BRITISH ACADEMY COMMISSION: COVID AND SOCIETY

THE HISTORY OF PUBLIC HEALTH CRISES

GOVERNANCE AND TRUST

CENTRE FOR HISTORY IN PUBLIC HEALTH, LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE

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KEY MESSAGES

Governance:

- Levels of governance have helped shape the response to public health crises in the past.
- The role of politicians has been important, and crises have been used for political purposes.
- Arm's length and other bodies have played an important role in recent public health crises, often reconstituted for political purposes.
- Modes of scientific advice have changed, as has the role of scientific advisors.
- Crises are seen and remembered in a standard way which underpins the next crisis response: from 'delay' to 'over-reaction'.
- There are limits to planning: elements of public health crises are always unpredictable.

Trust:

- There have long been differences between expert and public conceptions of health risks.
- Past public health crises can have a negative impact on levels of public trust in relation to current ones.
- Levels of trust in public health measures and levels of trust in government are linked.
- 'The public' is not one entity, different publics may have different levels of trust.
- Health education campaigns can have unpredictable effects on public trust.

INTRODUCTION

In order to understand the impact of recent public health crises it is important to take a longer view of the role of public health in Britain and how it has evolved. In this report we consider the twin issues of governance and trust and explore how these were impacted by different public health crises in the late twentieth and early twenty-first centuries. We analyse a series of case-studies, drawing out the challenges, opportunities and long-term implications presented by each. Collectively, these examples demonstrate that whilst public health crises undoubtedly present significant difficulties for government, the wider public, and the relationship between these, these are also moments which offer potential for beneficial change.

The report begins with a brief overview of the historical context to the development of the governance of public health in Britain, and the changing nature of public trust in relation to public health. The main body of the report is divided into two main sections. First, we present an analysis of governance in relation to public health crises. We consider two key examples: HIV/AIDS in the 1980s, and Swine Flu in 2009-10. In the second section we turn our attention to trust and public health crises. We look at three broad areas – health surveys, vaccination, and health education – and we examine two different examples for each. We conclude the report with some reflections on the broader implications of these specific examples.

CONTEXT: GOVERNANCE AND TRUST IN THE DEVELOPMENT OF PUBLIC HEALTH IN BRITAIN

Public health initially emerged as an arena of activity in response to the problems of industrialisation and urbanisation in the nineteenth century. Cholera pandemics which swept globally were major motors for action, but behind this also lay the fears of infection of middle-class society by infection among the labouring poor. Opposition in the middle of the nineteenth century to the 'despotism' of the central state undermined early public health institutions in Britain, which developed subsequently at the local level. The emergence and maintenance of public trust was central to the effective delivery of public health initiatives. Trust formed part of the social capital inherent within civic development and the introduction of municipal health amenities in nineteenth century Britain.[1] The universal appointment of a local medical official, the Medical Officer of Health (MoH), came after the 1872 Public Health Act. From the late 1880s, these local government officials were enforcing notification and isolation in the case of infectious disease. [2]

The MoH remained responsible for public health at the local level for over a century - into the 1970s. In the inter-war years, public health doctors in Britain substantially increased their powers and ran a widening range of services provided by local authorities. These services were confidently expected to provide the basis of an eventual national health service. In the event that came about rather differently. Historians have spent much time in discussing the role of public health and the general consensus of opinion currently is that running services was not a diversion for public health and that some areas spent substantially on public health programmes in the inter-war years.[3]

After the war, public health services remained in local government but the focus of the new National Health Service was on hospitals and the GP service. Public health dealt with infection control, but increasingly much of its work after the 1960s was on chronic disease and issues such as smoking, heart disease and obesity. This was part of what was called the 'epidemiologic transition' in which epidemics of infection were replaced by degenerative and chronic diseases as major causes of death. It was confidently believed that the age of infectious disease was over.

By the early 1970s, however, doubts about the successes of biomedicine were beginning to set in. Intellectual attacks on the power of the medical profession, the supposed victories of biomedicine and public health, and high-profile healthcare scandals undermined the unquestioning acceptance of medical authority. A weak global economy and the rising costs of healthcare also raised questions about the value for money of some treatments and approaches. At the same time, patients and the public were demanding more say in their own treatment and that of others.[4] Individual and public trust in health systems and health professionals could no longer be taken for granted.

Alongside changes in the dynamics of public trust, there were also changes in the location and parameters of public health services. In the early 1970s, there was a move stimulated by the report of the Seebohm committee, to initiate a new role for public health in what was called 'community diagnosis'. Public health doctors, previously Medical Officers of Health, moved into the NHS as consultant community physicians. This role did not operate effectively and public health was side-lined within health services.[5] The coming of HIV gave public health, as we see below, an enhanced role. HIV also made it clear that the age of epidemics was far from over.

How did such crises affect the governance of public health and the character and nature of public trust?

1. GOVERNANCE AND PUBLIC HEALTH CRISES

The systems of public health government that had evolved over the course of the late twentieth century were put to the test by a series of crises. Here we explore the impact of HIV/AIDS in the 1980s and Swine Flu in 2009.

1.1HIV/AIDS 1980S

Overview

HTLVIII (as it was at first called) initially appeared in the US, Africa, and Haiti. It arrived in the UK in a visible way in 1982 with small numbers of cases appearing in the London hospitals, often through the GUM/STD route. Initially risk appeared to be concentrated within the gay community, but knowledge of transmission through the blood and through injecting drug use led to fears of a national crisis. Harm reduction tactics (condoms, needle exchange) and mass advertising were called into play. The anticipated epidemic did not happen and HIV/AIDS ceased to be a major issue in the UK, although this is not the case in African and Asian countries where it continues.[6]

Challenges

These were many. Infectious epidemic disease was not the standard public health model: this was focused on chronic and lifestyle disease. The unexpectedness of the disease and inevitable death within a short space of time through lack of treatment or vaccine was totally new, as was the potential threat to the whole population.

Fears of the overwhelming of health services and facilities and society were rife. Discussions of how to respond drew on issues of human rights - the tensions in health responses between individual liberty and coercive control of the whole population. The ‘gay plague’ characterisation in the media gave way to a generalised fear of infection.

The role of public health was muted because of its location within the NHS and poor track record since the relocation of the 1970s. Other health disciplines took the lead, primarily genito-urinary medicine, virology and immunology, with infectious disease in Scotland.

Getting buy-in from politicians was difficult but was eventually achieved by the CMO and by pressure from interested civil servants at the highest level. ‘Delay’ on the part of politicians was discussed and attributed to anti-gay prejudice but challenged by one historian who argued that this was a characteristic response of government to crisis.[7]

Messages to the public were disputed and there were fears of government control of the media, especially the BBC.

Testing and screening came on the agenda but there was much discussion of the implications of testing and how it should be done. Screening/testing of health care workers was a controversial issue since it implied they were conduits of infection.

Later, after the crisis response of 1986-7/8, there was a fear within government that the response had been an overreaction. It was nevertheless presented as a success.

Later spread of the infection saw black Africans involved but this was never publicly discussed until much later (during the Brexit campaign by a UKIP MP) for fear of stigma.

The international response was an important one. The WHO set up its Global Programme on AIDS in 1987, led by the American Jonathan Mann. This was central to the dissemination of a standard model of response globally which stressed human rights. Sir Donald Acheson, the British CMO, was a key figure at the international level and this style of response also drew on the British response to the crisis. European mechanisms were important but Europe as a governmental organisation had less of a public health role in the 1980s.

Opportunities

The crisis was an opportunity to achieve changes in governance which might not otherwise have happened.

The role of the CMO (Sir Donald Acheson) was enhanced and the role of public health was also heightened through a committee he chaired on the public health function. Acheson set up his own expert advisory committee (EAGA) which advised him directly. There was also a committee on health education strategy with a wider membership.

The Cabinet committee on AIDS brought politicians directly into the response. This was chaired by William Whitelaw, the deputy prime minister, a conciliatory and experienced figure within government. This committee was time limited.

Political opportunities were used. The central agency responsible for health education campaigns (the Health Education Council) was replaced by a new body, the Health Education Authority (HEA), whose primary responsibility was campaigns on HIV/AIDS. Government ministers could continue to exert influence over campaigns but at arms-length. There were many ongoing debates about how to communicate to the population and to young people and children. The Central Office for Information and the Department of Health mounted separate drugs campaigns which were different in emphasis to the HEA AIDS ones. These continued the ‘shock-horror’ approach which had characterised the early AIDS campaigns. The Scottish approach to drugs campaigning remained distinctively different as well, under the aegis of SHEG (Scottish Health Education Group).

The role of the voluntary sector was an issue and the government set up its own sponsored voluntary organisation, the National AIDS Trust (NAT), intended to supersede the Terrence Higgins Trust, which also eventually had DH funding.

There were opportunities for research disciplines. Modelling was important initially, although later discussion focussed on its over apocalyptic conclusions. Social science disciplines were very active and were primarily coordinated by the MRC.

Longer term implications

AIDS in the UK was seen as a 'success story' through harm reduction and the arrival of treatment (but not a vaccine) and eventually preventive medication meant that it dropped out of the news. Its incidence was primarily overseas and so it garnered less attention.

There was no overall committee of enquiry and other public health outbreaks and potential epidemics, e.g. BSE, followed.

The AIDS epidemic was managed by medical civil servants, high level non-medical civil servants (Permanent Secretary at the Department of Health, Cabinet Secretary) working in tandem with politicians. Politicians also had their own agendas advanced through the crisis in terms of the reconstitution of public and other bodies (such as the HEA and the NAT) to suit their interests.

Levels of response to the crisis were important in terms of governance. The WHO played a key role and Britain was influential there. Later, the United Nations took over the global response through the body UNAIDS. In the UK, there were distinct differences between England and Scotland in particular over health education tactics and organisation. The crisis was an opportunity to direct funding to health services and also to local government, where AIDS coordinator posts proliferated and there were more sustained moves to coordinate health and social care.

1.2 SWINE FLU 2009-2010

Overview

Intensive pandemic planning had taken place in the UK and in Europe since the early 2000s. A new avian influenza virus (H5N1) had been shown to pass from birds to humans in 1997. Its high fatality rate combined with limited preparedness plans sparked global interest in pandemic preparedness**.** In late 2003 WHO raised concern about new pandemics; it set out guidelines for preparedness in 2005.[8] The European Union and the European Commission and member States also developed preparedness plans after 2005.

In the UK this had been initiated by the CMO, Sir Liam Donaldson, who was the driving force behind the report Getting Ahead of the Curve (2002) which focussed on the threat from both epidemic disease and also chemical and radiological hazards, possibly through a terrorist attack.[9] Several disease outbreaks, e.g. SARS, occurred but did not transfer to the UK. Pandemic planning exercises such as Winter Willow in 2007 took place and raised issues which were not dealt with before the arrival of swine flu. Swine flu arrived in the UK in April 2009. Over the next 17 months, there were two waves of infection. Responses moved from

the initial policy of containment of spread, to one of treatment only; and then to a vaccination programme. An extensive information campaign was mounted across all media. The vaccination programme began in October 2009 and concentrated on specific risk groups; young people; immune compromised patients and pregnant women. In the event, most people experienced a relatively mild illness and numbers who died were relatively small - 457 by March 2010. In August 2010, the WHO declared the end of the pandemic.[10]

Challenges

Although the pandemic had been extensively planned for, its arrival was still a surprise, and events did not work out according to plan. A new agency, the Health Protection Agency (HPA), had been set up in 2003, amalgamating the Public Health Laboratory Service (PHLS), the Communicable Disease Surveillance Centre (CDSC) and other agencies. It was an arm's length body from government. It also had a regional and local dimension and had gained experience in dealing with serious threats to public health prior to swine flu. Its brief included giving independent advice to government and supporting the NHS.

The plan was for the NHS to run a National Pandemic Flu Service, but this did not happen initially. A policy of containment was decided on while the NHS organisation became operational and the HPA was asked to step in to provide those services. Its role unexpectedly became that of identifying cases, tracing contacts and providing anti-viral medication. This was done through flu response centres which had not figured in any pre-planning. These were based in the ten Strategic Health Authorities and stretched HPA staff to the limit. This role also caused problems with the NHS which was unconvinced that the HPA could be in the lead.

Confusion between agencies was particularly apparent at the local level. The NHS, local government and HPA structures jostled uneasily in relation to each other. The tactic in this early phase was closure of schools, following up of contacts, and prophylaxis. But the speed and spread of outbreaks (concentrated in Birmingham and in the West Midlands) soon made containment impossible. Ramping up the response caused major problems in finding and training staff and providing call centres capable of handling thousands of calls. By early June it was clear that containment was no longer practicable. The definition of flu in terms of symptoms was also changing from day to day.

Bringing this response to an end caused difficulties partly related to the nature of national policy making and the structures in place for planning. The structure of national planning was based on the Civil Contingencies Committee located in the Cabinet Office (COBRA). Scientific advice was provided through expert committees, primarily the Scientific Advisory Group for Emergencies (SAGE) and also the Joint Committee on Vaccination and Immunisation (JCVI). The CMO also provided advice. The HPA provided information to these bodies but was in a subordinate position. It was thus difficult to convince interests involved and politicians that the situation needed to change.

Political support was needed but politicians could see that the crisis response was popular and there was no incentive to change. Andy Burnham took over from Alan Johnson as health minister during this period, came to Birmingham and saw the situation on the ground. The move to a new approach followed soon after.

The government was subsequently criticised for over reaction when the expected pandemic did not reach the levels expected. It was argued that vaccine stocks were too high and money had been wasted.

Surveillance and research were crucial elements of the response. It was argued that there was an over-reliance on modelling and less emphasis on serological surveys. However, the centralised NHS data systems and its laboratory services gave the UK an enviable advantage compared to other nations. Serological data might have given a better picture of the epidemic and of its resurgence in 2010, which took people by surprise. This later resurgence provoked quite a different government response with a limited policy of vaccination and no national advertising campaign.

Risk communication was another area of difference between key players. The CMO had a close relationship with the media and gave daily briefings. The HPA staff however were dubious about this approach which led to an overfocus on worst case scenarios.[11]

Opportunities

The crisis again led to a change in structures with the pending formation of Public Health England (PHE), a new agency which would bring together all the public health bodies. This gave the advantage of better coordination but also loss of independence in advice giving and a closer relationship with political decision making.

Public health within the NHS was also changing its location and moving back into local government, where it had been located up to the 1970s.

Longer term implications

An official review of the response to swine flu was undertaken by the Welsh CMO Dame Deidre Hine and published in 2010.[12] This raised certain issues, such as the overreliance on modelling; the tendency to talk about ‘worst case scenarios’ and the need for population based serological surveillance.

The international (WHO) and European dimension of pandemic planning remained important.

The structural confusion demonstrated over swine flu did not appear to be sorted longer term. The interface with other agencies responsible for pandemic planning and response remained. Further developments took place as part of the Lansley reforms when public health services moved back into local government in 2013, along with drug and alcohol treatment. Those with knowledge of the historic role of public health at the local level

expected that this would be a 'new dawn' for public health. However, economies within local government often fell heavily on public health activities and budgets; and the interface with the new agency, Public Health England, at the regional and local level, was tenuous. [13]

2. TRUST AND PUBLIC HEALTH CRISES

Public health crises can precipitate a decline in trust in public health authorities and services. At the same time, a decline in trust can also cause or worsen public health crises. Here we examine three different crises in relation to public trust: the response to public health surveys; vaccination and health education.

2.1 HEALTH SURVEYS

2.1.1 THE GOVERNMENT SURVEY OF SICKNESS, 1943-52

Between 1943 and 1952, the Government Survey of Sickness interviewed 300,000 people about their health. Randomly sampled members of the public were asked questions about their health over the preceding three months by trained fieldworkers. Whilst most members of the public agreed to take part in the survey, a small number of people complained about the experience of being surveyed. Complainants saw the survey as a violation of privacy; an infringement of liberty; a waste of money and time; or they were concerned about the conduct of the fieldworker. A particularly sensitive issue was when respondents were asked about their income. The survey was scrapped in 1952, largely due to cost, although public complaints about government intrusion did play a part.[14]

Challenges

Complaints about the Survey of Sickness cannot be seen as representative of the public as a whole, but they do reveal a strand of hostile public opinion and lack of trust in the motives of government and its agents. This was particularly the case for groups who were unused to the intrusions of the state, in this case most often middle-class men, who found themselves on the receiving end of government scrutiny for the first time.

Opportunities

Most people agreed to be surveyed without complaint and were prepared to accept a degree of intrusion into their lives in order to benefit themselves and others. Surveys, and the process of being surveyed, were not a one-way process but also gave the public an opportunity to speak back to public health and therefore increase trust.

Long term implications

Public trust in surveys and other information gathering enterprises is related not only to the specific survey or instrument, but also wider levels of trust in government and its apparent motives. Issues that may not appear sensitive to survey designers, like income, may be seen differently by the public.

2.1.2 RACE AND ETHNICITY IN GOVERNMENT HEALTH SURVEYS, 1965-1981

'Race' based understandings of health and disease had long been present in Britain, but it was not until the 1960s that attempts were made to capture information about ethnicity in health surveys. Rising immigration, the development of a new 'science' of 'race relations' and political interest in race and racial discrimination made the gathering of data on participants' 'race' seem more pertinent. Initially, studies like the General Household Survey asked participants about their parents' country of birth, and interviewers were asked to code all respondents who were not in their estimation 'white' as 'coloured'. By the 1970s, most BME people living in Britain had being doing so for several generations, so parental birthplace no longer functioned as a proxy of 'race' or 'ethnicity'.[15] The 1981 Census was the last to ask about parental birthplace: the 1991 Census and subsequent studies asked participants to self-identify their ethnicity from a list of categories.

Challenges

Gathering information on 'race' and 'ethnicity' is clearly important for the identification of patterns and inequalities in health and health conditions. Finding an appropriate tool for doing so is difficult, as it encounters problems related to identification (or self-identification) that also reflect dominant, often racist, assumptions. Trust amongst BME communities may be undermined by the use of outdated racist language and norms.

Opportunities

Health surveys and other studies help render racial and ethnic inequalities in health visible. They also offer an opportunity to re-think the very 'racial' categories that are being captured.

Long term implications

The language used to describe and identify 'race' and 'ethnicity' changes over time. This is not just an issue of identification, but one related to the wider politics of race, ethnicity and structural racism.

2.2 VACCINATION

2.2.1 PERTUSSIS (WHOOPING COUGH) VACCINATION CRISIS, 1974-79

A study published in 1974 linked Pertussis (whooping cough) vaccination to brain damage in some children. Public confidence in Pertussis vaccination was undermined.[16] Vaccination rates fell from 78.5% in 1971, to 37% in 1974. There was an outbreak of whooping cough in 1978-79 that was as bad as any since the 1950s. A government commissioned review of the evidence established that the risk of brain damage to children as a result of the Pertussis vaccination was small. Compensation for those parents whose children were harmed by the vaccine was made available. A public health education campaign was launched encouraging parents to choose to vaccinate their children.[17] Vaccination rates gradually recovered, and cases of whooping cough declined by the early 1990s.

Challenges

Communicating clearly and effectively about the risks and benefits of vaccination to the wider public can be difficult. There is a need to take into account concerns about risks to the individual as well as the wider benefit to the community of vaccination at the population level and achieving herd immunity.

Opportunities

Working with voluntary organisations in producing legislation, other means of support, and health education messaging, is more likely to gain public support and confidence. This was the case with Pertussis and also the Rubella vaccination a few years later.

Long term implications

Public trust in specific vaccines (but not necessarily vaccination as a whole) can be undermined by safety concerns. These can be ameliorated by: a) clear communication of the evidence for the safety and efficacy of the vaccine; and b) adequate compensation and support if the vaccine does cause harm.

2.2.2 MMR VACCINATION CRISIS, 1998-2004

A study published in *The Lancet* by Andrew Wakefield et al. in 1998 alleged that there was a link between the MMR vaccine and autism. Although the study was quickly shown to be unsound, vaccination rates for MMR declined in the early 2000s as public trust in the vaccine waned. In England, average uptake of the MMR vaccine fell from 92% in 1996 to 80% in 2004, although there were significant regional variations. A lack of public confidence

in the MMR vaccine surrounded safety concerns with the triple vaccine but was also rooted in longer running issues. Recent public health scandals around BSE/CJD, as well as lack of knowledge about the aetiology of autism, and the payment of GPs to administer the vaccine, undermined public trust.[18] An initial health education campaign designed to improve MMR uptake was unsuccessful. Subsequent attempts that engaged with a more sophisticated understanding of the public's attitudes towards risk, had more impact.

Challenges

The MMR vaccination crisis was one of the first to play out in the internet age. Information and misinformation could circulate amongst networks of parents rapidly. Health education messaging that focused solely on 'the facts' did not land well. Once again, scientific and medical understandings of risk and benefit did not necessarily align with those of the public.

Opportunities

Engagement with social science research on public attitudes towards risk resulted in a more nuanced understanding of public beliefs, perceptions and decision making. This led to the design and implementation of a more sophisticated health education campaign that went some way to restoring public trust in the MMR vaccination.

Long term implications

The MMR vaccination crisis was crucial to the development of notions of vaccine hesitancy and vaccine confidence. It is likely to be central to how policy makers and practitioners conceptualise and attempt to build public trust in a Covid-19 vaccine. But it also sowed the seeds of a revitalised anti-vaccination movement that may prove problematic.

3. HEALTH EDUCATION

3.1 'HEROIN SCREWS YOU UP' AND 'CHOOSE LIFE NOT DRUGS', 1985-86

Rising rates of heroin use in the early 1980s were the subject of political and media concern. In order to be seen to address the problem, anti-drug use campaigns were introduced, although this went against expert advice. The 'Heroin Screws You Up' campaign ran in England from 1985-6. It depicted young people encountering health, social and financial difficulties as a result of heroin use. The tone of the campaign was dark and disturbing. The 'Choose Life not Drugs' campaign ran in Scotland from 1985-6. This delivered an anti-drug use message in a more positive way.[19]

Challenges

Both campaigns were seen by many young people, although neither appeared to have resulted in a decline in drug use. Moreover, these anti-drug campaigns were appropriated by young people who rejected their anti-drug message. The 'Heroin Screws You Up' campaign may also have increased the stigmatisation of drug users, worsening the social impact of heroin use.

Opportunities

Examining the reception of health education campaigns can provide an insight into public knowledge, attitudes and behaviour. These may differ significantly between groups, eg. the attitudes of some young people towards drugs and drug use vs. those of campaign designers.

Long term implications

It is difficult for health education campaigns by themselves to change individual behaviour, but that does not mean that they should not be attempted. Mass media health education campaigns can have a significant reach. They can also satisfy more than one objective, such as being seen to be doing something which may be politically and socially important.

3.2 HEARTBEAT WALES, 1985

From the 1970s onwards there were increasing rates of morbidity and mortality as a result of cardiovascular disease. To combat this, a pilot health education programme was launched in Wales. Heartbeat Wales combined mass media health education messaging with private sector initiatives such as workplace fitness schemes and food labelling. The results of this campaign were examined by a multidisciplinary team including epidemiologists and anthropologists. They found that the public's beliefs about the causes and effects of heart disease were a complex mixture of official advice, mass media messages and the lived experiences of friends and family. The researchers termed this 'lay epidemiology'.[20]

Challenges

'Lay epidemiology' did not necessarily reflect medical and scientific understandings of the risks of developing heart disease. This, combined with a degree of fatalism, made it difficult to both communicate and receive risk reducing messages.

Opportunities

Taking lay epidemiological perspectives and peoples' lived experiences into account can result in more acceptable public health education messaging.

Long term implications

The 1980s was a time when wider doubts about the ability of health education to result in behaviour change were being voiced. This resulted in the development of a broader set of health promotion messages that located health behaviours and health outcomes in social, economic, environmental context.

CONCLUSION

What can the response to these various public health crises tell us about governance and trust?

Governance

Levels of governance have been important

Britain has operated within a nexus of international agencies in the response to recent epidemics. The role of the WHO was especially important for HIV/AIDS and again for swine flu. European agencies have become increasingly important as, for example, in pandemic planning. Britain has played a significant role in shaping the policies and responses of these organisations.

Within the United Kingdom, there have been noticeable differences across the nations, in particular between Scotland and England. These demonstrated themselves in the field of health education with different approaches for HIV/AIDS, but also in terms of different systems of health and social care. The response to drug use and the policy of harm reduction was a Scottish initiative at the outset before being adopted in England. Local government was historically the leader in terms of infection control, in alliance with the Chief Medical Officer. But this role was undermined by the move into the National Health Service in the 1970s. After the confusion of agencies at the local level during swine flu, it had been hoped that the reorganisation of public health within local government presaged a bright future. However, the structural confusion over relationships between NHS, central public health (PHE) and local government public health continue and are unresolved.

Arm's length and other bodies have played an important role in recent public health crises

They have been bodies through which politicians and central government have sought to exert control while appearing not to do so. Change within these organisations has been a feature of response to epidemics in recent times e.g. HEC/HEA; National AIDS Trust; HPA/PHE.

Modes of scientific advice have changed

The ad-hoc advisory system apparent during HIV/AIDS has solidified into formal structures. It is uncertain whether it operates more effectively. Modelling and its role has been subject to criticism both during HIV/AIDS and swine flu. The role of senior civil servants to manage events has apparently diminished.

The role of politicians has been important

The role of politicians is crucial, but crises have been used for political purposes as well; for example, continuing crisis responses which are popular; using crises to change organisational structures.

How crises are seen and remembered

There is a standard narrative which is applied both to HIV and to other epidemics such as swine flu. Initially this highlights 'delay', but can easily turn later into 'over-reaction' as the dominant trope and criticism on that basis. This template then affects reaction to subsequent potential epidemic crises. The memory of the last crisis always structures the initial response to the next one. Nonetheless the continuity over time in terms of personnel is limited and institutional memory is poor. The role of Fauci in the US has not been replicated in the UK.

There are limits to planning

It is also clear that however much planning takes place, it is insufficient/inappropriate for events as they present themselves. As Chris Whitty commented in a lecture at Gresham College in 2018, 'The reality … is that we will need to respond to the epidemic we are confronted with and that is inherently unpredictable.'[21]

Trust

There are differences between expert and public conceptions of risk

Public understanding of the health 'risk' and 'benefit' of particular interventions does not necessarily align with those of scientists and health professionals. This should not be dismissed as ignorance or seen as a set of erroneous beliefs that need to be corrected, but rather something to be taken seriously and engaged with. There are occasions when public trust in a measure, intervention, body, authority, etc., is lacking. This may be due to a specific crisis and concerns about safety and efficacy, as with MMR and the Pertussis vaccine. But it may also be rooted in a disconnect between public health officials/actors/agents' views and the priorities and those of the public themselves. What might look like a lack of trust or unwillingness to follow health advice may actually be a different ordering of priorities or way of evaluating the benefits and drawbacks of an intervention.

Past public health crises affect current ones

Public health crises leave a legacy that can impact upon the next public health crisis. For instance, the denting of public trust over BSE impacted confidence around MMR vaccination; and lingering concerns about MMR are likely to contribute to hesitancy around vaccination against Covid-19. Trust, once undermined, can be hard to win back especially if elements of a new crisis emulate previous ones.

Trust and government are linked

Lack of trust in government is likely to lead to poor take up of public health interventions. Public trust can be enhanced through effective communication and also working through and with broker agencies such as voluntary organisations that may be more trusted, especially amongst 'hard to reach' groups.

The public is not one entity, different publics may have different levels of trust

Levels of trust vary between and within population groups and may be different on different issues. Whether it was middle-class men in the 1950s who were unused to the scrutiny of public health surveyors, or teenagers in the 1980s rejecting anti-drug messaging, trust in public health authorities and initiatives is not uniform.

Health education campaigns can have unpredictable effects on public trust

Health education campaigns can be useful but they cannot change behaviour on their own. Poorly designed campaigns can also have negative effects such as increasing stigmatisation and undermining trust with some groups.

Governance, trust and the history of public health

Taken together, these examples highlight the enduring significance of issues related to governance and trust in the response to public health crises. Good governance leads to high levels of public trust and vice-versa. Unexpected public health crises are inevitable, and will always throw up new challenges, but these also contain many enduring features that an analysis of the past will help identify and potentially mitigate.

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