

REVIEW ARTICLE

The history of European public health education accreditation in perspective

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Abstract

Aim: The aim of this paper is to investigate the history of accreditation of academic public health education and understand why there is a 65 year gap between the first system in America and the uptake of accreditation in Europe. The paper intends to search for parallels and dissimilarities between the development in America and Europe and then consider if any parallels could be used for determining the future role of accreditation in Europe.

Methods: The paper draws heavily upon a literature review and analysis and the examination and interpretation of primary and secondary sources. Firstly there is an exploration of the American development which is complemented by an evaluation of the developments in Europe.

Results: The paper demonstrates that there are two key features required for the development of accreditation: interstate collaboration and a liberalisation or opening up of the education market.

Conclusions: Since the Second World War, Europe has embraced interstate collaboration which has led to a liberalisation of certain economic markets. The future for sector based accreditation of public health education will be determined by the extent Europe pursues liberalisation and whether a competitive environment will bring into question the transparency and trust in state sponsored accreditation agencies.

Keywords: European Public Health Education Accreditation.

Conflict of interest: None.

The accreditation of higher education programmes and institutions has its roots in American higher education (1) and the history of accreditation of public health education is no exception. However histories do differ in the role of the state in education. In 18th and 19th century Europe, education was taken away from the church and placed under state control to reinforce the legitimacy of the emerging, and competing, European nation states (2). American political development differed from the European model and when the states came together to form the US, education was not among the functions specifically expressed as a federal responsibility (3). Europe continues to develop and embrace individual nation states with an increasing trend for laissez faire deregulation as a route to diminish barriers to free trade but it is yet unclear how this will affect the future of education and accreditation at a nation state level.

The research is based around a literature review and search of key websites including the American Journal of Public Health, Pubmed and Google scholar. The reviews took place between July and October 2014 based upon the search terms of “public health education accreditation”. The analysis of key themes highlighted mainly American development and this was complemented for European development, by the use of the physical archives from the Association of Schools of Public Health in the European Region (ASPHER). The searches delivered over 150 separate books and articles covering the subject to varying degrees. Together these allowed for a demonstration and reflection of the origins of public health accreditation in both Europe and America.

The American laissez faire approach to federal governmental responsibility toward education was not without its detractors especially when combined with a comparable economic approach. In 1910 Abraham Flexner criticised the free market nature of medical education in America, “*over-production of ill trained men is due in the main to the existence of a very large number of commercial schools*” (4) and that, “*the schools were essentially private ventures, money-making in spirit and object*” (5). As a result, Flexner recommended that 120 of the 155 medical schools should close. Flexner was to become soon after the head of the general education board within the Rockefeller foundation (6). Five years after Flexner’s report, Wycliffe Rose and William Welch submitted their views on the development of schools of public health to the Rockefeller foundation. Given the utter calamitous state of contemporary medical education it was no surprise that the authors recommended that schools of public health should not be part of medical schools. Apart from the notion that the public health worker was not identical with that of a practitioner of medicine no other reason for the independence of schools of public health was given in the report (7).

Institutionally splitting public health from medical education did not however allay concerns about the quality of public health training. In 1920, the American Public Health Association (APHA) established a committee on the standardisation of public health training and one year later it reported on what it saw: “*the most serious defect in the whole system at present, however, lies in the fact that certain institutions give not only the Certificate in Public Health but even the Doctorate in Public Health for a course of a few weeks, while others require a period of almost three years, and it seems most desirable to effect some form of standardization in this field*” (8). Similar to the findings of Flexner, there were also complaints of profit-making public health training programmes of questionable quality offering public health degrees (9). An editorial in the American Journal of public health in 1924 noted that, “*as far as the medical end of this scandal goes the matter can be left to the strictly medical journals but unfortunately public health is also involved*” (10). This situation continued for the next twenty years with some schools being recognised as, “*merely seeking to attract students by deliberately and grossly misleading prospectuses*” (11).

It took 26 years from the origins of the committee on standardisation until the adoption of an accreditation system in 1946 which coincided with the Committee for Professional Education within APHA taking on the responsibility for monitoring standards. This committee was headed by William Shepard who strove for the recognition of public health as a profession, “*whether we fully*

realize it or not, public health has become a profession” (12). Accreditation would play a role in producing well trained individuals and supplying relevant data on the needs of the national public health, as Shepard noted, “to my knowledge this is the first occasion in modern times that a learned profession has kept its educational house in order as it developed. Since becoming a recognized profession, we have been spared the developmental blight of having our ranks flooded with pseudo-trained people” (12).

In 1946 there were 11 criteria which comprised the minimum requirements of institutions to be accredited to the master of public health (13). The criteria had been developed by another member of the Rockefeller board and pioneer of modern public health, Charles-Edward Winslow, who had deliberately kept the criteria flexible and small enough to allow time for schools to comply and maintained that too much standardisation was undesirable (12). The basis for Winslow’s criteria came from the notion that “public health is not a branch of medicine or of engineering, but a profession dedicated to a community service which involves the cooperative effort of a dozen different disciplines” (14).

Accreditation at this point consisted of seven criteria which looked at the institution and a further four criteria which were course specific (13). Out of these latter four, one criterion stipulated the content, see Table 1. By 1974, when accreditation became housed within the Council on Education for Public Health (CEPH) (15), these criteria had evolved to express a mixture of educational and practical competencies (16), which saw the retraction of elements such as economics and parasitology but the addition of health systems. These criteria are kept in place into the modern period (17), albeit more succinctly phrased as biostatistics and epidemiology were included as part of investigation, measurement, and evaluation (18). The one omission is focussed on the biological features of the curriculum.

Table 1. Changes in American accreditation compulsory curricula contents 1946 to 2014

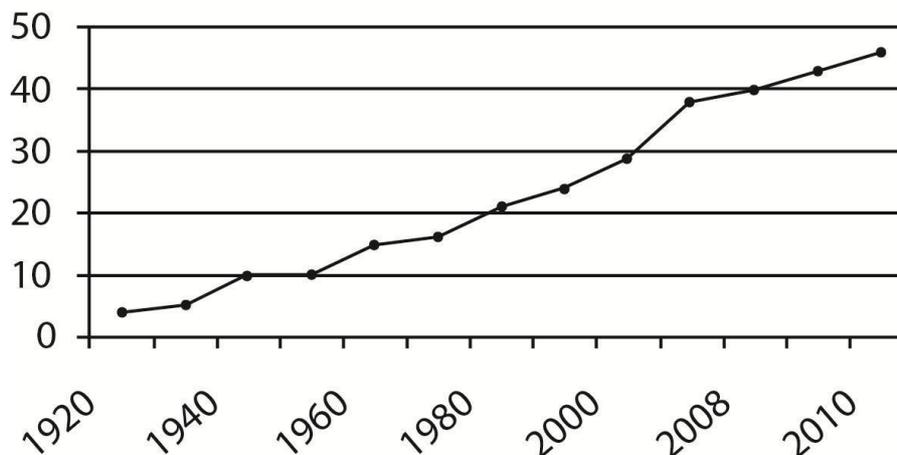
APHA 1946	CEPH 1974	CEPH 2014
1. The nature functioning of human organisms;	1. Biological, physical, and social factors;	1. Biostatistics,
2. The nature behaviour of various forms of parasitic life;	2. Social and behavioural sciences;	2. Epidemiology,
3. The physical environment;	3. Health service delivery systems,	3. Environmental health sciences,
4. Social and economic factors;	4. Community health needs;	4. Health services administration
5. The major source of quantitative information and its numerical presentation and analysis.	5. Information collection, storage, retrieval, analysis, and dissemination;	5. Social and behavioural sciences.
	6. Environmental monitoring, analysis, and management.	

The history of American accreditation therefore took root at a time when public health was beginning to find its feet as a profession and against a laissez faire backdrop, which saw many schools geared toward profit making above quality and this is perhaps a situation which continues in a sense today with the growth of unrecognized, illegitimate degree and accreditation mills that “sell” (19). Against these developments, were the architects of an alternative and earnest public health movement based on the research focus of the German schools and the practical training methods on the English schools (20). This period of development can be seen as 1916 to 1946, from the first Rockefeller School of Public Health to the implementation of a fully functioning accreditation scheme. This period directly coincides with an epoch engrossed in war.

Although initially the criteria had been kept flexible to allow more schools to participate, the arithmetic growth of accreditation in the U.S. was not overwhelming until around the turn of the twenty first century (21) see Figure 1. In 1946, there were nine schools of public health accredited in America (13). Nearly 30 years later, in 1975 after the move to the CEPH there were 19 schools

(22). This had risen to 27 in 2000 (23) and by 2014 there were over 50 schools accredited and over 100 programmes of public health accredited (17).

Figure 1. Accredited American SPHs by Decade (compiled by Rosenstock, L. *et al*)



After the Second World War, Europe began a process of reconciliation culminating in the present union enshrined through the 1992 Maastricht treaty where, under article 126, the role of union in education was to “encourage cooperation”. It is in these post war collaborative movements where European accreditation, like its American counterpart, found its foothold. As one commentator phrased, “*there was an intensified development of accreditation during the 1990s in various European countries. This trend is parallel with the rapid growth in international and trans-national organisations after the Second World War*” (24). Moreover, the first large scale appearance of accreditation was a direct result of competition and the post communist transformation in the Central and Eastern European region where the markets were opened up to private and foreign providers (25).

This European movement of the 1980s and 1990s was to create a fertile environment for international collaborations at a public health school level with examples being, The European Training Consortium in Public Health (ETC-PH) (26), BRIMHEALTH (27) and the European Masters of Public Health (EMPH). The latter of these, the EMPH was a collaboration between ASPHER and the World Health Organisation (WHO) to develop a European master's degree in public health based on the WHO's 38 Health For All (HFA) principles (28). This followed from a momentum in European Public Health created by the elaboration of these principals into practice which was given the title of “new public health” (29). Although this term was not new, it was first coined in 1913 as a bacteriological approach (30) and again in 1923 as health promotion (31), it did reflect the more comprehensive view of public health which still resounds today. The EMPH embraced three distinct areas: a) it should be concerned with the masters level, b) it should reflect the philosophy of the WHO's HFA and c) students should be exposed to a European perspective (32). It was enthusiastically anticipated that the EMPH would raise the standards of education and training across the European region and would provide a “gold standard” of which other schools and programmes would eagerly follow (33). Alas, attempts to realise the programme failed.

The failure of the EMPH was a product of several reasons: credit transfer mechanisms were poorly developed; systems didn't accept qualifications from other institutions; the programme was too inflexible and did not respect the diversity and traditions of the countries; European content didn't need to be all encompassing as it could be integrated into existing courses; and moreover, given the heterogeneity of public health training programmes in Europe it was not possible to introduce a rigorous quality assessment and assurance (34). As a result of these failures the introduction of accreditation was seen as a necessary and fundamental step. However, accreditation

was not introduced but rather a process of mutual recognition of courses, modules, programmes and institutions was established entitled the Public Health Education European Review, more commonly known as the PEER review (35). The three central principals of this review were a reflection of its EMPH foundations (33):

- The course/module/programme/institution should be concerned with postgraduate training in public health.
- The course/module/programme should be based on the philosophy of the Health for All policy.
- The students should be exposed to a European perspective.

The PEER review was established by 1994 but it differed from accreditation as it was devised primarily as a quality improvement tool conducted through academic peers in a collegial manner. Although the initial anticipation was for a multi-agency quality assurance approach this did not materialise until the advent of accreditation proper which was proposed and accepted in 2001. This was exactly the same time that ASPHER began to use the PEER review for the establishment and quality improvement of new schools and programmes of public health in the Central and Eastern European region (36). This project gave valuable insights for accreditation (37) and also showed how PEER could be used as a framework for development.

In 2011, the Accreditation Agency was established and consisted of ASPHER and four other public health based NGOs, European Public Health Association (EUPHA), European Public Health Alliance (EPHA), European Health Management Association (EHMA) and EuroHealthNet. At the time of its establishment European accreditation focused solely upon the accreditation of postgraduate (so-called second cycle) public health degrees. Similar to the American model, the processes also contained specific criteria on core curricula content: introduction, methods, population health and its determinants, Health Policy, economics and management, Health Education and promotion, cross-disciplinary themes and culminating experiences. These areas were based on the core subject domains developed through earlier ASPHER work on Public Health Core Competencies (38).

In 2014, following a two-year review of its processes, APHEA introduced two new aspects in addition to programme accreditation. The first was a curriculum validation process which replaced its initial eligibility criteria by ensuring that curricula contain the basic structure and core content expected from a modern comprehensive public health offering. The second addition was to focus on institutional accreditation which would assess the relationship of an institution, in terms of education, research and service, to the specific local, national, regional or international environments in which they serve, their so-called “social accountability” (39). This development represents a reversal of the American model which started with institutional accreditation followed by programme level accreditation.

So far, the remit of APHEA was in keeping with the first and third central principals of the earlier PEER review. However, for future development, the postgraduate focus was also brought into question with proposals to develop accreditation for bachelor and PhD programmes, thus covering the whole spectrum of school based education in public health. APHEA also began consultations on the development of training accreditation which would cover smaller units from continuous personal development (CPD), MOOCs through to summer schools which can be delivered outside of school settings. Finally, the role of using the accreditation criteria as a framework for quality improvement and development also requires future scrutiny as the PEER review had worked exceptionally well in this regard (36).

The second central principle of the previous PEER review is based upon the health for all policies of the 1970s which has been superseded of late by the development of the WHO's Essential Public Health Operations (EPHOs) (40). An encompassing definition given for these is, “*a set of fundamental actions that address determinants of health, and maintain and protect population*”

health through organized efforts of society” (41). The potential therefore lies in the ability to change the older HFA targets for these later EPHOs, for example, by translating the operations in to a series of competences and then assessing how these competences are integrated into the education of the workforce. However, care will need to be taken so that any system will be flexible enough to respect the diversity and traditions of different countries and thus, hopefully avoiding some of the reasons for the failure of the EMPH whilst learning the lessons from Charles-Edward Winslow’s introduction of accreditation in America.

All of these activities however are predicated on the future potential for sector based professional accreditation and there are two areas within the history of Public Health accreditation which may help determine its future trajectory. The first area is one of collaboration and second, the liberalisation of the education sector. The origins of both the American and European models of accreditation appeared as a result of interstate or supranational collaboration and an opening up of markets in education. The realisation of Europe has installed significant economic liberalisation, especially in the service markets. Many services in Europe are now no longer a state responsibility but rather a subject of the free market and how far this free market extends remains to be seen. For example, what will be the influence of the mooted agreements between the North American Free Trade Area (NAFTA) and the European Union on the liberalisation of the educational market? In many ways perhaps the free movement of people already enshrined in the European project has created a quasi liberalised market with students being free to study in any country. This freedom of movement is often liberally extended to international students travelling the globe. Equally important for the forthcoming years will be the influence of technologies in teaching which allow for students to receive a foreign based education without the need or hindrance of travel. The result of these present and future changes is conceivably then one of burgeoning competition above that of collaboration where education systems both within and between states increasingly compete for students and their own subsequent economic survival. The origins of the Bologna declaration and the resultant European Higher Education Area is a cooperation based on mutual trust between education systems of the member states (42) but the reason why America had accreditation before Europe is because accreditation is not best suited to centralised governments (1). The question must then be raised, if collaboration turns in to competition, will the national state accreditation agencies be seen as a credible guardian of trust or will they be seen as protective of their national systems, anti-competitive and riddled with conflicts of interest?

References

1. Maassen PA. Quality in European higher education: recent trends and their historical roots. *Eur J Educ* 1997;32:111-27.
2. Ramirez FO, Boli J. The political construction of mass schooling: European origins and worldwide institutionalization. *Sociol Educ* 1987;60:2-17.
3. Evans P. Accreditation in the United States: Achieving Quality in Education. Third European Symposium. Zurich; 2000.
4. Flexner A. Medical education in the United States and Canada. From the Carnegie Foundation for the Advancement of Teaching, Bulletin Number Four, 1910. *Bull World Health Organ* 2002;80:594-602.
5. Flexner A. I Remember: The Autobiography of Abraham Flexner: Simon and Schuster; 1940.
6. Fee E. The education of public health professionals in the 20th century. In: Institute of Medicine. In: Gebbie KM, Rosenstock L, Hernandez LM, editors. Who will keep the public healthy? Educating public health professionals for the 21st century. Washington: National Academies Press; 2003. p. 222-61.
7. Welch W, Rose W. Institute of Hygiene: a report to the General Education Board of Rockefeller foundation. New York: The Rockefeller Foundation; 1915.

8. Abbott AC, Boyd M, Bristol LD, Brown WH, Geiger JC, Greeley SA, et al. Standardization of Public Health Training: Report of the Committee of Sixteen. *Am J Public Health (NY)* 1921;11:371-5.
9. Gebbie KM, Rosenstock L, Hernandez LM. Who will keep the public healthy? Educating public health professionals for the 21st Century. Washington, D.C.: National Academy of Sciences; 2003.
10. The medical diploma scandal. *Am J Public Health (NY)* 1924;14:141-2.
11. Accreditation of Schools of Public Health. *Am J Public Health Nations Health* 1945;35:953-5.
12. Shepard WP. The professionalization of public health. *Am J Public Health Nations Health* 1948;38(1 Pt 2):145-53.
13. Shepard W, Atwater RM, Anderson GW, Bauer W, Defries RD, Godfrey Jr ES, et al. Institutions Accredited by the American Public Health Association to Give the Degree of Master of Public Health (Diploma of Public Health in Canada) for the Academic Year 1946-1947. *Am J Public Health Nations Health* 1946;36:244-7.
14. Winslow C-EA. The accreditation of North American schools of public health: American Public Health Association; 1953.
15. Association News. *Am J Public Health* 1974;64:853-933.
16. Manual for accreditation of graduate schools of public health 1975. *Am J Public Health* 1975;65:317-9.
17. CEPH. The Council on Education for Public Health 2014: <http://ceph.org/> (accessed: February 01, 2015).
18. Criteria and guidelines for accrediting Schools of Public Health. *Am J Public Health Nations Health* 1966;56:1308-18.
19. Altbach PG, Knight J. The internationalization of higher education: Motivations and realities. *J Stud Int Educ* 2007;11(3-4):290-305.
20. Fee E. The WelchRose Report: blueprint for public health education in: The WelchRose Report: A public health classic, a publication by the Delta Omega Alpha Chapter to mark the 75th anniversary of the founding of the Johns Hopkins University School of Hygiene and Public Health, 1916 1992. Baltimore: Delta Omega Honorary Public Health Society; 1992:1.
21. Rosenstock L, Helsing K, Rimer B. Public health education in the United States: then and now. *Public Health Rev* 2011;33:39-65.
22. Matthews MR. Some trends in schools of public health. *Am J Public Health* 1975;65:291-2.
23. Sommer A. Toward a better educated public health workforce. *Am J Public Health* 2000;90:1194-5.
24. Hämäläinen K, Haakstad J, Kangasniemi J, Lindeberg T, Sjölund M. Quality assurance in the Nordic higher education: European Network for Quality Assurance in Higher Education; 2001.
25. Schwarz S, Westerheijden DF. Accreditation and evaluation in the European higher education area: Springer; 2004.
26. Colomer C, Lindstrom B, O'Dwyer A. European training in public health: A practical experience. *Eur J Public Health* 1995;5:113-5.
27. Kohler L, Eklund L. BRIMHEALTH. A successful experience in Nordic-Baltic co-operation in public health training. *Eur J Public Health* 2002;12:152-4.
28. Eskin F, Davies A. Steps towards the development of European standards for public health training. *Eur J Public Health* 1991;1:110-2.
29. Ashton J, Seymour H. The new public health: the Liverpool experience: Open University Press; 1988.
30. Hill HW. The new public health: Press of the Journal-Lancet; 1913.

31. Winslow CA. *The Evolution and Significance of the Modern Public Health Campaign*. New Haven (CT): Yale University Press; 1923.
32. Köhler L, Bury J, de Leeuw E, Vaughan P. Proposals for collaboration in European public health training. *Eur J Public Health* 1996;6:70-2.
33. Bury J, Köhler L, de Leeuw E, Vaughan P. The future of ASPHER collaboration in European public health training. *Zeitschrift für Gesundheitswissenschaften (German Journal of Public Health)* 1994;2:119-30.
34. Cavallo F, Rimpela A, Normand C, Bury J. Public health training in Europe. Development of European masters degrees in public health. *Eur J Public Health* 2001;11:171-3.
35. Bury J, Gliber M. *Quality Improvement and Accreditation of training programmes in Public Health*. Lyon: Fondation Mérieux; 2001.
36. Goodman J, Overall J, Tulchinsky TH. *Public Health Workforce Capacity Building: Lessons Learned from “Quality Development of Public Health Teaching Programmes in Central and Eastern Europe”*. Brussels, Belgium: Association of Schools of Public Health in the European Region (ASPHER); 2008.
37. Otok R, Levin I, Sitko S, Flahault A. European Accreditation of Public Health Education. *Public Health Rev* 2011;33:30-8.
38. Birt CA, Foldspang A. The developing role of systems of competences in public health education and practice. *Public Health Rev* 2011;33:134-47.
39. Boelen C, Woollard B. Social accountability and accreditation: a new frontier for educational institutions. *Med Educ* 2009;43:887-94.
40. World Health Organization (WHO). *European action plan for strengthening public health capacities and services*. World Health Organization, 10-13 September 2012. Report No.: EUR/RC62/Conf.Doc./6 Rev.2.
41. Bjegovic-Mikanovic V, Vukovic D, Otok R, Czabanowska K, Laaser U. Education and training of public health professionals in the European Region: variation and convergence. *Int J Public Health* 2013;58:801-10.
42. Chauvigné C, Ottenwaelter M. *Accreditation of public health training programs in Europe: Mapping and analysis of quality assurance and accreditation systems in public health education*. Rennes, France: Working Package 2 Report, Leonardo Da Vinci Programme, 2006.