

# So whose business is public health?

Industry involvement in public health should not surprise anybody, says **Nigel Hawkes**

To listen to some critics, the UK coalition government's plans for public health are a betrayal of Judas-like proportions. My local paper, in southeast London, managed to see Tory wickedness even in the abolition of free swimming in the local pool. Since when, I'm tempted to ask, has free swimming been every English person's birthright and its denial a sickening hammer blow to public health?

That is not to say that the plans of England's health secretary, Andrew Lansley, are beyond criticism, though it is hard to know precisely what they are before the public health white paper is published. But this has in no way deterred those who want to persuade us that the health secretary has sold his soul to the food and drinks industry, giving them the right to determine what his policy will be.

Whatever it is, it can hardly be less effective than Labour's performance in government between 1997 and 2010. For an entertaining read I commend the evidence taken on 14 September this year by the House of Commons Committee on Public Accounts, investigating the failure to narrow health inequalities over this period (*BMJ* 2010; 341:c5103, doi:10.1136/bmj.c5103). The committee, chaired by Labour's Margaret Hodge, gored and tossed the witnesses from the Department of Health for England with an almost bloodthirsty zeal. "Claptrap" was among the kinder words she used.

What got the committee's blood up was the gap between rhetoric and action. The need to put health inequalities at the heart of policy was announced in 1997, yet it took nine years, until 2006, before it actually became a priority. Why? Because, explained the hapless Richard Douglas, interim permanent secretary at the health department, it took that long to develop an evidence base.

Once this was developed, the conclusion was that three major interventions—lowering cholesterol concentrations, lowering blood pressure, and smoking cessation—

were the priorities. (You could have learnt that by asking Google, one committee member unkindly interjected.) Implementing these in a coherent way would have cost £24m (€28m; \$38m) in the "spearhead" primary care trusts (those with the greatest inequalities) out of a total budget for these trusts of £3.9bn, National Audit Office figures show.

Yet in these spearhead trusts the gap in life expectancy has widened by 7% for men and 14% for women since 1995-7. Only in some trusts in London was this target, later abandoned, likely to be met, and the witnesses could not tell the committee why London had apparently succeeded where all others had failed. So, even when their policies worked they didn't know why. They thought it probably had more to do with changing populations than with any policy that had been implemented.

It is easy to mock, and some might argue that Labour's policies will have long term benefits. That is possible, if we exclude the ones that are now forgotten, such as health action zones (the big idea of 1997) and healthy living centres, launched in 1999 with £280m arm-twisted out of the National Lottery. The final report on this enterprise concluded that it had achieved all that it set out to do: promoting good health, reducing health inequalities, and improving the health of the worst-off people. It would be nice to know where.

There was no end to these good ideas. The healthy living initiative (2007) focused on families with children aged under 11, while Change4Life (2008) aimed to encourage a healthy diet and an active life by using social marketing tools. Mr Lansley has said that he approves of Change4Life but won't be giving it any more money. It will be up to industry, which was already heavily involved, to provide the funds if the programme is to continue.

Why did Labour's initiatives fail? It wasn't out of bad intentions or misplaced aims. The plans may have been too ambitious, given the limited



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leverage available to government to influence people's behaviour. The problem with well meant advice—which is what a lot of it amounted to—is that those who listen are not necessarily those who ought to hear. Public spending on poster, television, and cinema campaigns rose 30-fold under Labour, reaching nearly £60m in 2009-10. But drinking levels barely changed, the incidence of sexually transmitted diseases rose, and smoking fell at a slower rate than it had before. Fruit consumption rose by a whisper, but vegetable consumption fell. At the 2010 election Labour claimed credit for the single most effective public health initiative of its tenure, the banning of smoking in public places—even though this was pushed through in the teeth of opposition from the then health secretary.

Given this record, it is hard to deny Mr Lansley a bit of leeway to do things differently. He has promised a ringfenced budget for public health, which is to be welcomed. He also plans to devolve its running to local authorities, which may not prove such a good idea. He has certainly taken advice from food and soft drink companies, rather than demonising them. Should we be scandalised by this, as some people apparently are? It depends entirely what emerges, but the involvement of industry should not have come as a surprise to anybody, as he launched such "responsibility deals" with them when still in opposition.

A dyed in the wool Tory, which Mr Lansley isn't, would say it's none of his business how much people choose to drink or what they prefer to eat. These are personal decisions that, like the choice of what to read or watch on television, are not the business of anybody else, least of all government. The chances of him saying that are nil. But it would be refreshing if somebody did.

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## MEDICINE AND THE MEDIA

# Should we be selling health to the public?

The NHS advertises services such as vaccination and screening. **Margaret McCartney** considers the implications of summing up complex interventions in soundbites

We are all used to advertisements urging us to try the latest in jeans, mobile phones, television programmes, and beer. But should the NHS use its resources to entice us to seek its services, such as flu vaccination or screening for cervical or breast cancer?

The problem with advertising is also its strength—namely, that it quickly delivers a short memorable message, such as “Don’t let the flu turn on you,” which is NHS Scotland’s plea for you to roll up your sleeves for a seasonal vaccination. The campaign leaflet depicts a sketch of a man connected to an oxygen mask and a drip. Inside we are told, “Anyone who suffers from heart or lung problems, has certain other medical conditions, or is 65 or older, should get the flu vaccine.” Stephen Fry provided the voiceover for an official national advertisement for the NHS in 2008, stating, “If you knew about the flu, you’d get the jab”; but the NHS now seems to produce different but similar advertisements in different regions, with the message that everyone in groups at risk should make an appointment at their general practice.

When it comes to cervical screening, NHS Scotland has produced pink themed posters featuring smiling young women and asking viewers to “put it on your list” of things to do.



Missing the small print

Similarly, breast screening also occupies the same lurid end of the colour range, with NHS South Essex having launched a campaign that features topless women covered with calendars and stating, “The earlier the diagnosis, the better the outcome, so 30 minutes every 3 years is a date we never miss.” One woman is quoted as saying, “It’s a no brainer finding the time for screening.”

Posters from the NHS breast screening programme implore the reader, “It’s time to look after yourself.” At the bottom of the poster, shot with a woman with her grown-up children in the background, it says, “You’ve looked after them all their lives.

Now, how about you? The NHS Breast Screening Programme saves 1400 lives every year. All women aged 50 or over are entitled to regular breast screening. Some things are worth making time for.” Bowel cancer screening is the subject of several NHS posters, one of which is luminous yellow and says, “You can’t always see the signs. 60+. Take the test. Bowel cancer is the third most common cancer in the UK. The earlier it’s found, the more effectively it can be treated.” Another poster, this time in bright orange, comes with the message, “Eat well. Keep fit. Use the test kit.”

But the short messages beloved of advertising campaigns don’t make it easy to convey unbiased information to readers. Although it’s easy to set out catchy emotional clichés, it’s far harder to inform people of the availability of such services while treating them as competent adults, capable of deciding on the merits of healthcare interventions for themselves. Flu vaccination campaigns, for example, do not explain that Cochrane reviews have found a lack of evidence of usefulness in vaccinating people older than 65 years<sup>1</sup> and uncertainty about whether vaccinating people with asthma reduces flare-ups,<sup>2</sup> but they have found some evidence for reducing the frequency of exacerbations in chronic obstructive pulmonary disease.<sup>3</sup>

When it comes to breast screening it is apparent that the rather more complex messages of systematic reviews focusing on the ratio of potential benefits and harms are somewhat obscured; the most recent evidence indicates

that, for 2000 women invited for screening throughout 10 years, one will have her life prolonged; 10 healthy women, who would not have been given a diagnosis if they had not been screened, will have a diagnosis of breast cancer and will be treated unnecessarily; and 200 more will have a false positive result.<sup>4</sup> Cervical cancer screening, similarly, is not a process quite as simple as adding to a health

shopping list but an intervention with potential hazards. For example, a modelling study published in the *BMJ* in 2003 indicated that about 40% of women were likely to have an abnormality detected in screening that would require further testing

and follow-up.<sup>5</sup> About 1000 women have to be screened for 35 years to prevent one death, and screening will reduce, not stop, deaths from cervical cancer. It is also known that some screening related interventions are capable of doing harm—for example, cone biopsy can lead to premature labour.<sup>6</sup> Is it fair to use the snappy lure of advertisements to draw customers in?

The question of whether advertising works has been in part answered by a recent review in the *Lancet* concluding that some public health campaigns have had a measurable effect on uptake of services or in changing behaviour.<sup>7</sup> Crucially, however, the measurable outcomes have not included how well the evidence is imparted and explained or how people are enabled to make the best use of it.

It could be argued that posters like these merely do a duty of informing a public that services are available and provide a push for people to get further information about benefits and harms of that intervention. However, we have no evidence that they do. Rather, NHS advertising has the potential to overshoot the evidence, and none of the current NHS advertising highlights the fact that flu vaccinations and screening interventions are choices with nuances rather than stipulations. True, advertising would find it hard to do anything but. Yet the NHS is meant to be more than spin. Do we really need any of this advertising anyway?

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OUT OF HOURS Christopher Martyn

# A lesson from Lapland

What the snowmobile did to one Lapland community illustrates what medicine is doing to us. Why don't we take notice?

I'm not sure whether the sociologist Everett Rogers actually coined the terms opinion leader, early adopter, and change agent, but it was certainly his famous book *The Diffusion of Innovations* that shifted them into the vocabulary of people keen to promote new ideas and new products. The book explores the reasons why some innovations are rapidly adopted while others, on the face of it equally good ideas, never get off the ground. It carries no torch for change as an end in itself. Indeed one of Rogers's central themes is that it's usually impossible to manage the effects of an innovation in a way that separates the desirable from the undesirable consequences. He gives several examples where the initial advantages of new ways of doing things were far outweighed by the long term harms they caused.

One of these is an account of what happened when the snowmobile was introduced to an isolated community of Skolt Sami (Skolt Lapps) in northern Finland. The economy and social structure of this community centred on the reindeer, which provided food, clothing, and transport. The Skolt saw themselves as reindeer herders, and social status went with a good string of draught animals. In 1961 one of the schoolteachers purchased a snowmobile for recreational travel, and the vehicle rapidly became useful for hauling wood and supplies. A trip to the nearest town that took three days by reindeer sled could be done in five hours on a snowmobile. A decade later almost every household owned one. The machine had come to be seen as a necessity, completely replacing ski and sled for transport and for herding animals.

Unfortunately the reindeer were frightened by the speed and noise of the snowmobiles. They were driven into a near wild state, and their fertility declined. Families needed to sell

more animals to pay for the fuel and maintenance of their machines, and because fewer reindeer calves were born each year their resources became overstretched. In what had been a fairly equal society many people were gradually forced out of raising reindeer, while a few families built up very large herds. In the end the snowmobile revolution pushed the community into cash dependency, debt, and unemployment.

Apart from the obvious paradox that an invention that initially seemed to make life easier ended up destroying the community that adopted it, Rogers drew out another point from the story. At no stage were the Skolt able to create an opportunity to take stock of what was going on. The possibility that the introduction of snowmobiles could be checked or opposed never arose.

It's easy to see a parallel with modern medicine, which also started as something that made life better and easier. Later the costs ran out of control, and the harms of medicalising everyday life became apparent. But by that time it was beyond discussion and hardly possible to resist.

There are, of course, a few disobliging people prepared to point out that the law of diminishing returns has long been operating in healthcare and that it would be far better to spend the money on other things. Others of a sceptical disposition have drawn attention to the way that risks have been reframed as diseases—for example, the metabolic syndrome and osteoporosis—and to conditions that have been redefined to include ever larger numbers of people needing drug treatment—such as bipolar disorder, social phobia, and erectile dysfunction. But these arguments are strictly at the margins. Most people believe that medicine is altogether a good thing, and the only thing that bothers them is access and availability. Even in a



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bleak economic climate the healthcare budget is ringfenced. Government ministers speak of improving efficiency and doing more for less. The possibility that we could just do less never arises.

It's not only society as a whole that can't say no to medicine. It's going the same way with individual decisions too. For all the talk about autonomy, empowerment, and patient choice, it's actually getting harder to turn down medical interventions. Parents who choose not to have their children vaccinated are viewed as deviant and irresponsible. Someone who declines an invitation to take part in a cancer screening programme is made to feel that their decision is wrongheaded by the repeated letters that are sent to try to persuade them to change their minds.

In some cases interventions are forced on people whose chances of benefiting are negligible. Should you think I'm exaggerating, read a harrowing *BMJ* personal view by a retired physician who was unable to prevent his dying wife being resuscitated after a cardiac arrest despite an advance directive stipulating the contrary (2009; 339:b4982) or a recent *JAMA* paper reporting that a sizeable proportion of people with advanced cancer had undergone screening mammography, prostate specific antigen testing, or colonoscopy even though an early diagnosis of a second malignancy could be of no conceivable advantage to them (2010;304:1584-91).

The difficulty, always assuming you agree that there's a serious danger that healthcare will do to us what the snowmobile did to the Skolt, is in finding a way forward. Don't we need to do what the Skolt failed to do and create an opportunity to take stock of what is going on?

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