

OBESITY AND THE ROLE OF GOVERNMENT IN DIET

MEETING OF THE PARLIAMENTARY AND SCIENTIFIC COMMITTEE ON MONDAY, 12TH JULY 2004

What is the nanny state doing in the local supermarket and in our kitchen?

Confronted for the first time ever with predictions of reduced longevity coupled with increases in overweight and obese people having the potential to overwhelm a reformed NHS, the Government has commissioned the Wanless 2 report. Is this response sufficient and how can the food and drink industry help to improve our nutrition? Derek Wanless sets the scene by outlining the Government's response, Robert Pickard discusses nutrition and Gaynor Bussell provides a response from the food manufacturers to this intractable problem.

The Future Health of the Nation - The Wanless 2 Report and Beyond

Derek Wanless

This is a fascinating time for public health, full of opportunities that are in danger of being missed. They require patience for the groundwork needed to build a physically and mentally healthier UK workforce that can generate economic growth. These are vital roles for Government in public health involving many determinants of health, including obesity. We do not simply need a list of unco-ordinated short-term frenetic activities that can be stopped as easily and quickly as they began.

My 2002 report illustrated the huge prize to be gained with higher productivity from the supply of health services and healthier lifestyles on demand and concluded that action is vital on both. We virtually wrote that first report around the single word "capacity", so powerful is its influence. The headline-grabbing conclusion is that the difference in spending between the worst scenario "slow uptake" and the best "fully engaged" will be £30 billion per year by 2022.

Our target is delivery of financial savings and of health services much better placed to face potentially very difficult decades in the 2020s and 2030s, when more older people could be joined by younger people in need of care, too many of whom have lived unhealthy lives. And don't forget the older people are baby-boomers,

pampered since birth and likely to be demanding patients.

The 2004 report set out the changes needed if we move towards full engagement. High productivity in public health as well as healthcare will require adequate workforce capacity having an appropriate and broad mix of skills, extended by self-care and the imaginative use of the knowledge and time of patients. Information handling must be revolutionised and resources redirected to areas of proven effectiveness, supported by enhanced research programmes and better measurement tools.

"How do we get onto the fully engaged path?" That's the question this year's report seeks to answer, based again on lousy information. It's designed to ensure spending is well-directed, whether spent on tackling inequalities, providing support, changing personal behaviours or on more personalised health services. A framework is devised to assess spending.

The report made recommendations that would enable the key determinants to be tackled, including obesity. A sample of determinants was examined to see how close we are to "full engagement" in England. How had targets been set and strategies developed, evidence collected about what works and progress assessed?



We drew conclusions and made recommendations, by no means all for Government. And they're not a "pick and mix" list. They're an attempt to tackle all the most important reasons for our past failures.

The existing conventional definition of "Public Health" seems very narrow and doesn't describe what preventative public health should become in the early 21st century. The definition should be debated and changed to help mobilise widespread support. It should operate through "the organised efforts of society" and additionally "through the organised efforts and informed choices of society, organisations, public and private, communities and individuals". The report is based on that wider re-definition. It recognises that the health of the population is affected by issues and organisations outside the health sector. Not surprisingly, but unhelpfully, medical models of intervention have dominated since 1974.

The key question is why we have done so badly in recent decades in influencing those determinants crucial to prevention. Not for want of reports. Yet we have failed. We examined how targets had been set for our sample of determinants and found inconsistencies in ambition, realism and timescales. The target setting process did not encourage a belief that resource

management was remotely near optimal for any of the major determinants.

We need national objectives for all the major determinants to inform resource planning and priority setting and to drive action in the short and medium term. This will enable progress to be measured and new knowledge and information recycled for use. Research, analytic thinking and consensus building are needed. Sub-groups, children, ethnic groups and the economically deprived may need separate objectives.

Public health objectives require more ambition. The White Paper should propose objectives, plans, budgets and research programmes. One objective should be to stop the obesity rise now, with an increasing pace of reductions into the medium term. Objectives should be based on independent medical and managerial advice. The Government should establish the structure that it will use to obtain advice regularly.

Networks designed to tackle local issues will emerge locally. National objectives should inform local decisions but centrally calculated targets should not be imposed on local organisations. Placing smoking cessation targets on Primary Care Trusts is probably the worst example of this type. Local networks know local problems, priorities and complex trade-offs. Crude bureaucratic administrative systems corrode professionalism, but well co-ordinated and directed central efforts can add value.

Our evidence on cost-effectiveness is weak due to the lack of research funding for public health intervention, the very slow acceptance of economic perspectives within public health, and the lack of a coherent set of Government research priorities. The future research programme will be technically very demanding and will require greater resources and greater expertise and depth in core disciplines.

The need for action is too pressing to excuse inertia and this should help to build the evidence base that must be rapidly incorporated in a comprehensive research programme with an agreed evaluation procedure. The sound methodology being developed by the National Institute for Clinical Excellence should be the base, forcing consideration of costs and benefits and introducing techniques to involve "real" people in making difficult assessments of value.

Capacity problems, the impact of recent organisational change and the lack of alignment of performance management systems limit achievement. Primary Care Trusts (PCTs) have spread resources thinly yet are vital in making new mechanisms – such as new contracts – work to advantage, rather than becoming a bureaucratic nightmare and a diversion away from sound professionalism towards opportunistic point-scoring. Close review and evolution of local structures are recommended; wholesale reorganisation is not.

Our well developed network of primary care providers could provide a unique resource for evaluation and health promotion. If the National Health Service is to be "the best insurance policy in the world", it must start to manage risks like an insurance company. Pooling of resources between PCTs and local authorities should be closely reviewed to see if that produces the expected benefits.

Workforce capacity planning, including attention to significant skill shifts, must encompass the wider public health workforce and take a long-term view, taking into account the way delivery is likely to develop as primary care transforms. The opportunity must be taken to consider what primary care should become over the next couple of decades. How will knowledge of genetic make-up and of individual risk assessment influence personalised health promotion and disease prevention? Information Technology will drive change and marketing techniques will be facilitated and will find their place.

Huge commitments being made to improve technology will have, as part of their justification, identification of personalised risk profiles. Government must also address the threat to public health research arising from the difficulty of obtaining access to data. Debate is needed about the balance between individual confidentiality and public benefit.

I recommended primary care pilot exercises to assess the benefits of additional resources in information systems, in monitoring risk, in varying degrees of attention and in advisory services directed towards areas of inequality where access is a crucial issue. Many organisations need to be shown the business case and the self-interest from engaging their employees, members and insurees. The NHS, for example, should be showing how to

help their employees engage. Private sector organisations can help too by creating markets which capitalise on individuals' concern about their future health. They should be encouraged and not vilified.

A Cabinet member, the Secretary of State for Health, should ensure that action across Government is having its public health impact assessed and that co-ordinated action is tackling the wide-ranging objectives for the determinants of health. So, an objective about obesity in children must produce action in schools on the provision of food and knowledge. Government, in its arms-length bodies' review, must not only eliminate overlaps and ineffectiveness but also address the gaps the review identified as well as the provision of educational messages. Communication needs more marketing professionals to help send the right messages.

The report suggests principles to govern the Government's help to individuals making informed choices; to overcome the lack of information and confusion of messages, for example in food labelling. To check whether messages have been received, believed and understood. To ensure people take account of the wider costs of their behaviour. To help shift social norms, a legitimate activity for a Government when it has worked through and gained commitment for objectives for behaviour change. To find out what works at acceptable cost even those programmes which worsen inequalities in isolation, provided they are accompanied by programmes addressing the resulting inequalities. And to report on progress annually.

Strong, persuasive leadership will make the difference between success and failure. It is most likely to be effective in our society, nationally and locally by establishing aggressive goals, building widespread consensus, encouraging action by the self-interested as well as by the community conscious and driving through voluntary engagement.

It is good news that the Government has reacted with its review of arms-length bodies, consultation and the proposed White Paper. All are welcome but not enough to guarantee success. My report was designed to establish a checklist against which the Government's responses can be judged. But so can the responses of all those who have parts to play if we are to achieve the prize of full engagement.