Editorial

Evidence for public health practice

While public health academics and practitioners have argued for many years the need, there is finally increasing widespread recognition, accompanied by resources and action, for improving the evidence base for public health practice and ensuring interventions are effective.

The initiative by the National Institute of Health Research in England to establish a programme to provide new knowledge on the benefits, costs, acceptability and wider impact of non-NHS interventions intended to improve the health of the public and reduce health inequalities is to be warmly welcomed.1 This ambitious programme should (in time) provide evidence for national and international policymakers to shape public health strategies. Together with the recent initiative to establish the UK Economic and Social Research Council (ESRC) Centres for Public Health Excellence2 it marks a welcome investment in public health research, and in particular the need to invest in research into the effectiveness of public health interventions.

This edition of the journal brings evidence to bear on public health practice from a variety of research methods and paradigms. Using routine data,3 based on the UK General Practice Research Database, have found a striking decline in the frequency of consultation and antibiotic prescription for colds, rhinitis and ‘upper respiratory tract infection’ alongside a reduction in the rate of antibiotic utilisation for these conditions. The role of qualitative research in illuminating key public health issues such as physical activity in children and avian influenza is shown in papers by4,5; whereas modeling can help prioritize community interventions.

However, it is clear that many and varied challenges remain for the implementation of scientific evidence. Green et al. looked at the impact of NICE guidelines on the uptake of laparoscopic surgery.7 A study of the views of staff on heat wave plan for England found that awareness was low, despite good evidence that excess heat has real risks, particular for older people,8 and poses challenges for implementation. The demonstration of low levels for functional health literacy in patients attending primary care clinics in Belgrade poses a challenge as to how we communicate health promotion messages and empowerment for those with long-term and chronic conditions.9 In contrast, it is a pleasure to report an implementation success story with the elimination of neonatal tetanus from Nepal,10 and as a public health community we need to learn how best to learn from these successes.

A salutary reminder of the difficult balance between evidence, communication and trust with the public, particularly in the areas of risks from terrorism and pandemic flu, is provided in the Perspective article by McKee and Coker11 and associated commentaries.12–14 This highlights the need for public health leaders to tread the fine line of difficult decision-making in the public domain so graphically described in our series on public health leadership earlier in the year.15

Selena Gray, Gabriel M. Leung

Journal of Public Health

References