

Public Health Symposium

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SYDNEY WATSON SMITH LECTURE FOCUSING THE EQUITY LENS: HOW SHOULD WE GO ABOUT EVALUATING PUBLIC POLICIES TO REDUCE HEALTH INEQUALITIES?

Professor Margaret Whitehead, WH Duncan
Professor of Public Health, University of Liverpool,
Liverpool, UK

It is increasingly being recognised that there are unacceptable, and in some cases widening, inequalities in health within European countries. Concerted action is needed, made more urgent by the predicted effects of the global economic downturn. The Global Commission on Social Determinants of Health made three overarching recommendations for such action: improve the conditions of daily life; tackle the inequitable distribution of power, money and resources; and measure and understand the problem and assess the impact of action.¹ On this last point, the Commission called for 'health equity impact assessment of all public policy and market regulation' – a tremendous conceptual and methodological challenge for the research community.

Approaches are beginning to be developed that show promise in starting to meet this challenge, the underpinning principles and examples of which are discussed in this lecture. Above all there is a need to find ways of identifying differential policy impacts, asking: Who are the winners and who the losers? Who benefits and who pays? What is the impact of a policy on the most vulnerable in society? A note of caution is sounded in the final section, as we enter treacherous waters globally. There is a risk of indiscriminate cuts in public funding and services, but resulting in differential consequences, which need to be monitored very carefully. Last but not least, there is a danger of the abuse of evidence to justify public policy reforms, a development that requires the utmost vigilance by researchers and policymakers alike.²

References

- 1 Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization; 2008. Available from http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
- 2 Whitehead M, Hanratty B, Popay J. NHS reform: untried remedies for misdiagnosed problems? *Lancet* 2010; 376:1373–5.

WHAT DO WE MEAN BY 'EVIDENCE' – SCIENTIFIC AND POLITICAL VIEWPOINTS

Professor Ian Sanderson, Professor of Policy and Analysis and Evaluation, Leeds Metropolitan University, Leeds, UK

The legacy of the Enlightenment lives on in our resilient optimism about the extent to which we can change and improve the world through action informed by scientific knowledge. An 'evidence-based' approach to policy making and practice is widely accepted as epitomising rationality in the conduct of human affairs. But the notion of 'rationality' is contested and this presentation seeks to cover the key dimensions of controversy.

Dispute over what constitutes 'evidence' is rooted in controversies in the philosophy of science. Critics of the notion of 'evidence-based policy making' argue that it is a species of 'scientism' and privileges a 'foundationalist' view of evidence, manifested in the 'hierarchical' model with evidence from randomised controlled trials at the pinnacle. Fallibilist critics argue that evidence is provisional, partial and socially contingent and can never provide an immutable foundation for action. Moreover, it is argued that there are other forms of 'valid knowledge', deriving from experience and relating to the interests and values of stakeholders, that are important in helping policy makers and practitioners make 'good' decisions. What constitutes 'relevant' evidence depends on the particular context of practice – in terms of purpose, participants, power relations and procedure.

From a perspective rooted in pragmatism and neoinstitutionalism, and employing MacIntyre's Aristotelian notion of 'practice', it is proposed that the concept of 'appropriateness' encapsulates the logic of 'good practice' and encompasses the domains of effectiveness, feasibility and acceptability in policy making. From this perspective, practical wisdom ('phronesis') would be manifested in the concept of 'intelligent policy making' in which evidence is combined with other relevant knowledge in deliberative processes that encompass ethical-moral issues, promote learning and guarantee transparency.

DEVOLUTION AND HEALTH POLICY: FOUR STORIES AND FIVE LESSONS

Dr Scott Greer, Associate Professor of Health Management and Policy, University of Michigan School of Public Health, Ann Arbor, Michigan, USA

This presentation reviews health policy and policymaking since political devolution in 1998. Day-to-day policy can be understood as the result of the chancy interaction of politicians, problems and policy ideas in governments with the power to act. These vary from country to country; the political agendas, party politics and policy debates have different participants and contents. The result is the divergence such as that between England, with its strong Conservative party and pro-market policy ideas, and Scotland. It is difficult to characterise the experience of health policies over such time in anything but the broadest of strokes, and policy trajectories have changed with politics and as their consequences become clearer. Over the longer run, however, we can see lessons emerging from the different experiences of the devolved health systems. Governments might not learn them, but we can see the case for each in the experience of the four UK health policies.

MASS VERSUS TARGETED CARDIOVASCULAR SCREENING

Dr Simon Griffin, Assistant Director, MRC Epidemiology Unit Institute of Metabolic Science, Addenbrooke's Hospital, Cambridge, UK

Cardiovascular disease continues to be a leading cause of morbidity, mortality and health service use. As Rose described, tackling this problem requires a population-based strategy to shift the distribution of risk factors. A complementary approach is also likely to be necessary, including the estimation and communication of risk in order to motivate behaviour change and allocate scarce preventive resources efficiently.

However, considerable uncertainties remain, particularly concerning the overall cost-effectiveness of a programme of population screening. In addition there are few data available to inform policy decisions about relative investment in population and high risk approaches and increasing overlap between the two strategies in the era of the 'polypill' and accessible, far-reaching technological applications. Nevertheless, governments and health services around the world are considering, developing or implementing programmes of population screening to identify individuals at high risk of cardiovascular disease.

Using data from the EPIC-Norfolk study we have demonstrated that a targeted approach to risk assessment is likely to be associated with a similar reduction in the incidence of cardiovascular disease and type 2

diabetes as a mass population screening programme, but at lower cost and with lower risk of adverse consequences. Targeting can be achieved using data currently routinely available in general practice electronic records.

LEGISLATIVE APPROACHES TO IMPROVING DIET

Dr Mike Rayner, Director British Heart Foundation Health Promotion Research Group, Oxford University, Oxford, UK

This talk will provide a definition of 'law', and discuss law as it relates to public health at local, national and European levels. It will show how the law might be used to regulate the food chain for public health benefits in relation to the production, manufacturing, retailing and marketing of food, and the 4Ps of marketing (product, price, promotion and place).

It will suggest that the law cannot be used to regulate diets, except in rare circumstances (e.g. school meals); discuss the relationship between legislative and voluntary approaches to the regulation of the food chain; and propose how legislation that regulates the marketing of foods might be extended, for example, through:

- compositional standards for foods in relation to certain nutrients (particularly trans-fatty acids and salt);
- taxes on unhealthy foods and subsidies for healthy foods (and other means of regulating the price of foods);
- bans on the promotion (advertising) of unhealthy foods to adults as well as children; clearer labelling of foods as healthy or unhealthy;
- restrictions on the sales of unhealthy foods in particular locations (e.g. at or near schools).

Finally, it will propose that in future there might be synergies between legislation aimed at regulating the marketing of foods in order to improve diets and in order to protect the environment.

PREVENTING ALCOHOL-RELATED HARMS: THE CHALLENGES FOR TRANSLATION?

Professor Eileen Kaner, Institute Director & Professor of Public Health Research, Institute of Health & Society, Newcastle University, Newcastle upon Tyne, UK

Excessive drinking is currently the second greatest risk to health and well-being in developed countries. Indeed, it has been estimated that alcohol-related problems cost the UK £25 billion each year. Moreover, the burden of these problems falls on a wide range of public sector organisations. The wide-scale nature of the health and social consequences of excessive drinking have led to the concept of the 'preventive paradox'. Thus it has been proposed that the greatest impact in tackling alcohol problems can be made by dealing with the very large group of non-dependent drinkers who are at risk or

harm due to their drinking, compared with a focus on the relatively small group of individuals with the most severe problems (including dependence).

This presentation will describe the role of the National Institute for Health and Clinical Excellence (NICE) Programme Development Group in evaluating the wide ranging evidence-base relating to the prevention of excessive drinking and alcohol-related problems, as well as the challenge of formulating this evidence into public health guidance incorporating both upstream (population level) and downstream (practitioner level) interventions.

A large and high quality evidence base was identified for both population-level and practitioner-level interventions (primary and secondary prevention respectively). However, much of this work was conducted outside the UK and often in particular population groups. Thus it was necessary to consider the applicability and specificity of the evidence base to the wider population. In addition, it was also necessary to consider the resource implications of the recommendations which were relevant to policy-makers, commissioners, service managers and practitioners both inside and beyond the National Health Service.

HOW MUCH CAN POLICY INTERVENTIONS DO TO REDUCE ALCOHOL-RELATED HARMS?

Professor Petra Meier, Section of Public Health, School of Health and Related Research (SchARR), University of Sheffield, Sheffield, UK

Controlling alcoholic affordability and availability and supporting drinkers in cutting down their consumption are among the most effective policy options available to governments. These policies can be unpopular with consumers and industry, so it is imperative that decisions are based on sound evaluation of evidence, modelling of predicted outcomes and evaluation of actual effects.

The UK is at a turning point with regard to alcohol policy and the international policy and research community are observing with interest. Until 2007, legislative and economic developments facilitated a gradual deregulation of availability (e.g. abolishing restrictions on hours of sale in England and encouraging a 'vibrant night-time economy') alongside real-terms price reductions which made alcohol significantly more affordable, especially in supermarkets and off-licenses (off-trade). During 2008 to 2010 there was evidence of substantial public, media and political concern about alcohol-related harm and a possible reversal of policy direction, with several tax increases, a mandatory code and a proposed bill on minimum pricing. Now, in 2011, the situation is less clear.

This presentation will take a closer look at the potential effects of different pricing, availability and screening and

brief intervention policies on alcohol-related morbidity and mortality, and contrast these with a 'do nothing' policy option.

PREVENTION OF OBESITY IN CHILDREN: ARE WE TACKLING THE RIGHT THINGS?

Dr Jennie Macdiarmid, Public Health Nutrition Research Group, University of Aberdeen, Aberdeen, UK

In the 2009 Scottish Health Survey, more than one in four children aged 2–15 years were either overweight (14%), obese (6%) or morbidly obese (8%). Significant progress has been made in improving nutritional standards in schools in the past decade, but food eaten outside school may have a greater impact on overall dietary quality. From 2003–6 free fruit was provided to younger primary school children, but increasing fruit intake is unlikely to reduce obesity, while increasing fruit juice intake has adverse effects for dental health and possibly for glucose tolerance. Breastfeeding is often considered protective for child obesity, but evidence is accumulating that this may not be a causal association.

Increasing active travel and sport in children is also widely advocated, but the change in energy balance needed for an overweight child to achieve a healthy weight would be difficult to achieve by exercise alone. It is also increasingly recognised that reducing sedentary activity may be important for preventing excess weight gain. Parental obesity is a strong predictor of child overweight, but many parents fail to recognise obesity in their children, increasing the challenge for prevention. A survey of children across Scotland in 2006 found that intake of sugar and saturated fat was too high and that wide-ranging changes to the diet would be needed to reach the targets for these nutrients. These changes will be difficult to make but could be supported by policies on availability and promotion of high energy foods consumed outside the home or school.

OBESITY AND EVIDENCE: A PUBLIC HEALTH CHALLENGE

Dr Harry Rutter, Consultant in Public Health Medicine, University of Oxford, Oxford, UK

The growth in the level of obesity across the population in recent years presents a wide range of challenges for research, policy and practice. The evidence base to support actions to reduce obesity is growing, but remains patchy and limited. Obesity is an outcome of a complex adaptive system, which poses particular problems for research, and also for interventions. There is a pressing need to look beyond the biomedical paradigm if we are successfully to tackle this epidemic. This talk explores these issues, and considers approaches to remedy the situation.

DEVELOPING AND IMPLEMENTING A NATIONAL PUBLIC MENTAL HEALTH POLICY IN SCOTLAND: A VIEW FROM THE POLICY FRONT LINE 2001–2008

Gregor Henderson, National Lead for Wellbeing and Population Mental Health, the National Mental Health Development Unit, London, UK (previously, Director, National Programme for Improving Mental Health & Well-being, Scottish Government 2003–08)

This lecture will use a mental health case study to identify how a public mental health and health improvement policy was developed and implemented in Scotland over the past decade.

The lecture will begin with an introduction to public mental health and mental health improvement and why this area has emerged as a key component of both public health and mental health policy over the past decade and across a number of governments.

The initial policy work in Scotland was prompted by a range of factors, including concerns at rising rates of mental illness, particularly more common mental health problems and by rising suicide rates, along with the demands of grass roots activists, voluntary sector agencies and key professional organisations and academics that there be a more determined policy response with high levels of political support to improve the mental health of people living in Scotland.

Informed by research and evidence and a range of innovations from across the UK and other parts of the world, widespread engagement of stakeholders and partners across and outwith Government and with the support of local agencies responsible for delivery, a national public mental health programme was initiated and implemented by the Scottish Government.

Drawing on a series of published sources and personal experience and reflection, the lecture will identify the key drivers for this work, the major components of the policy programme, its successes, failures and lessons learned. The case study aims to highlight a number of key themes and issues relevant to the development and implementation of current and future public health policies.

SCOTLAND'S SUICIDE PREVENTION STRATEGY ('CHOOSE LIFE'): EVIDENCE AND POLITICS

Professor Stephen Platt, Professor of Health Policy Research, University of Edinburgh, Edinburgh, UK

Following a high profile conference at the University of Edinburgh in November 1999 ('The Sorrows of Young Men') which highlighted adverse suicide trends in Scotland, particularly among young to mid-aged adult men, the Scottish Parliament signalled its concerns in a debate held in April 2000, during which the then Deputy Minister for Community Care articulated the Scottish Executive's determination to tackle the issue. This ministerial commitment was the basis for a development process which culminated in the publication (December 2002) of *Choose Life*, a ten-year suicide prevention strategy and action plan, with the overarching aim of reducing suicide in Scotland 20% by 2013.

The *Choose Life* strategy reflected the consensus that suicide prevention should not be addressed in isolation, but should be part of a national public health policy to promote and support a positive approach to mental health. It set out a public health, population-based approach designed to raise public awareness and build skills and capacity within communities to recognise suicide risk, and improve knowledge of what works to prevent suicide. Independent evaluations have been conducted on phase 1 (2003–6) and phase 2 (2006–8) and findings have been published.

This presentation will explore the interplay of research, evaluation and politics in the development, implementation and evolution of *Choose Life*. It will consider the challenges of establishing and mainstreaming a new policy priority and discuss the implications of the Scottish experience for international efforts to prevent suicide.

Further reading

- Russell P, Lardner C, Johnston L et al. *Evaluation of phase 2 (2006–08) of the Choose Life strategy and action plan*. Edinburgh: Scottish Government Social Research; 2010. Available from <http://www.scotland.gov.uk/Publications/2010/03/30174735/14>
- Platt S, McLean J, McCollam A et al. *Evaluation of the first phase of Choose Life: the National Strategy and Action Plan to Prevent Suicide in Scotland*. Edinburgh: Scottish Executive Social Research; 2006. Available from <http://www.scotland.gov.uk/Publications/2006/09/06094657/22>
- Scottish Executive. *Choose life: a national strategy and action plan to prevent suicide in Scotland*. Edinburgh: Scottish Executive; 2002. Available from <http://www.scotland.gov.uk/Publications/2002/12/15873/14481>