Introduction
The "essential public health functions" (EPHFs) concept originated from concerns that countries at all stages of development are experiencing rapid changes in their health and social environments and within their health systems, and that these changes may result in negative health impacts. Many countries, for example the newly independent states of the ex-USSR, have been under increasing pressure to downsize, decentralize and privatize, and the rapid changes to the system created immediate, dramatic health impacts (1). In addition to the reorganization of health systems, shifts in demographic and epidemiological trends and changes to the health environment are occurring simultaneously. Elderly populations are expanding in all countries. Morbidity and mortality due to chronic non-communicable diseases are increasing, often associated with the ageing of populations. At the same time, many long-standing communicable diseases continue to be public health problems, and some, for example tuberculosis and malaria, may be worsening. Moreover, the threat of emerging and re-emerging communicable diseases is increasing, which raises the importance of national and international surveillance. Social changes are also occurring which, in many countries, are resulting in increasing instability at the family, community, and national levels. Therefore, environmental and lifestyle "hazards to health" are undergoing rapid transformations, and require continuous monitoring, policy responses, and appropriate interventions.

Within this context of change, the EPHFs approach has emerged. It has become increasingly evident that failures in public health work have a common feature: they result from some flaw in the continuum of public health policy, systems and services. In order to address these situations, the question was posed whether it is possible to identify a set of functions in public health which are so essential because they ensure that the public health system continues to respond to emerging and priority needs in an optimal way through a range of public health services. Added impetus was given to this initiative when a working group on EPHFs was set up in 1996 as part of the policy preparation work for the renewal of Health for All in the 21st century.

Following a discussion of EPHFs in January 1997, the WHO Executive Board recommended that work proceed on the concept as a tool for implementing the renewed HFA policy in the 21st century. In response to these recommendations it was decided that an international Delphi study should be conducted as a way of refining the concept of EPHFs and to obtain an international consensus on the core features of EPHFs. This paper outlines the methodology and principal findings of this study.

Methodology
A Delphi approach of eliciting expert opinion and achieving consensus on key technical and policy issues was selected for this study. The Delphi technique provides a method for structuring communication in a way that allows a group of respondents to confront a complex problem and to reach consensus (3). In each round of a Delphi study a questionnaire is distributed to the members of the respondent group and returned to the coordinating group after filling out. After the first round is completed, a summary of the results from the previous round is prepared by the monitor team and included as a preamble to the following rounds. This continues until stability of responses appears and general convergence of opinion emerges, a respondent group fatigue factor emerges, or the point when diminishing returns are reached (4-6).

The Delphi technique offers several advantages:
• The Delphi methodology allows a group of experts to address a specific group of complex
problems and to come to consensus on a set of core issues.

- Electronically administered questionnaires reduce the risk of influence by dominant individuals that may develop in face-to-face expert panels. This allows individuals to express their views without inhibition because their responses are not disclosed to other members of the respondent group.
- Controlled feedback: conducting the survey in a sequence of rounds, with the results provided to all participants at the end of each round.
- Statistical definition of the group response can be used to describe the degree of consensus achieved with regard to certain issues and problems. The reliability of the Delphi technique is dependent upon the size of the respondent group and the number of rounds conducted (5, 6).

Study design and description of study group

Study objectives
The main objectives of this study were as follows:

(i) to define the concept of EPHFs;
(ii) to establish international consensus on what functions constitute essential public health functions; and
(iii) to determine which public health functions are likely to be the most essential in all countries in the future.

Respondent group
During February and March 1997, the respondent group was identified through an international process of consultation with WHO regional offices, the World Federation of Public Health Associations, regional associations of schools of public health, and other bodies. The respondent group consisted of 145 persons, and was comprised of public health leaders/experts, public health managers, educators, as well as national/local government and non-governmental leaders/practitioners of public health. In selecting the respondent group every attempt was made to ensure that experts were drawn from a diversity of professional backgrounds, and from both developing and industrialized countries.

Prior to sending out the Round 1 questionnaire in May 1997, each of the 145 respondents completed a pre-study questionnaire. The characteristics of the respondent group are shown in Table 1.

Sixty-seven countries in all WHO regions are represented by the Delphi study group.

AMRO, EURO, and WPRO are approximately equally represented, as are AFRO, EMRO, and SEARO (Fig. 1).

Core monitor group
The questionnaires for each round of the Delphi study were developed through collaboration between the EPHF WHO working group members and an external (core) monitor group comprised of 8 senior government officials, academics, and public health experts from developing and developed countries (see acknowledgment section for a complete list).

Questionnaire design
In each round, the draft of each questionnaire, the previous round feedback report, and the raw data collected from the previous round were sent to each of the 8 core monitor group members. Subsequently, in each round every member of the core monitor group forwarded his/her suggested additions/deletions, general concerns, and queries to the WHO headquarters study team. Accordingly, each questionnaire was revised on the basis of this feedback from the core monitor group before being sent to the respondent group. The method by
Fig. 1
Delphi respondent group
Groupe d'enquêtes de l'étude Delphi

Regional distribution
Répartition régionale

- EMR 10.3%
- WPR 24.8%
- AMR 24.8%
- EUR 20%
- AFR 11%
- SEAR 9%

Study design
Conception de l'étude

Essential public health functions
fonctions essentielles
de santé publique

Draft questionnaires dispatched
Envoi des projets de questionnaires

Completed questionnaires sent
Renvoi des questionnaires remplis

to study team by fax/e-mail
par télécopie ou courrier électronique

Finalized questionnaires and feedback summaries of
previous round results dispatched
to respondents by fax/e-mail

Specific comments/edits/additions
and deletions to questionnaires

Completed questionnaires sent
to study team by fax/e-mail

External core monitor group
Groupe restreint de
surveillance extérieure

General feedback to the study group
Transmission de données générales
sur les progrès de l'étude

Respondent group
Groupe des personnes sondées

Regular feedback to the working group regarding
study progress
Transmission régulière
d'informations au groupe de travail
au sujet des progrès de l'étude

WHO 98225
Rapp. trimest. statist. sanit. mond., 51 (1998)
Categories of public health functions

In Round 1, respondents also agreed (over 75% of respondents agreed or strongly agreed) or strongly agreed (over 75% of respondents strongly agreed) with the following seven general categories of public health functions:

To what extent do you agree/disagree that public health functions include the following categories?

- Monitoring the health situation. Strongly agree
- Protecting the environment. Agree
- Health promotion. Strongly agree
- Prevention, surveillance and control of communicable diseases: Strongly agree
- Public health legislation and regulations. Agree
- Occupational health. Agree
- Public health services. Agree

It was suggested in Round 1 that a management category be added to the list of public health functions categories. In Round 2 it was agreed (80.6% of respondents either strongly agreed or agreed) that a specific category of public health management should be included under public health functions.

Also, although the category “care of vulnerable and high risk populations” was included in Round 1 under personal health care functions, in later rounds the majority of respondents felt that certain functions, for example “infant and child care” and “maternal and reproductive health care and family planning” should be included under public health functions. Thus, in the final listing of EPHFs 9 general categories are listed (Box 1).

Box 1

Categories of EPHFs

- Monitoring the health situation
- Protecting the environment
- Health promotion
- Prevention, surveillance and control of communicable diseases
- Public health legislation and regulations
- Occupational health
- Public health services
- Public health management
- Care of vulnerable and high risk populations

Identification of EPHFs

The Rounds 2 and 3 questionnaires focused on reaching consensus on a list of EPHFs. In Round 2 the respondent group was presented with a generic list of 46 public health functions, and in Round 3 the respondent group was presented with an additional list of 29 public health functions suggested by the respondent group in Round 2.

In Rounds 2 and 3 the respondent group identified a list of 37 EPHFs (EPHFs)\(^a\), 28 EPHFs from Round 2, and 9 EPHFs from Round 3. This list of EPHFs is summarized in Box 2.

Reasons for selecting EPHFs

Respondents were also requested to indicate the reasons they considered each function to be an essential one.\(^b\) The following results describe the percentage of respondents who chose a specific EPHF because they considered that it was either a public good, cost-effective, or highly significant in terms of its public health impact.

The following EPHFs were emphasized to be public goods (i.e. those items rated highly as public goods alone or in combination with other reasons):

- Production and protection of safe water (75.5%)
- Hazardous substance control (75.3%)
- Controlling food quality and safety (75.0%)
- Outbreak control (69.8%)
- Vector control (65.7%)
- Reproductive health and maternal care (63.3%)
- Enforcing health legislation (63.2%)
- Prevention of injury (62.8%)
- Review and formulation of health legislation (53.2%)

Immunization was considered to be the most cost-effective EPHF by the respondent group (64.2%).

The EPHFs chosen for their public health significance (i.e. those items rated highly significant alone or in combination with other items) were:

- Monitoring morbidity and mortality (49.5%)
- Monitoring health determinants (48.1%)
- Linkages with politicians (47.7%)
- Disease surveillance (46.3%)
- Review and formulation of health legislation (45.6%)

\(a\) The number in parenthesis is the relative rank of the individual functions based on the mean score from the Delphi study. These scores were determined on the basis of the following scale: 4=EPHF (is a most essential function in all countries); 3=PHF (is a public health function, but may not be essential in all countries); 2=PHF in certain conditions (is a public health function, yet only under certain conditions); 1= Not a PHF (does not constitute a public health function, and should be deleted from the list of public health functions). A mean score of 3.00 to 3.49 indicates a public health function, 3.50 to 3.99 indicates a public health function in certain conditions. A few public health functions overlap with the lower range of the EPHF category when the confidence intervals are considered. The detailed statistical results are available on request from the authors.

\(b\) Respondents selected from significance, cost-effectiveness, or public good as the primary reasons for selecting a certain function as essential.
<table>
<thead>
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<th>Essential public health categories and functions (resulting from the international Delphi survey of 1997) (Rank out of 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Prevention, surveillance and control of communicable and noncommunicable diseases</td>
</tr>
<tr>
<td></td>
<td>• Immunization (1)</td>
</tr>
<tr>
<td></td>
<td>• Disease outbreak control (3)</td>
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<td></td>
<td>• Disease surveillance (4)</td>
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<td></td>
<td>• Prevention of injury (20)</td>
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<tr>
<td>2.</td>
<td>Monitoring the health situation</td>
</tr>
<tr>
<td></td>
<td>• Monitoring of morbidity and mortality (2)</td>
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<td></td>
<td>• Monitoring the determinants of health (6)</td>
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<td></td>
<td>• Evaluation of the effectiveness of promotion, prevention and service programmes (10)</td>
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<td>• Assessment of the effectiveness of public health functions (11)</td>
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<td></td>
<td>• Assessment of population needs and risks to determine which subgroups require service (12)</td>
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<td>3.</td>
<td>Health promotion</td>
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<tr>
<td></td>
<td>• Promotion of community involvement in health (5)</td>
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<td></td>
<td>• Provision of information and education for health and life skill enhancement in school, home, work and community settings (9)</td>
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<td></td>
<td>• Maintenance of linkages with politicians, other sectors and the community in support of health promotion and public health advocacy (14)</td>
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<tr>
<td>4.</td>
<td>Occupational Health</td>
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<tr>
<td></td>
<td>• Setting occupational health and safety standards (18)</td>
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<tr>
<td>5.</td>
<td>Protecting the environment</td>
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<tr>
<td></td>
<td>• Production and protection of, and access to, safe water (7)</td>
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<tr>
<td></td>
<td>• Control of food quality and safety (8)</td>
</tr>
<tr>
<td></td>
<td>• Provision of adequate drainage, sewerage and solid waste disposal services (15)</td>
</tr>
<tr>
<td></td>
<td>• Control of hazardous substances and wastes (16)</td>
</tr>
<tr>
<td></td>
<td>• Provision of adequate vector control measures (17)</td>
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<td></td>
<td>• Ensure protection of water and soil resources (29)</td>
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<td></td>
<td>• Ensure environmental health aspects are addressed in development policies, plans, programmes and projects (32)</td>
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<tr>
<td></td>
<td>• Prevention and control of atmospheric pollution (33)</td>
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<td></td>
<td>• Ensure adequate prevention and promotive environmental services (34)</td>
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<td></td>
<td>• Ensure adequate inspection, monitoring and control of environmental hazards (35)</td>
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<td></td>
<td>• Controlling radiation (36)</td>
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<tr>
<td>6.</td>
<td>Public health legislation and regulations</td>
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<td></td>
<td>• Review, formulation and enactment of health legislation, regulations and administrative procedures (13)</td>
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<td></td>
<td>• Ensure adequate legislation to protect environmental health (22)</td>
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<td></td>
<td>• Health inspection and licensing (23)</td>
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<td></td>
<td>• Enforcement of health legislation, regulations and administrative procedures (24)</td>
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<tr>
<td>7.</td>
<td>Public health management</td>
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<tr>
<td></td>
<td>• Ensuring health policy, planning and management (19)</td>
</tr>
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<td></td>
<td>• Use of scientific evidence in the formulation and implementation of public health policy (21)</td>
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<tr>
<td></td>
<td>• Public health and health systems research (30)</td>
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<td></td>
<td>• International collaboration and cooperation in health (37)</td>
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<td>8.</td>
<td>Specific public health services</td>
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<td></td>
<td>• School health services (25)</td>
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<td></td>
<td>• Emergency disaster services (27)</td>
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<td></td>
<td>• Public health laboratory services (28)</td>
</tr>
<tr>
<td>9.</td>
<td>Personal health care for vulnerable and high risk populations</td>
</tr>
<tr>
<td></td>
<td>• Maternal health care and family planning (26)</td>
</tr>
<tr>
<td></td>
<td>• Infant and child care (31)</td>
</tr>
</tbody>
</table>
Box 2
Essential public health categories and functions (resulting from the international Delphi survey of 1997) (Rank out of 37)

1. Prevention, surveillance and control of communicable and noncommunicable diseases
   • Immunization (1)
   • Disease outbreak control (3)
   • Disease surveillance (4)
   • Prevention of injury (20)

2. Monitoring the health situation
   • Monitoring of morbidity and mortality (2)
   • Monitoring the determinants of health (6)
   • Evaluation of the effectiveness of promotion, prevention and service programmes (10)
   • Assessment of the effectiveness of public health functions (11)
   • Assessment of population needs and risks to determine which subgroups require service (12)

3. Health promotion
   • Promotion of community involvement in health (5)
   • Provision of information and education for health and life skill enhancement in school, home, work and community settings (9)
   • Maintenance of linkages with politicians, other sectors and the community in support of health promotion and public health advocacy (14)

4. Occupational Health
   • Setting occupational health and safety standards (18)

5. Protecting the environment
   • Production and protection of, and access to, safe water (7)
   • Control of food quality and safety (8)
   • Provision of adequate drainage, sewerage and solid waste disposal services (15)
   • Control of hazardous substances and wastes (16)
   • Provision of adequate vector control measures (17)
   • Ensure protection of water and soil resources (29)
   • Ensure environmental health aspects are addressed in development policies, plans, programmes and projects (32)
   • Prevention and control of atmospheric pollution (33)
   • Ensure adequate prevention and promotive environmental services (34)
   • Ensure adequate inspection, monitoring and control of environmental hazards (35)
   • Controlling radiation (36)

6. Public health legislation and regulations
   • Review, formulation and enactment of health legislation, regulations and administrative procedures (13)
   • Ensure adequate legislation to protect environmental health (22)
   • Health inspection and licensing (23)
   • Enforcement of health legislation, regulations and administrative procedures (24)

7. Public health management
   • Ensuring health policy, planning and management (19)
   • Use of scientific evidence in the formulation and implementation of public health policy (21)
   • Public health and health systems research (30)
   • International collaboration and cooperation in health (37)

8. Specific public health services
   • School health services (25)
   • Emergency disaster services (27)
   • Public health laboratory services (28)

9. Personal health care for vulnerable and high risk populations
   • Maternal health care and family planning (26)
   • Infant and child care (31)
Public health functions in the future

In the Round 3 questionnaire the respondent group considered the list of 27 EPHFs identified in Round 2 and respondents were requested to indicate the changing importance of functions in the year 2020 and to indicate the main reasons why they think a given EPHF will increase or decrease in importance. Overall, there was the highest degree of consensus that EPHFs in the general categories of environmental health and health promotion would increase in importance by the year 2020.

The respondent group indicated that the following EPHFs would increase in importance by the year 2020:

- **Prevention and control of atmospheric pollution (78%)**
  - **Main reasons cited for increasing importance of this function**: environmental degradation/ozone depletion/global climate change; economic globalization; and increasing urbanization/industrialization.

- **Promotion of community involvement in public health (74.3%)**
  - **Main reasons cited**: increasing decentralization of health systems; increased importance of health promotion/prevention (especially to address the increased noncommunicable disease burden); limited effectiveness of state interventions; and increasing democratization worldwide.

- **Ensuring that hazardous substances and wastes are adequately controlled (73.1%)**
  - **Main reasons cited**: globalization of industry/industrial contaminants/waste traffic/free market exchange; increasing population and urbanization.

- **Provision of information and education for health and life skill enhancement in school, home, work and community settings including the use of mass media (71.6%)**
  - **Main reasons cited**: improved access to new technologies; emergence of the global information society; most diseases of the future will be behaviour-based and will require behaviour modification; and increased shift of burden of disease towards noncommunicable diseases.

- **Monitoring of the determinants of health (59.7%)**
  - **Main reasons cited**: increased global pressure on water supplies; overpopulation; climate change/environmental degradation; and increased industrialization and pollution, especially in developing countries.

- **Evaluation of the effectiveness of promotion, prevention and service programmes (57%)**
  - **Main reasons cited**: greater need for accountability/evaluation/ transparency, and community ownership of resources.

- **Setting of occupational health and safety standards (54.1%)**
  - **Main reasons cited**: globalization of industry and industrial contaminants; global trade agreements may compromise existing standards; and increased move towards private entrepreneurship.

- **Disease surveillance (53.6%)**
  - **Main reasons cited**: globalization of trade will make transnational outbreaks more important; electronic capabilities and computing networks will be extended more widely; changing patterns of virulence and resistance of communicable diseases; and increasing crowding, conflict and migration.

- **Control of food quality and safety (53.2%)**
  - **Main reasons cited**: globalization of food production and trade makes it increasingly difficult to maintain food quality and safety standards; increased urbanization will aggravate dependence on stored foodstufs; contamination of natural water resources; emerging and re-emerging infectious diseases; and new threats to health from agricultural biotechnology.

- **Maintenance of linkages with politicians, other sectors and the community in support of health promotion and public health advocacy (52.4%)**
  - **Main reasons cited**: the greater need for intersectoral collaboration in the future will make health a priority political issue at all levels; strong political advocacy will be needed to resolve long-term public health problems e.g. smoking-related diseases/cancer/injury/environmental health hazards.

- **Assessment of the effectiveness of public health functions (51.4%)**
  - **Main reasons cited**: as public finances become more scarce, the cost-effectiveness of interventions will have to be evaluated; demands for greater accountability/ transparency, and increasing community ownership of resources in the future.

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1 Respondents identified EPHFs which would increase in importance in the future according to the following scale: 1=significant decrease in importance by 2020, 2=decrease in importance by 2020, 3=importance will remain the same by 2020, 4= increase in importance by 2020, 5= significant increase in importance by 2020. An EPHF was considered to increase in importance by 2020, if over 50% of the respondent group considered that a function would increase/decrease in importance by 2020, or significantly increase/decrease. All EPHFs which did not fall into either of these two categories was considered to remain of equal importance in 2020.

2 Percentage of respondents who strongly agreed or agreed that an EPHF would increase in importance in 2020.

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Rapp. trimest. statist. sanit. mond., 51 (1998)
• Assessment of population needs and risks to determine which subgroups require services (51.3%)

Main reasons cited: economic and environmental changes may have disproportionate effects on poor groups; increasing focus on equity will direct public health efforts towards measuring and reducing inequities in health.

Delivery and financing
Although there was strong agreement in Round 1 that public health functions need not be carried out by government agencies, but may be performed by nongovernmental organizations, the community and the private sector, a few respondents in Round 2 had the impression that they need to be provided by the public sector. In Round 3 this issue was revisited. The respondent group agreed (89.4% agreed or strongly agreed) that EPHFs could be managed in three different ways at a given time in a country, and could thus be divided into three categories:

• Those financed and provided for by the government;
• Those financed by the government but provided for by other agents;
• Those financed and provided for by other agents (but which the government still considers to be its ultimate responsibility and will step in and cover if no one else takes care of them).

It was also suggested that a fourth category could also be conceived: EPHFs financed by other agents, including individuals, but provided for by the government. For example: a government delivers vaccination services but the vaccines are donated by a nongovernmental institution.

Controversial issues
One item proved to be particularly controversial in Round 1. In an attempt to define the relationship between public health functions and personal health care services, no consensus was reached regarding the following statement:

Although public health work may include personal care services, such as the detection and treatment of infectious disease, individual patient care is not generally considered to be a public health function.

However, a high degree of consensus was reached that personal health care services are part of public health functions to the extent that they provide population-wide benefits. Numerous respondents disagreed with the generalization that public health functions exclude patient care. Many comments indicated that individual patient care should only be considered as a public health function when such care provides benefits to a larger population (i.e. when such care has externalities/spillover benefits for the population at large). Although externalities/spillover benefits for populations were felt to be important criteria for public health functions, it was pointed out that measurement of these externalities is in practice difficult. In this regard, it is important that better measurement criteria be developed in the future.

In Round 1, the ethical implications of targeting public health functions to specific populations within a country were queried. When this issue was posed to the respondent group in Round 2, over 94% of respondents felt that it was ethical to direct public health resources for the health benefit of population subgroups that are exposed to a specific risk or which suffer from a specific health problem. Several respondents indicated that a major concern of public health is its advocacy role for protecting underprivileged groups.

Discussion

Reliability of findings
A high level of consensus was reached in each round of this study on key areas of the investigation: the definition of EPHFs, identification of specific EPHFs, and determining which EPHFs would increase/decrease in importance in the future. Regarding the list of EPHFs identified in this study the list identified in Round 2 was cross-checked in Round 3. In the Round 3 questionnaire, the respondent group was requested to rank the EPHFs identified in Round 2 according to how they would spend each incremental dollar of their budget. This exercise proved to be a cross-check on the rankings identified in Round 2 as the relative rankings were very similar. Respondents were also able to reach a high level of consensus on the core features of the definition. For areas which proved controversial in earlier rounds, for example the relationship of personal health care services and public health functions, consensus was eventually reached after the diverging views within the respondent group were considered.

The reliability of the study is increased by the very high response rates achieved which compared well with other Delphi studies reporting high response rates (6, 7). However, other studies were not as large as this one. When the response rates are

\footnote{This exercise provided a consistency check between the Round 2 and Round 3 rankings. In Round 3, respondents were requested to rank from 1 to 20 the list of EPHFs identified from the second round according to a hypothetical situation where they had a limited budget which must be spent so as to have the maximum health impact. This exercise contrasted with Round 2 in which respondents considered individual functions on a sliding scale (see footnote \textsuperscript{6}).}
compared to studies with initial respondent groups of over 100 (8) the response rates were very high. Also, considering that the study was conducted in 67 different countries, often with communications bottlenecks, the response rate is more impressive. Furthermore, the motivation of the expert panel, which included a wide range of public health professionals indicates that respondents took the study very seriously. The better-motivated respondents were selected for the study on the basis of a pre-study questionnaire describing the study design and expectations of the monitor group. In line with the conventional Delphi technique, the study group considered that three rounds were adequate.

The consistency check which was performed between the second and third rounds indicates that the rankings of EPHFs are very consistent. The questionnaire format also encouraged qualitative comments by respondents for each item. This technique allows the group members to express their divergent views, and these were taken into consideration in designing subsequent questionnaires and preparing feedback reports.

The possibility of bias in selecting the respondent group is one of the major criticisms of the Delphi technique. In this study every attempt was made to include a wide range of public health disciplines and to represent countries at all levels of development. The reliability of the findings in this study would be enhanced if similar findings are achieved in other studies undertaken at regional or national levels.

Gaps and unfinished work
In Round 3, respondents identified specific public health functions which would be placed under the new category of "public health management". The following functions were identified:

- Human resources management, including training;
- Management of health and technical resources, and resource allocation;
- Management of insurance schemes;
- Health information management;
- Management of political policy;
- Logistics management;
- Managing cross-sectoral communication;
- Management of resources, organizations, systems, environment; and
- Public health management: planning/evaluation, communication, organizational development, human resources development, infrastructure, financing.

At the end of the study it was not completely resolved how the new category of public health management functions relates to the health systems management functions, which the respondent group in Round 1 agreed was one of three components of a national health system. Moreover, although the respondent group, in Round 2, favoured the incorporation of public health management as a category of public health functions, the generic management functions identified in Round 3 were not considered in more depth. This would have required a fourth round. However, because of logistical constraints and a slight decrease in response rates which appeared in the third round, it was not felt that another round was warranted.

Priorities in public health
This study represents the first attempt at ascertaining the core content of public health work in countries at all levels of development. National studies, such as the Public health in America project (9, 10), have developed a list of 10 essential public health services and have proceeded to outline core competencies for the future public health workforce based on this work. Without consensus on the approximate boundaries of public health work, it would not be possible to determine the training and planning priorities in the future. The results of this study emphasize the need for governments to provide oversight monitoring for the delivery of EPHFs, even if they are not always the direct providers of these essential public health services.

The EPHFs project and Delphi study have demonstrated that consensus can be reached globally on the core areas of public health work in all countries at all levels of development. Although it is evident that this approach will need to be tailored to meet the needs and priorities of different national contexts, it is an important step in arriving at consensus on the present and future projected core elements of public health work. In this regard, it will be important that national studies be launched as a means of defining a set of EPHFs within specific national contexts; it is likely that the lists of specific EPHFs would vary between countries. For instance, care for the elderly would probably appear as an EPHF in many industrialized countries which have a rapidly ageing population. Further, many countries and communities would likely rank mental health higher than the respondent group in this study.

In summary, this study has implications for future work which needs to be performed at national and global levels, including:

- the confirmation of international performance standards for essential functions;
- the elaboration of assessment methods;
- support of national assessments for public health performance and human and institutional capacities;

1 The decrease in response rates in the third round is consistent with the experiences of other Delphi studies.

Rapp. trimest. statist. sanit. mond., 51 (1998)
• the identification of common performance problems;
• the development of strategies to strengthen performance; and
• the development of global EPHFs to address the globalization of public health problems and opportunities.

Within countries, further studies involving decision-makers, public health experts, and interest groups could be carried out to arrive at a consensus on the EPHFs to be addressed. These studies would also provide a cross-check on the findings of this study, and help to tailor the EPHFs approach to specific contexts of implementation.

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Summary

The essential public health functions (EPHFs) approach is an integral component in the elaboration of the Health for all (HFA) policy in the 21st century and a necessary element for building sustainable health systems. An international Delphi study on EPHFs was conducted in 1997. This international study included a respondent group of 145 public health experts from all regions of the world. The core monitor group included the members of the WHO EPHFs working group and 8 senior public health figures from both developing and developed countries. The primary objectives of this study were: to define the concept of EPHFs; to establish consensus on what functions constitute EPHFs, and to determine which public health functions are likely to be most essential in the future and to confirm which public health functions require the elaboration of performance standards. Three rounds of the study were completed in December 1997, and this paper provides an overall summary of the findings.

Résumé

Fonctions essentielles de santé publique: résultats de l’étude internationale Delphi

L’approche fondée sur la notion de fonctions essentielles de santé publique est un élément à part entière de l’élaboration de la politique de la santé pour tous au XXIe siècle et une composante nécessaire de la mise sur pied de systèmes de santé durables. Une étude internationale Delphi portant sur les fonctions essentielles de santé publique a été menée en 1997. Pour cela on a consulté un groupe de 145 experts de la santé publique appartenant à toutes les régions du monde. Le groupe de surveillance central était constitué de membres du groupe de travail de l’OMS sur les fonctions essentielles de santé publique et de 8 sommités de la santé publique appartenant à des pays développés et développés. Les principaux objectifs de cette étude étaient les suivants: définir le concept de fonctions essentielles de santé publique; parvenir à un consensus sur la nature de ces fonctions et déterminer les fonctions de santé publique probablement les plus importantes pour l’avenir. Les trois séries d’enquêtes ont été achevées en décembre 1997 et on la trouvera dans cet article un résumé général de leurs résultats.

References – Référence


