Dec. 2008.
[268] Brian Smyth, Jan. 2009.
[269] Ibid.
[270] Nigel McMahon, Jan. 2009.
[271] John Watson, Nov. 2008.

Appendices

Appendix 1. Chief Administrative Medical Officers and Directors of Public Health (1973–2009)

Eastern Health and Social Services Board

John Andress	1973–74	CAMO
James Taggart	1974–81	CAMO
James McKenna	1981–88	CAMO
Gabriel Scally	1988–93	DPH
Angela Greer*	1988–93	DPH
Janet Little	1993–94	DPH (Acting)
Philip Donaghy	1994–95	DPH (Acting)
David Stewart	1995–2007	DPH
Janet Little	2007–2009	DPH (Acting)

**Angela Greer deputised on many occasions as CAMO*

Northern Health and Social Services Board

James McKenna	1973–1981	CAMO
John Watson	1981–1988	CAMO
John Watson	1988–2009	DPH

Southern Health and Social Services Board

Seamus Maguire	1973–87	CAMO
Seamus Maguire	1988–89	DPH
Paula Kilbane	1989–92	DPH
Anne Marie Telford	1992–2009	DPH

Western Health and Social Services Board

N. E. Gordon	1973–1985	CAMO
Bill McConnell	1985–1988	CAMO
Bill McConnell	1988–2009	DPH

Appendix 2. Chief Medical Officers of Northern Ireland (1973 to present)

T. T. Baird	1973–1978
R. J. Weir	1978–1988
James McKenna	1988–1995
Henrietta Campbell	1995–2006
Ian Carson	2006 (Acting)
Michael McBride	2006 to present

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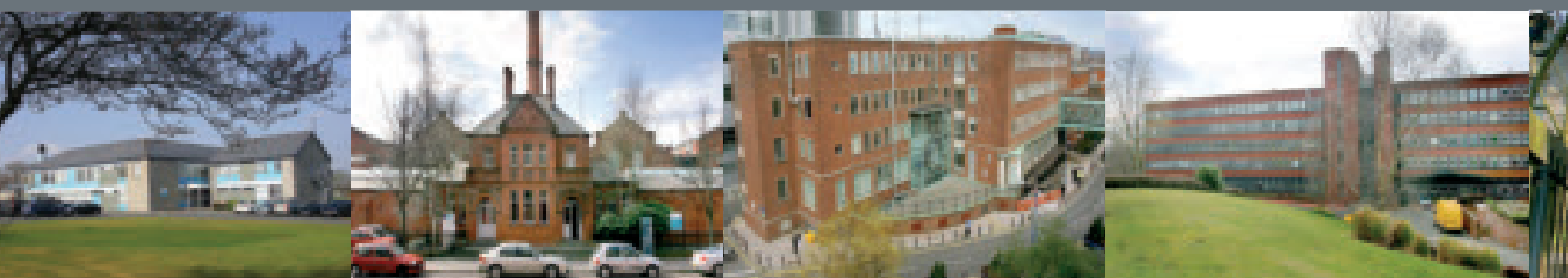
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