

Summary and Implications

Population health improvements envisaged under the “fully engaged” scenario would require large changes in individual behaviour across the whole population. The aggregated actions of individuals will ultimately be responsible for whether or not such a scenario unfolds. However, people need to be supported to make better decisions about their own health and welfare because there are widespread, systematic barriers to decision making.

People have limited and often conflicting information on healthy lifestyle choices, they differ in their ability to understand and interpret the consequences of their actions and there are not always mechanisms which encourage individuals to take full account of the wider social costs of their decisions (such as second hand smoke). Engrained social attitudes are not always conducive to individuals pursuing healthy lifestyles. Persistent socio-economic inequalities in the UK, combined with a greater severity of market failures affecting lower socio-economic groups, seem to have contributed to significant inequalities in health outcomes which, unless tackled, will present a significant barrier to many in society becoming “fully engaged”.

These failures should be recognised and can be tackled, not only by individuals, but also by public services, government, media, businesses, society at large, through families, and the voluntary and community sector. Collective action must however respect the individual’s right to choose whether or not to be “fully engaged”.

Consequently, the following principles are suggested for adoption by government:

1. Interventions should tackle public health objectives and the causes of any decision-making failures as directly as possible;
2. Interventions should be evidence-based, though the lack of conclusive evidence should not, where there is serious risk to the nation’s health, block action proportionate to that risk;
3. The total costs of an intervention to the government and society must be kept to a minimum and be less than the expected benefits over the life of the policy: interventions should be prioritised to select those which represent best value;
4. The distributional effects of any programme of interventions should be acceptable; and
5. The right of the individual to choose their own lifestyle must be balanced against any adverse impacts those choices have on the quality of life of others.

7.1 Personal behaviours have a direct impact on the level of disease and morbidity in modern society. The combination of smoking, lower levels of physical activity, and diets that are high in salt, sugar and fat, has contributed to the increasing prevalence of chronic diseases in England¹. There is significant scope for improving population health by reducing the risks associated with particular lifestyles, activities and behaviours, so preventing and limiting early death and disease, with their attendant healthcare, social and personal costs.

¹ *Population Health Trends*, Derek Wanless, 2003

7.2 Therefore, the development of a fully engaged scenario requires great changes in individual behaviour across the whole of the population. Population health improvements will derive from individual decisions to stop smoking, to eat more healthily, to drink alcohol moderately, to take more exercise, and to avoid unnecessary risks.

7.3 Individuals are, and must remain, primarily responsible for decisions about their and their children's personal health and lifestyle. Individuals must be free to make their own choices about their own lifestyles. They are generally the best judges of their own health and happiness; people differ significantly in their preferences and their situations in life. But this does not remove the duties on government and many organisations in society, including businesses, to help individuals make better decisions about their health and welfare. Significant failures in how decisions are made can lead to individuals inadvertently making choices that are bad for both themselves and society. Therefore, to promote improved health outcomes and to reduce health inequalities, the government and other bodies need to act to reduce these failures and assist individuals to make better decisions.

7.4 If government or other bodies do intervene, it is essential that social welfare is improved and that personal freedoms are respected. This chapter analyses how failures in individual decision-making occur. It also sets out the principles that should guide the development of policies that support individuals in their decisions.

INDIVIDUAL DECISION-MAKING

7.5 One approach would be to leave all decisions completely up to the individual. On the whole, a fully informed, rational person could be expected to choose a range of health and lifestyle options that will satisfy themselves most. Generally, if individuals know best about their own health and personal tastes and preferences – as well as their own resources – they will make better choices than others on their own behalf. Furthermore it is standard economic theory that the choices of such individuals, trading with firms and each other in a fair market, would also maximise the welfare of society in general. But for good decisions to be made both for the individual and for society as a whole, it is important that:

- the individual is fully informed about all possible options, and their consequences;
- the individual is forced to take all the consequences of a decision (including those that affect others) into account;
- the social context within which individuals make decisions is conducive to making good choices; and
- opportunities exist for individuals to engage fully in the management of their health and general welfare, regardless of their background and circumstances.

DECISION MAKING FAILURES

7.6 In practice health is unlike other goods and services in many respects, and the conditions above rarely hold. First, few individuals have all the medical, scientific and statistical facts required to make fully informed decisions about their health, such as knowing what diet is best for them. Second, individuals find it difficult to gauge the risks and benefits of decisions related to health and healthcare (see box 7.1). Third, there may be failures in the social and behavioural context influencing personal decisions, such as with addiction or misinformation about healthy lifestyles. Finally, the effects of preventative health decisions can take place over a long time, often over the course of a whole lifetime (see box 7.2).

Box 7.1 Risk

Many of the health consequences of particular actions are uncertain. Smoking does not always kill, but it substantially increases the risk of a smoker dying early of a smoking related disease. Similarly, regular exercise does not guarantee a long life, but does reduce the chances of suffering a wide range of chronic illnesses.

The fact that the consequences of actions are not certain does not stop individuals from making rational choices. In other situations where outcomes are uncertain, people can make good decisions. However, crucial to such decisions is an understanding of possible outcomes and their likelihood. If these are not understood, poor choices can be made. For instance, people often find it difficult to compare highly unlikely outcomes with a large impact to more likely outcomes with a small impact.

Communicating information about risk can be very difficult. Typically, discussions on risk are either highly mathematical or specialised, and difficult for the general public to understand. Statistical facts about risks may not be mirrored in personal experience, and consequently tend to be ignored or disbelieved. There is a situation in public health known as the population paradox; that what is true at a population level (such as the smoker having an increased chance of dying from certain diseases) is not true for every individual (not every smoker will die from smoking-related disease). This influences the perception of risk by the public, to whom the obese individual who lives until age 100 or the evidently fit non-smoker who dies at 30 are seen as validation of unhealthy behaviours, when in fact such occurrences are outliers and outside normal expectations. In addition, there are areas where we do not fully understand what causes disease, or why some individuals have poor health consequences from their behaviour and some do not. The reporting of many, sometimes apparently conflicting, pieces of research in the media also make judgements difficult for the public.

An example of where risk is poorly understood is addiction. People underestimate the level of addictiveness of cigarettes and therefore the risk of addiction. This is seen in young people who smoke believing that they will be able to give up smoking at any time without difficulty, which is rarely true.

The problems with risk perception form a case for trying to individualise communication of risk information as much as possible when communicating public health problems to an audience.

Box 7.2 Time preference

In health and health care, costs and benefits often do not occur at the same time². For example, the pain and risk of an operation must be paid before a patient benefits from improved health; conversely, smoking may be enjoyable initially, but poor health, and a premature death, is more likely to result eventually. As a result, many academics analyse health as an investment and not a consumption decision³.

Individuals are perfectly capable of balancing, for instance, costs arising in one period, and the related benefits expected to arrive later. However, as costs and benefits move into the future, people typically value them less, a concept called time preference. Put simply, £1 today seems of more value to people than £1 in the future. This has been found to be true in many areas, such as pensions, where it is seen as a primary cause of low levels of savings for retirement and part of the necessity for government intervention in pension provision. A health example of this is that the cost of lung disease may well be greater than the pleasure derived from smoking. But, because the disease is likely to occur well into the future, if at all, teenagers may only give this a small value. Relative to their perceived pleasure in smoking (peer pressure being a common feature at the time of taking up smoking), the risk of disease at some point in the future is very heavily discounted. Though such behaviour may seem illogical, discounting the values of future costs and benefits is widely observed outside health and is based on rational principles.

However, although time preference may be essentially rational, some people seem to discount the future very heavily, which can lead them to take actions now that they may regret in the future. In the same way that the Government seeks to change people's attitudes to saving for their future, implicitly encouraging them to discount the future less, there is also a role to influence the manner in which people discount their future health.

7.7 The implication is that, without help, individuals cannot be expected always to choose courses of action which are beneficial for both themselves and society. In these cases, there is a role for others to support individuals, enabling them to take better decisions.

7.8 This section examines the types of failures that afflict decisions about preventative health and health care. These are:

- information failures;
- incomplete appraisal of costs and benefits;
- social context failures; and
- health inequalities.

² This varies between types of interventions, and there are some desirable actions for which this is not a problem as they have relatively short payback periods, such as with investment in prevention of teenage pregnancy and sexually transmitted diseases.

³ On the concept of health capital and the demand for health, Grossman, *Journal of Political Economy*, 1972

Information failures

7.9 Individuals rarely have full information about their own health, their healthcare needs, and the effects of their lifestyles on both their own health and on the health of others. Indeed, the knowledge of experts continues to shift as more evidence becomes available. For people to be fully informed, they need access to the most accurate information, the time and willingness to assimilate it, and the ability to understand and weigh up the risks involved with potentially harmful goods, behaviours and activities.

7.10 However, health is a very complex subject. Most individuals cannot assess their own health needs fully, nor can they know what treatment is required when they fall ill. Without knowledge about good preventative choices, individuals may unwittingly engage in damaging activities and behaviours. In practice people rarely have the time or ability to understand fully all these dimensions of health and health care. Consequently, they may choose to pursue lifestyles that are damaging, and ignore or even refuse beneficial treatments, when, with better information, they may have chosen differently.

7.11 This is particularly important in preventative health. While medical professionals need to understand the correct medical intervention to treat an acute condition, patients usually do not require the same level of knowledge. This does not prevent good health outcomes from being secured because the advice of the medical professional is generally taken. However, for preventative measures, individuals usually do need an understanding of health risks and the actions required to reduce them, so that they are both able and motivated to change behaviour. This requirement for the patient to be more knowledgeable affects both primary and secondary prevention.

7.12 To assist the full engagement of the population, advice should be made available freely in formats all find accessible, including the development of internet and telephone services. The developing NHS Direct brand should be considered for expanded use in this way.

7.13 Clearly, providing better information is one solution. However, there are difficulties with merely providing information as a strategy for improving individual decision-making. The amount an individual would need to read and assimilate in order to be informed of the health impacts of each choice they make in a day makes full information for every person unrealistic, even if it were theoretically possible. Much information will be open to challenge and may subsequently change as new evidence becomes available and general information may be difficult to relate to an individual's total circumstances. Instead, various analyses of human behaviour indicate that people have a set of in-built rules that subconsciously guide their choices⁴, which would need to be accurate for good health outcomes to result.

7.14 In summary, through having insufficient information or receiving conflicting messages, and through misunderstanding information about health, individuals may not manage effectively their own health and health care.

⁴ *Judgement under uncertainty: Heuristics and biases*, A Tversky and D Kahneman, 1974

7.15 At a time when full engagement requires the public and the health workforce to have more support, it has been noted that the educational role, previously played by the Health Education Authority, is not a clearly assigned responsibility. There is no single easily accessible source of advice for interested or confused individuals. It is recommended that this be considered in the Department of Health's review of arm's length bodies.

Incomplete appraisal of costs and benefits

7.16 To make good decisions for the health and welfare of themselves and society at large, individuals need to appraise fully all the costs and benefits of their actions – either consciously or sub-consciously. The full costs and benefits should include all those that affect the individual, and those that the individual creates for others by his or her action. However, individuals do not always take account of all these costs and benefits.

Externalities

7.17 Externalities are costs or benefits associated with the consumption of a good or service that accrue to society in general but are not borne by the consumer. As the costs or benefits are not borne by the individuals, they are not automatically considered and consumption levels can be higher or lower than is beneficial to society as a whole. Annex E discusses the theory underpinning externalities in more detail. For public health, the effect of externalities is that individuals may only take into account what happens to them as a result of behaviours, and not think of the wider social impact of their choices.

7.18 Externalities can be either positive or negative. Positive externalities exist when the actions of an individual have benefits to society separate from the benefits they experience directly. Examples include vaccination programmes where there are benefits to one person from another person being vaccinated (see below).

7.19 Negative externalities exist when the actions of an individual have a negative impact on society, separately from the negative impacts the person experiences individually. Examples of negative externalities include:

- lower productivity at work related to health problems (when not reflected in employees own earnings);
- the total disease costs (including pain and discomfort and the cost of early death) from smoking-related diseases in passive smokers⁵;
- irritation or distress to the public (such as smoky rooms or alcohol-related anti-social behaviour or crime);
- the total cost of deaths and injuries arising from accidents or crime induced by alcohol.

7.20 For example, when people smoke, they might consider the price of cigarettes, and the risk of poor health, as the main costs to them. But they will not necessarily consider all the impacts of smoking, such as the risks for passive smokers. The presence of significant externalities has often provided the justification for government intervention in other fields (such as the environment). Chapter 8 discusses how public

⁵ The external costs of a passive smoker are greater than those for the smoker, as the pain and the lost productivity arising from the disease are included. For the smoker, these costs still exist, but they are internal. When deciding to smoke, the smoker would normally take account of his or her personal costs, including the increased risk of disease. However, the smoker does not bear the personal costs of the passive smoker; they are external costs. Appendix E discusses the distinctions between internal and external costs in more detail.

health externalities can be built into prices by taxes and subsidies, ensuring that individuals do not ignore them.

Public goods 7.21 A good is defined as public if there are no limits on the number of people who can simultaneously use it (non-rival), and if it is hard to prevent people benefiting from it (non-excludable). The market will under-supply such goods and services, since every individual has an incentive to free ride on the provision funded by other users, and it is difficult to charge any one individual. This can result in individuals taking less action on their health than would be ideal for society as a whole.

7.22 A public health example is the herd immunity conferred by vaccinations. When a certain threshold of a population at risk is vaccinated, the infection is unable to spread in the population and the chances of an unvaccinated individual coming into contact with an infected individual and subsequently catching the disease can be reduced to practically zero. This ‘public good’ conferred by herd immunity in relation to some childhood infections is essential for the protection of young infants who are too young to be vaccinated. However the ‘positive externality’ provides an incentive for the parents of other children to decline vaccination for their child – the unvaccinated individual enjoys the benefit of herd immunity without incurring the costs of getting vaccinated – such as medical costs, the time involved, and the small risk of an adverse reaction. There is an incentive to ‘free ride’ and avoid vaccination. However, if enough people were to adopt this strategy then vaccination policy would collapse, leaving society, and particularly those too young to be immunised, vulnerable to an outbreak of disease.

7.23 For example, measles is one of the most infectious diseases known causing about a million deaths each year worldwide. Those aged less than 12 months are particularly vulnerable to severe disease and long-term complications including brain damage. The vaccine (MMR) is only 90 per cent effective in routine use. Thus, if 95 per cent of children were given the vaccine, only 86 per cent of the cohort would be protected. Essentially all children aged over 13 months need to be immunised in order to achieve herd immunity and protect those in whom the vaccine is ineffective and those who are too young to be immunised. Clearly, the smaller the proportion vaccinated, the greater the susceptible population, year on year, and the higher the risk of outbreaks and epidemics. MMR vaccine is therefore offered routinely at 13 months and 4 years of age, to provide the best chance of covering the whole cohort. The recent scare over MMR has reduced take up of the vaccine by about 10 per cent, such that small outbreaks have occurred (around 400 cases last year). Major epidemics threaten if this persists over time.

Capacity 7.24 Finally, some individuals will always need support to take good decisions. Young children and those with severe mental illness or suffering from certain learning disabilities need others to help them take decisions which bring them happiness and health. Many others lack the motivation or time to ensure they have the information needed for healthy decisions. Alternatively they may not know how to seek the information from which they personally would benefit. Those suffering high levels of stress and older children who are not yet fully responsible are also vulnerable, and may engage in unhealthy behaviours knowingly as coping mechanisms or due to a lack of engagement with the health system and the broader public health agenda, so facilitation is required to increase the chances of individuals choosing healthier behaviours.

Box 7.3 Intervention in Children's Eating Behaviour

Issues surrounding rights and responsibilities in health are brought to the fore when discussing children. Either in economic terms (as consumers) or in social terms (as dependants), children are greatly affected by the decisions of others. A key question is therefore 'who is responsible for children's health?'

Although it is generally agreed that parents have the greatest responsibility, attitudes towards state intervention, when parents are not performing their parental roles, have changed quite significantly in recent years. This has been reflected in policy, with moves towards conditionality in service provision, where the responsibilities of parents are clearly defined. Home-School Agreements and tighter control of truancy through legally enforcing parents' responsibilities are examples of this in practice.

Advertising of food to children and the quality of food in schools have both been raised as contributory factors in the childhood obesity. These are areas in which parents have voiced concerns over their ability and capacity to manage their children's eating behaviour and have engaged significantly in public health issues.

The Faculty of Public Health, the NHS Confederation, Association of Public Health Observatories, Local Government Association and the UK Public Health Association raised concerns about the poor quality of school meals in their submission to this review – 'common sense tells us that some things are obvious health threats, such as tobacco and unhealthy school meals'. This engagement of both the professional public health community and the public is central to driving action forward in England, potentially along the lines of the Scottish Nutrient Standards for School Lunches. Lessons from that approach should be fed back into policy for English schools.

Intervention in children's eating behaviour should be strongly considered for many reasons; formation of social norms around consumption of fruit and vegetables; the influence on eating habits in later life and the impact on children's understanding of appropriate nutrition. The issues of food promotion to children and school meals illustrate the importance of the involvement and engagement of stakeholders in public health issues – as awareness, consensus for action and support for future public health measures can all be gained.

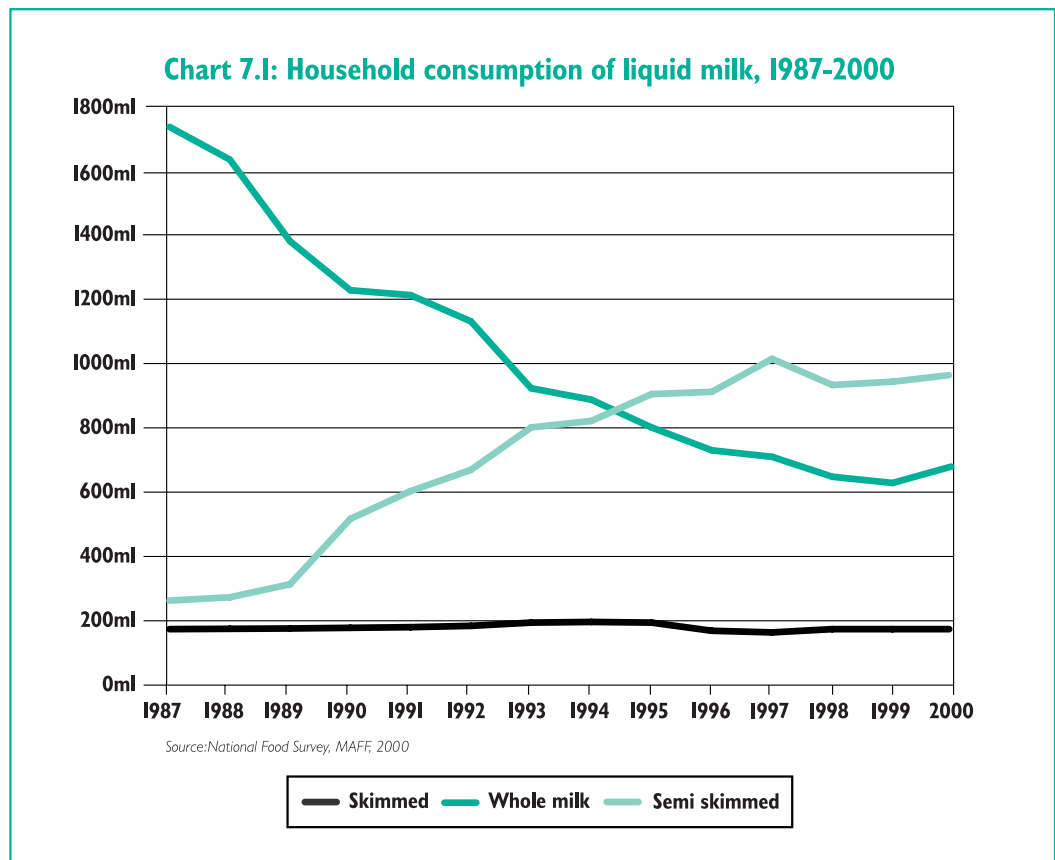
Social context failures

Social context 7.25 Social context can have a powerful influence on individuals' decisions. A person's tastes and attitudes – which form the basis of how individuals value the benefits and costs of an action – are shaped, in part, by environment. The effect of the family and social environment on children is particularly strong. Peer approval (or disapproval) can also have a profound effect.

7.26 Where decisions are made in an environment where unhealthy lifestyles are prevalent, it can be difficult for individuals to choose healthy options. Their tastes and attitudes will be shaped so that unhealthy choices will be seen as preferable. Shifts away from the social norm carry the additional costs of potential disapproval.

Framing healthy choices 7.27 On the other hand, where healthy lifestyles are more common, it is much easier for individuals to choose healthy options. Both their tastes and the social norms will tend to encourage better choices. Furthermore, if a healthy lifestyle is also seen as enjoyable, individuals will not need to trade-off their long-term health against their short-term enjoyment.

7.28 Government action, for example in legislating or providing information, can change widely held social norms and values, which determine the nature of our social welfare in public health. Education can influence not just underlying values, but also, indirectly, tastes in demand for goods and services. For example, attitudes have changed significantly following the introduction of laws prohibiting drink driving, coupled with associated information campaigns. Another illustration is milk, where information provided about the benefits of drinking lower-fat skimmed or semi-skimmed milk instead of whole fat milk coupled with no price differences, slowly changed attitudes and behaviour over time (see chart 7.1). This principle could be applied to areas such as alcohol, where public information levels and social attitudes currently differ from public health goals and what the evidence base indicates is healthy.



7.29 Influencing and, over time, changing social attitudes to health and lifestyles is likely to be much more effective in the long run than a punitive approach that does not also aim for a change in attitude. Laws and regulations not accompanied by public support incur high enforcement costs, and could jeopardise the development of a consensus for future public health measures.

Addiction 7.30 Addiction usually refers to the physiological condition where consumption of a product becomes habitual and any reduction in consumption causes adverse withdrawal symptoms. It is often cited as an additional failure; it could be argued that addicts are simply irrational. However, research indicates that addiction can be explained on a rational basis⁶. Individuals assess the enjoyment or benefit of starting or continuing to use an addictive good against the corresponding costs of not starting or

⁶ A theory of rational addiction, S Becker and K Murphy, Journal of Political Economy, 1988. An empirical analysis of cigarette addiction, G Becker et al, America Economic Review, 1994

giving up, in the same way as for other goods and services. Like other goods and services, costs and benefits are often expressed in terms of social norms – peer pressure, perhaps, versus parental disapproval, in the case of a teenager deciding whether or not to smoke.

7.31 For adults, other dimensions of context such as solidarity or social capital from a smoking community are an additional incentive to unhealthy action. Whether or not a ‘failure’ in a rational sense, addiction has a profound effect on the individual’s health (in some cases devastating), and drives much of the external costs of alcohol and drug abuse and smoking. Its influence therefore must be recognised and the need for action must be taken into account. Addiction obviously has implications for policies aimed at curbing unhealthy lifestyles. It is more difficult to wean someone from a harmful, addictive product than from one that is merely harmful.

Health inequalities

7.32 The distribution of goods and services between individuals is dependent on their initial resource endowment; wealthy individuals will gain a greater share of the goods than poorer individuals. Whilst the optimal solution may be efficient, it may also be inequitable. If the relevant market failures described have a significant socio-economic dimension, then it might naturally be expected to see health inequalities emerge from the rational behaviour of individuals. Interventions to tackle market failures could also potentially have a positive contribution to play in reducing health inequalities.

7.33 As our society places significant value on social solidarity and supports actions to reduce inequity, interventions to encourage greater equity in society also need to be considered. Effectively, society has decided that it is willing to sacrifice some of its total welfare to improve the distribution of this welfare amongst its individuals.

7.34 In public health, as in other areas of life, significant inequalities exist. All types of failure described earlier may have greater effect on lower socio-economic groups.

Inequity in information provision

7.35 The social context also affects the way in which information is presented and assimilated. It has been found that different social groups vary in the degree of uptake and action resulting from health education and information campaigns (see box 7.4). Health literacy, particularly the ability to understand information about health and health care, is an important precondition for taking preventative health action. Differences in health literacy contribute to variations in behaviour and health inequalities.

7.36 As health literacy varies significantly between social groups, generic educational campaigns could be seen as inequitable as they may not reach those in greatest need. Insufficient consideration of the language used, the medium of communication, the degree of targeting and campaigns that are not context-specific can exacerbate inequalities.

7.37 A programme of research should be undertaken to identify what forms of intervention best improve health literacy, personalising messages for population subgroups, including those with low health literacy where the prevalence of chronic diseases is often high.

Box 7.4 Health literacy and chronic disease management

The importance of health literacy, and its relevance to population health are illustrated in the care and management of chronic diseases such as diabetes and heart conditions.

The increasing importance of self-care, when individuals monitor and treat their own conditions, means that the ability for patients to understand and then act upon information about their condition, medication and personal surveillance (such as monitoring their blood glucose levels) is crucial to good health outcomes.

Ensuring that individuals have access to appropriate, targeted health information that is relevant to them is vital for the fully engaged scenario to develop. In the United States, Managed Care Organisations (which care for those with chronic diseases) have flagged the differences in health literacy among those they serve as important to the effectiveness of self-management of disease and have recognised that low levels of health literacy pose a major barrier to the education of patients with chronic diseases^{7,8,9}.

There is therefore a need to research what forms of intervention best improve health literacy and take account of levels of health literacy in different target populations. This may be particularly important in finding effective educational or information-based interventions for sectors of the community with low health literacy and where the prevalence of chronic diseases are often high.

Income inequalities **7.38** Income inequalities can also have direct impacts. People on lower incomes have fewer resources to devote to healthy goods and services. They may also be more time constrained. If more time is spent at work (to obtain overtime payments for instance), then there is less freedom to devote time to, or to access, preventative health strategies; a problem that can be exacerbated by inflexible working hours. Finally, with low incomes now, people may not be in the position to consider the future as fully as those on higher incomes; they may discount the future health benefits from behavioural changes to a lower value than those in high socio-economic groups¹⁰.

⁷ *Health literacy among medicare enrollees in a managed care organisation*, Gazmararian et al, Journal of the American Medical Association, 1999.

⁸ *Managing Chronic Disease: What can we learn from the US experience?* J Dixon et al, King's Fund, 2004

⁹ *Relationship of Functional Health literacy to patient's knowledge of their chronic disease: a study of patients with hypertension and diabetes*, M Williams, 1998.

¹⁰ There is evidence linking unhealthy lifestyles (e.g. smoking) with other indicators of a higher discounting of the future, such as less investment in education (Fuchs, 1982) and in future wages (Musasinghe and Sicherman, 2000), all of which tend to be more prevalent in lower socio-economic groups. *Time preference and health: an exploratory study*, V Fuch, 1982. *Economic Aspects of Health* (ed. Fuchs, V.R.). *Why do dancers smoke? Time preference, occupational choice and wage growth*, L Munasinghe and N Sicherman, 2002

Market access 7.39 Usually, when it becomes apparent that there is a demand for a particular product, business will have an incentive to supply it. However, there can be failures in a local market that prevent such supply, including:

- risk – entering a new market can be too risky for local businesses, especially if the start-up costs are high;
- lack of transport infrastructure – the cost of transporting some goods to a local market can be prohibitive;
- information failure – businesses do not realise there is a demand for the product or have overlooked a market; or
- scale – the demand in a local market can be below the threshold seen as viable by businesses.

7.40 The problem of market access can be compounded by poor transport links. Where transport is good, the potential size of the market is larger. Business will be able to sell more goods, and consumers will have more access to those goods. But without these links, the difficulties in linking customers with suppliers will increase. The impact of these problems increases within lower socio-economic groups, as those with lower incomes are disproportionately reliant on amenities within walking distance of their home.

7.41 Individuals may wish to pursue more healthy lifestyles, for instance, by buying more fresh fruit and vegetables, or going to a local gym. However, there may be an insufficient number of people within a particular local area to support the supply of such goods and services (for example, high quality fresh fruit and vegetables). Those with poor mobility may find it difficult to access these markets. In some cases, the costs of travelling (both in time and money) to access the markets for high quality health goods may be a high proportion of income, and the benefits may not be perceived to be worth these costs.

7.42 Other wider socio-economic failures can also have a significant impact. The lack of well-lit and safe walking or cycling routes to work can discourage people from building exercise into their daily routine. Existing socio-economic inequalities may therefore contribute further to health inequalities; and also contribute to establishing social norms that reduce the demand for healthy goods and services, hence providing little incentive to supply the local market directly. This cycle can be difficult to break. It is likely to need action on a local basis. Where national programmes exist, they need to be carefully considered and implemented on the ground by those who know the local issues.

ROLES IN SOCIETY

Individuals

7.43 Individuals are primarily responsible for their own health and lifestyles. As discussed in the analysis above, they are generally best able to make these decisions as:

- they know more about their personal preferences and situation and generally are the best judge of their own health and happiness; and
- any intervention into an individual's lifestyle can raise legitimate questions of personal freedom.

7.44 However, the analysis goes on to show that where individuals are unsupported in making decisions, they may choose activities that will harm the health and welfare of both themselves and the rest of society, as:

- they are not fully informed;
- all costs and benefits are not considered;
- choices may be made in an unhelpful context; and
- not all of society has the opportunities to adopt a healthy lifestyle.

7.45 The forthcoming consultation ahead of the White Paper is a good opportunity to engage the population on the issue of their own health and the balance between an individual's 'right to choose' and the impact that individual behaviour has on the well-being of others. In particular, the consultation should consider the acceptability of different ways of tackling smoking.

PRIVATE SECTOR

7.46 Individuals interact daily with the private sector in almost all of their activities. Therefore, the role of the private sector in facilitating full engagement in health is extremely important, both in creating healthy choices for individuals and enabling healthy behaviours. The private sector can be innovative in reacting to changing markets as consumers' behaviour alters.

7.47 The private sector, among other responsibilities, has a duty to provide clear, consistent and relevant communication on issues of safety, the health impacts of products and details of the contents of their products. Currently, standards for food labelling are set at supranational level by the European Commission, but issues of marketing of products are controlled at national level. Food Standards Agency research has indicated that many consumers find food labels difficult to use¹¹ and have found flaws in current labelling using terms such as 'fresh' and 'natural'¹², both of which influence the ability of people to make an informed choice about which products to purchase. Particular issues that have been of concern to this Review include further consideration of labelling of foods 'eaten out' and labelling of salt content in products.

¹¹ *Clear Food Labelling*, Food Standards Agency, 2002

¹² The FSA found that approximately 40% of foods samples surveyed used terms such as 'fresh' and 'natural', to be misleading or ambiguous.

EMPLOYERS

7.48 Employers have much to gain from considering the revenue implications of preventative health for their businesses. Sick leave cost the economy £11.6 billion in 2002, an average of £476 per worker¹³. Approximately 40 per cent of absence costs are from the long-term sick¹⁴ and since much chronic disease is preventable, companies could benefit from investment in their employees' health, and in particular, preventing ill health. Some companies have recognised this and initiated programmes to address the broad determinants of their employees' health¹⁵ (see box 7.5). This engagement in the health of staff fosters not only improvements in staff turnover and workplace absence, but contributes to long-term health gains for the population.

Box 7.5 Case Study of Employer Engagement in Health

One integrated health management programme being used, run by Vielife, provides all employees with access to personalised advice and information through an online service. Information covers four key areas; stress and how to manage it, nutrition, sleep and exercise. Anonymous data is used to provide feedback to the company on health issues. This tailored information is supported by generic information through email and work based stress management.

Positive initial results have been seen from companies using these interventions, such as Standard Life Healthcare and Unilever; aggregated company figures show the following impact on a sample size of over 2000 over a period of one year: 29 per cent decrease in stress, 9 per cent reduction in smoking, 72 per cent decrease in people reporting sleeping problems, and a 19 per cent improvement in nutrition score. The health management system has also played a part in reducing staff turnover and sickness absence and improving productivity.

Whilst these is very early data and these programmes are yet to be tried in a wide variety of organisations, such systems are potentially very positive. They facilitate individuals' engagement in their own health, aiming for improvements in the broad determinants of health and can reinforce messages in a society becoming fully engaged.

7.49 A reduction in sickness absence and increases in productivity can result from better management of employees' health. Organisations such as BUPA are recognising this and advocating employee assistance programmes and occupational health services to contribute towards a more dynamic and productive workforce. Ultimately this could lead to a reduction in costs for treating health issues due to earlier identification and prevention of health problems.

7.50 The NHS employs more than 1 million people and has relatively high levels of sickness absence, 4.9 per cent across all NHS Trusts¹⁶, costing the Department of Health an estimated £1billion per annum. In addition, the NHS has many low paid staff, so NHS action to improve employee health would impact upon many low-income individuals who are at higher risk of developing many preventable chronic diseases. The NHS should seek to illustrate the case for employers' engagement in staff health by piloting and evaluating programmes.

¹³ Sickness absence figures taken from *A Safer Place to Work*, NAO, 2003. 'Sickness absence' is measured as the time staff are absent from work as a proportion of time available. *Absence and Labour Turnover Survey*, CBI, 2003

¹⁴ *Business and Healthcare for the 21st Century*, CBI, 2001

¹⁵ Provision of screening for employees could be questioned on an ethical basis, as there is not an attendant duty-to-treat individuals that have been diagnosed

¹⁶ *Cost of Sickness Absence in the NHS, Back in Work Pack*, Department of Health, 2003

7.51 The NHS should give support to improving the health of its workforce and should undertake pilot exercises to evaluate how to promote the long-term mental and physical good health of their employees. PCTs and SHAs should be encouraged to experiment and lessons should be learnt and disseminated. The NHS should aim to become an exemplar for public and private sector employers.

Media

7.52 Two main dimensions of public health are affected by the media: the perception amongst the public of which public health issues are most important and what is reasonable advice for any given public health problem. Central to inaccurate perceptions of which issues are most important are the content and coverage of preventative health issues by the media, if these fail to reflect the large empirical impact that chronic diseases have on rates of disease and years of life lost (box 7.6). The failure to communicate risk effectively is a dual failing of media and public health professionals. Consideration needs to be given to the overall impact of the coverage and reporting of public health issues, but this must happen alongside a greater appreciation by public health professionals of media imperatives and how best to influence the presentation of health issues.

Box 7.6 King's Fund: Health in the News

A recent study by the King's Fund on the coverage of health issues in the news media raised questions about the balance of news coverage of health stories and their actual risks to health.

The study analysed the news content of selected media, explored the views of public health experts and considered the views of policy-makers towards media coverage of health issues. It found that two main categories of stories dominated all of the news outlets they studied; coverage of the NHS (predominantly NHS 'crises') and coverage of public health 'scares' (widely reported public health issues with little actual impact on rates of illness or premature death). Preventative health measures received relatively little news coverage.

A disproportionate picture of what were the important issues in health was a fundamental concern to the authors of the survey, due to the effect this could have on policy-makers, government priorities, and government spending patterns and the evidence that some kinds of media coverage of health issues impact upon the public's health behaviour.

The report advocated action from all parties concerned – including work to more accurately portray risks, to improve the proportionality between the scale of public health risk and news reporting and changes in advocacy so as to better shape news agendas.

7.53 The Phillis Report¹⁷ highlighted the importance of the communication of statistical information, stating that this information should be ‘automatically, routinely and systematically made available’. This should be applied to public health, where periodic communication about the state of public health at national and local levels should be available to encourage the involvement of individuals and organisations.

Voluntary and community sector

7.54 The voluntary and community sector currently plays an important role in advocating public health issues, contributing to the delivery of preventative healthcare, and in carrying out and funding research.

7.55 This sector is uniquely placed to provide a link between government, statutory bodies and communities. This is particularly relevant to the delivery of public health¹⁸ as this sector can offer types of service different from those offered by current primary or secondary care provision and can foster links with the wider community. Procurement and contractual relationships are developing between the different sectors, which include clear objectives and outcome measures for voluntary and community organisations¹⁹. The future development of the role of this sector is currently being addressed through The National Forum of Non-Governmental Public Health Organisations.

THE ROLE OF GOVERNMENT

7.56 There are areas of public health in which the roles and responsibilities of government are clearly defined. These include infectious disease control and areas where the law places a responsibility or duty on government agencies, such as the protection of vulnerable groups.

7.57 However, there are clear areas where government could contribute more to improving public health. In particular, it should ensure that evidence is collected and analysed on a timely basis and that comprehensible information is provided to the public. It should identify where the evidence base requires improvement. It needs to research its success in community awareness and in stimulating action, and should promulgate successful examples of interventions.

7.58 Beyond this, government also has a responsibility to assess the social and economic failures described above, to judge whether and to what extent it should intervene further, in order to improve social welfare and population health, while balancing individual freedom and individual responsibility for behaviours that affect the health of others.

¹⁷ An Independent Review of Government Communications, B Phillis, Cabinet Office, 2004

¹⁸ Section 64 of the Health Services and Public Health Act 1968, Chapter 46, permits statutory bodies to commission delivery of relevant services through voluntary organisations

¹⁹ The development of greater accountability and transparency was recommended in the Strategy Unit report *Private Action, Public Benefit*, 2002, which provides potential assessment procedures for voluntary and community organisations engaged in such delivery.

Policy principles

7.59 It is important that any government intervention is well managed, to protect against an inappropriate infringement of liberty or unintended consequences. To assist in the development of targeted interventions that increase both health and welfare, the following principles are suggested for adoption by government.

1. Interventions should tackle public health objectives and the causes of any decision-making failures as directly as possible;
2. Interventions should be evidence-based, though the lack of conclusive evidence should not, where there is serious risk to the nation's health, block action proportionate to that risk;
3. The total costs of an intervention to the government and society must be kept to a minimum and be less than the expected benefits over the life of the policy; interventions should be prioritised to select those which represent best value;
4. The distributional effects of any programme of interventions should be acceptable (aligned with societal equity objectives); and
5. The right of the individual to choose their own lifestyle must be balanced against any adverse impacts those choices have on the quality of life of others.

7.60 It is also important that these principles are supplemented by good practice. **Three recommendations for government are immediately relevant and important:**

- **advice should be made freely available in forms, languages, media and locations easily accessible by all;**
- **periodic communication about the state of public health at national and local levels should be available to encourage the involvement of individuals and organisations; and**
- **feedback should be sought regularly from the population indicating the degree of awareness about information and the acceptability of state interventions.**

7.61 The above principles and good practice recommendations are developed into a framework for government intervention in the next chapter, which discusses the levers available to the government, the issues which are relevant to their design, and the limits to government intervention.

