INTRODUCTION: THE POLICY ENVIRONMENT, WHAT IS THE PROBLEM?

Professor Mark Petticrew, Professor of Public Health Evaluation, London School of Hygiene and Tropical Medicine

There is sustained interest in how evidence can be used to inform health inequalities policy, and in particular in how we can assess the impacts of policies outside the health sector. However there are many challenges which make using such evidence difficult (but not insurmountable). One is that health inequalities are strongly socially determined, and so we generally require evidence on the effects of policies outside the health sector. There are many challenges to creating this evidence base, including conceptual challenges (because evidence is understood differently in different policy areas) and methodological challenges (because the main determinants of health - such as income, housing, transport and welfare policies - are not easily amenable to experimental manipulation. There are also ethical and political challenges. Among these is the acceptability to the public and politicians of using policy levers to address health problems at a population level, when such problems are often seen as simply matters of ‘poor lifestyle choices’ by individuals (e.g. smoking, obesity).

A further pressing issue is that evidence-based approaches often prioritise research questions about effectiveness above all else. However not all policy problems can be framed as simple ‘what works’ questions. This can pose particular difficulties when we move to considering the social determinants of health. Here, the simple separation of the social world into ‘things that work’ and ‘things that don’t work’ can be unhelpful. This presentation will discuss these and other issues relating to the production and use of policy-relevant evidence.

MOVING PUBLIC HEALTH RESEARCH TO POLICY: A CAUTIONARY TALE FROM SCOTLAND.

Professor John Frank, Director, Scottish Collaboration for Public Health Research and Policy, Edinburgh

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Background

Scotland’s current Early Years Collaborative (EYC) explicitly aims to optimise the developmental status of all Scottish children entering school, but includes no specific guidance on how that outcome should be measured. Our aim was to pilot an internationally validated tool, the Early Development Instrument (EDI), to assess global development in Scottish children shortly after school entry, in one Local Authority (LA) between 2011 and 2012. The phase 1 objective was to test and adapt the Canadian-designed EDI for the Scottish context. Phase 2 aimed to implement the EDI in one local authority so as to provide the community with anonymised information about their children’s strengths and vulnerabilities, down to the school level. In both phases, the psychometric and discriminatory properties of the EDI were tested.

Methods

During phase 1, 14 first-grade (P1) teachers assessed 154 of their students using the 104-item EDI, after a half-day of training in its use. Qualitative methods were used to gather feedback from teacher participants on the tool and the process. Using these results, very minor edits to the EDI were made. Phase 2 was conducted with 70 P1 teachers and 1,180 P1 children using a descriptive cross-sectional design. The parents of 18 children opted out of participation; 68 pupils were excluded for missing data, inadequate time spent with the teacher, or having special needs (the EDI is always used to assess only ‘normal children.’) The EDI scores in each of the five developmental domains were linked to socio-economic status (SES) based on the standard Scottish datazone values of the Scottish Index of Multiple Deprivation, for the residential addresses of all children. Results for geographic areas were GIS-mapped, down to the level of the six primary school clusters in East Lothian.

Results

The qualitative work demonstrated that the vast majority of teachers found the EDI to be easy to use, acceptable (98% of parents consented), feasible and appropriate to the Scottish context. Phase 2 analyses found the overall prevalence of ‘developmental vulnerability’ of East Lothian P1 children in 2011-12 to be 27% – a few percentage points higher than in Australia, and a few lower than in British Columbia, Canada. A clear SES gradient was observed across all five domains, very similar to that seen internationally, with...
one six children ‘developmentally vulnerable’ in the highest-SES quintile of children’s addresses, versus nearly 40% in the lowest-SES quintile of addresses. All five domains of the EDI exhibited good internal consistency (Cronbach’s α 0.76 or higher). In this setting, EDI data collection cost about £20 per child (for substitute teachers’ time during about a day of EDI completion for each teacher’s P1 class), which equates to about 7p per capita total LA population per annum, based on the current Scottish crude birth rate of about 1% and the Australian model of 3-yearly repeats.

Conclusion

The pilot results indicate that the EDI is appropriate and feasible for use in Scotland. During the current phase in East Lothian, local community groups are enthusiastically utilising anonymised EDI findings for improving various neighbourhoods’ early years’ services and resources. There are also plans for another P1 cohort to be tested in January 2015, if suitable funding can be found. However, despite the very promising performance, acceptability and cost of the EDI in East Lothian, SCPHRP and its collaborators have found there currently appears to be very little interest among key Scottish stakeholders involved in the Early Years Collaborative (EYC), in further roll-out of the EDI across Scotland. This is spite of the strong interest of a number of LAs in pursuing that approach to actually measuring what the EYC explicitly calls for: optimisation of the global developmental status of P1 children. This reluctance to further test the EDI’s practicability in Scotland appears to be related to the currently delicate relationship between the SG, and LAs. The current devolution of decision-making to Scottish LAs in many sectors, as well as recent major budget cuts, appear to make it awkward for the SG to actively promote specific actions (including the use of specific measurement tools, such as the EDI) by LAs across Scotland, although one suspects that this impasse might be resolved by new budgetary allocations from the SG to cover all the costs of such guidance. Further discussions with key stakeholders are addressing this issue.

A BRIEF HISTORY IN SCOTLAND – EVIDENCE-BASED POLICY

Dr Andrew Fraser, Director of Public Health Science, NHS Health Scotland

The development of evidence that is useful and useable for policy is a rapidly changing field. Variables are numerous, and the communities of evidence-makers, sifters, users, policy and decision-makers are still coming to terms with each other. The last two decades have seen important advances in Scotland, and lessons to learn. Evidence now provides clearer messages on the right policy steps to take, and to avoid. There are successful examples and models among them; in addition to professional and managerial skills, the finer human qualities of patience, timing, use of language, pragmatism and empathy with policymakers are some of the ingredients.

DISTORTING ‘EVIDENCE-BASED POLICY’: TOBACCO COMPANIES, HEALTH INEQUALITIES AND POLICY INNOVATION

Professor Jeff Collin, Professor of Global Health Policy, University of Edinburgh

The tobacco industry has a well-established history of distorting and manipulating ‘evidence’ to obstruct effect health policy and protect its product market. Historic tactics include attacking health research as ‘junk’ science and presenting industry-funded research as a legitimate dissenting voice. More recently, the tobacco industry has responded to the current policy focus on health inequalities by appropriating and misrepresenting language around the social determinants of health in order to argue against regulatory interventions such as taxation, cessation support and plain packaging. In the context of plain packaging, tobacco companies have also focused on a lack of evidence for positive health impacts as a basis for delaying policy innovation.

THE DRINKS INDUSTRY – EVERYTHING IN MODERATION?

Dr Jim McCambridge, Senior Lecturer in Behaviour Change, London School of Hygiene and Tropical Medicine

Alcohol industry actors claim to be concerned with improving public health and reducing health inequalities. Various possible adverse impacts on the poor are articulated in relation to policy measures which industry actors have a vested interest in opposing and which are expected to be effective, such as minimum unit pricing. This presentation reviews recent UK research work on the nature of the alcohol industry and considers the need for new research.
WHAT WILL REDUCE HEALTH INEQUALITIES AND HOW MIGHT THIS BE ACHIEVED?

Dr Katherine Smith, Reader in Global Public Health, University of Edinburgh

Despite a wealth of research and policy initiatives, progress in tackling the UK’s health inequalities has been limited. This presentation will explore whether there appears to be any consensus among researchers about the kinds of policies that are likely to reduce health inequalities. Drawing on the results of a two-stage online survey, which identified 99 proposals for addressing health inequalities from multiple sources, the talk will explore which policy proposals researchers most supported (41 researchers participated in the first stage and 92 in the second). The results suggest that some consensus does exist among researchers about the kinds of policy approaches likely to reduce health inequalities in the UK. This includes: a more progressive distribution of income/wealth, a minimum income for healthy living, greater investment in services for deprived communities (especially early years), and regulatory policies to limit the impact of lifestyle-behavioural risks. However, researchers’ support for particular proposals varies depending on whether they are asked to express their expert opinion or to comment on the strength of the available evidence. The talk goes on to compare these approaches with existing and past policy responses to health inequalities, highlighting differences and similarities. Finally, the talk considers what empirical studies of policy development reveal about the factors necessary to achieve the kinds of policy changes supported by researchers and considers to what extent these factors are evident within efforts to reduce health inequalities.

MAKING EVIDENCE MORE USEFUL: PROGRESS, CHALLENGES, PROSPECTS

Professor Laurence Moore, Director of MRC/CSO Social & Public Health Sciences Unit, University of Glasgow

The evidence base available to support decision-makers in health inequalities policy and practice remains deficient. A substantial cause of this deficiency is the separation of the many relevant academic disciplines that could potentially contribute to a more useful evidence base, both from each other and from public health policy and practice. Academic structures, processes and incentives encourage ever more focused enquiry, unidisciplinary reductionist approaches that control out heterogeneity, minimise uncertainty and increase generalisability. This produces nice papers in high impact journals, highly scored grant submissions, safe science and good academic careers. However, it tends not to produce sophisticated, theorised, multicomponent policies and programmes that can achieve large public health impact. Policy makers and practitioners have an imperative to act, and opportunities to research, evaluate and learn from these actions are frequently missed. Strategic investment is required in structures and processes that facilitate interdisciplinary applied research that (i) focuses on complex problems, the interdependence of these problems and candidate solutions, and (ii) maximises the exchange of knowledge and resources between academic researchers, decision-makers and practitioners, and the public.