THE FOUNDATION FOR SCIENCE AND TECHNOLOGY

The Academy of Medical Sciences

DINNER/DISCUSSION SUMMARY

Public health – imposing choice?

Held at The Royal Society on Wednesday 20th October, 2004

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In the Chair: **Dr Robert Hawley CBE DSc FRSE FREng**
Deputy Chairman, The Foundation for Science and Technology

Speakers:
Derek Wanless
Inquiry Chairman, Securing Good Health for the Whole Population
Melanie Johnson MP
Parliamentary Under-Secretary, Department of Health
Lucy Neville-Rolfe
Company Secretary and Corporate and Legal Affairs Director, Tesco
Professor Siân Griffiths OBE
Immediate Past President of the Faculty of Public Health and Senior Clinical Lecturer, Department Public Health and Primary Care, Oxford University

DEREK WANLESS outlined some of the actions which needed to be taken if the conclusions of his reports were to be followed up. His estimate of the £30bn gap between the slow and quick uptakes of his conclusions had been accepted. The quick uptake demanded the full engagement of the population for delivery – high productivity in the health services, self care, professional mixing and integration, IT and resource funding and better assessment. We must move from narrowly defining public health as being concerned with protection, to seeing it as including prevention. This meant both society and individuals having the information and impetus to make rational choices. Why had we done so badly in recent decades on such issues as smoking, obesity and sexual diseases? Inconsistent objectives; poor resource planning; lack of structure were some answers. New structures must involve local networks operating within national frameworks, but not confined by centrally imposed objectives. The evidence base for effectiveness must be strengthened; economic drivers identified, research delivered. We must integrate social care and health; understand the demographic changes; and plan capacity to deal with them. Employers and private organisations must play a major role in engaging employees and others in managing health. Marketing must be used to ensure messages were understood, believed and used. We needed both to shift social norms and use information to enable people to understand their own risk profiles.

MELANIE JOHNSON accepted the £30bn gap – one half the present NHS expenditure. She endorsed the view that full engagement meant action from all sections of the community. The government must provide strong leadership, support and information. The local government, the voluntary sector and employers had a large role to play but implementation was essentially down to individuals. Progress was being made – the "5 a day" programme was a success in increasing input of fruit and vegetables, smoking was down. The White Paper, which will be published latter this year after extensive consultation will seek to promote concerted and quick action. But it will only be the start of action, not the conclusion. Action within government will mean joint working across departments – e.g. the DHSS, DofE, and DCMS will work with local authorities on programmes about child obesity. It is crucial to get things right with children, reducing their intake of sugar, fat and salt and offering free fruit and vegetables. The NHS should be seen as a health, not a sickness, service - promoting with others preventative health information and services.

LUCY NEVILLE-ROLFE said that Derek Wanless and the government were right to concentrate on prevention as well as protection. People cannot be directed; they must be persuaded; all stakeholders needed to join in this. Persuasion can work – note the drop in smoking; the one third drop in usage of full fat milk, the drop in saturated fats, and the increase in eating fruit and vegetables. But success depended on clear and simple messages being given and understood. Supermarkets can help – they can encourage change and harness consumer power. Tesco's aim is to encourage lifetime loyalty – which meant studying what customers wanted – value for money and availability – and working with the changes in society – e.g. less home cooking and a greater demand for convenience food. You needed to go with the grain of social attitudes and develop trust in what you say. It is possible to target disadvantaged groups – e.g. Tesco's value products for low incomes, which deliver healthy eating for the same price as less healthy consumption. Note also the positive impact on healthy eating of opening new stores in deprived areas. It was crucial to create the right demand, and this could be done by simple messages, clarity on what is being sought, few but well chosen targets and targets which aim at achievements in the 70%/80% range, not 30%.

PROFESSOR GRIFFITHS showed how important it was to see the determinants of health in the wider context – social and cultural observances, education, work, housing, and income – and to understand the policy interactions between them. The widening mortality gap between the professional and unskilled classes showed a major unmet challenge. There were lessons from health protection experiences, which could apply to prevention – most importantly, when individual privacy and rights need to be subordinated to regulation for the general good. The SARS epidemic revealed some of the problems. There was failure to pass information between China and Hong Kong; there was refusal of an individual to pass crucial information, and finally, there was the tension between the needs of the community and individual rights, when people were isolated in a tower block and moved into a camp. But it was only by extracting information and overriding individual rights that the epidemic was successfully controlled. This was, of course, a serious epidemic risking lives; but is smoking all that different? People die, although not so dramatically. Who makes the choice to allow others to suffer the effects of smoking? What are the media doing? If people understood the message what would they support? Look at Ireland, and note how attitudes change.

A number of speakers in the following discussion focussed on the absence of firm evidence about why certain trends were happening, and what the effect of measures were likely to be. None had explained, for example, why there had been the step change in 1990 in eaten, and the components of a diet which lead to obesity were uncertain; and while there were clear correlations between eating certain foods and reducing certain illnesses, the reasons for them were still unclear. The evidence was equally unclear about how one might attempt to change lifestyles - the work/life balance – and how beneficial this might be. Making the workplace healthier, alleviating stress by helping with family problems (e.g. childcare) should benefit employers as well as employees, and so rapid progress should be made in these areas. But so far progress was limited, so perhaps the economic advantages to employers needed to be based on firmer evidence. The environment should feature prominently as a major feature of health risk – e.g. traffic fumes – but to effect changes in such areas would meet strong opposition and could only succeed on a firm evidential basis.

Indeed, throughout the discussion the importance and difficulty of research was noted; it was to be hoped that it would figure prominently in the White Paper, although it had not been mentioned in the Minister's speech. If it was to be an aim of primary care to show individuals what their personal risks were, in such a way that they would change life style to ameliorate them, then much detailed research was needed, including expensive longitudinal studies. The advent of the ability to forecast risks through gene technology, would increase the pressure. DNA tests would demonstrate inherited inequality in risk to health; their use must be accompanied by action, which would allow individuals to redress the balance.

There was a certain amount of scepticism about the commitment of supermarkets to healthy eating. It was noted that sweets were still placed strategically close to checkout points; suppliers had to cut prices to such an extent that they were forced to lower the nutritional levels of their products; shoppers shopped on impulse, and that led to purchases that tempted, rather than those which improved diet. It should be possible for a customer to check the healthiness of his shopping basket at the till. But supermarkets, or any other retail business did not live in an ideal world; they had to do what customers wanted and could only use marketing to change those habits, if such changes would not send the customer to another store. It was notable that when retailers briefed suppliers about what they wanted, health qualities were only a small part of the objectives.

The MMR controversy raised important questions about information, the role of the media, and, if the prospect of a measles epidemic were real, whether the rights of parents to refuse vaccination needed to be overridden for society's health. Where should the boundary lie there between personal choice and the community? The basic problem was lack of trust in the evidence. It did not matter how strong the scientific evidence that there was no relationship between the vaccine and autism, there were cases where a child had MMR and autism. These were admittedly, anecdotes but people prefer to believe anecdotes than scientific and governmental assurances, So to many these anecdotes proved the link. The reception of evidence is a social construct. Only very clear and focussed marketing could have given credence to the scientific position. But, even if there were the prospect of a measles epidemic, would that justify compulsory vaccination? One needed to look much more closely at those in risk and those who might protest. Almost certainly they were not the same.

Education was a priority; all professional training programmes, should feature a module on prevention. But the start should be in the schools. No doubt much was already going on to encourage healthy eating and understanding risks in the better schools but it was doubtful if such efforts affected those schools in low-income areas where the need to inculcate good life style was greatest. It was in these areas that the improvements in health and wellbeing experienced by the professional classes were most significantly lacking. Perhaps little could be done without increasing income levels and diminishing income inequality, but it was important now to see what programmes on obesity, smoking and sexual diseases could be rolled out which might impact on these children and to set demanding targets. It was, for example, quite inadequate to set a target of stablizing the increase in child obesity by 2010, when half the cohort in question had not yet been born.

Sir Geoffrey Chipperfield KCB

Wanless Report Link
http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_index.cfm

The presentations will be available on our web site **www.foundation.org.uk**