Consultation Response: Transforming Health Improvement in Wales

The Draft Final Report of the National Health Improvement Review

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The Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPHer) is a UKCRC Public Health Research Centre of Excellence. DECIPHer brings together leading experts from a range of disciplines to tackle public health issues such as diet and nutrition; physical activity; and alcohol, tobacco and drugs, with a particular focus on developing and evaluating multi-level interventions that will have an impact on the health and wellbeing of children and young people. The Centre, based at Cardiff University, Swansea University and the University of Bristol, engages strongly with policy, practice and public user communities as our stakeholders, to translate the research results into practical outcomes.

Overview

The intention to review Wales' health improvement programme in order to provide direction for programmes is admirable, demonstrating a commitment to evidence and reflection, two qualities often absent from the policy-making process. We agree with the Review's observation that the current health improvement model is often based upon "single approach solutions, silo teams, segregated budgets, inadequate evidence, outcomes and/or inappropriate targeting of need" and that this is no longer viable. However, whilst the Review seeks to provide *"a robust basis to move forward"* its process and methodology hinders its ability to do so and affects the Review's main conclusions and recommendations. In the following sections we identify the four main problems that arise in the report and the impact of the method on the recommendations.

Review Shortcomings

1. Scope of the review

The scope of the review is unclear, flawed and appears to have two logically inconsistent foci. The scope as described at http://www.wales.nhs.uk/sitesplus/888/page/62972 indicates a focus on:

[A] Reviewing the "health improvement programmes or initiatives funded by Public Health Wales and the Welsh Government's Department of Health, Social Services and Children" and also

[B] That "Information on other health improvement or related programmes outside the scope of the review are being taken into account to ensure that the review is robust even if they are not being actively 'reviewed'."

This second part of the published scope is unclear and in the draft final report seems to have morphed into a much wider review of the "wider context of health improvement in Wales" with a need to "take account of wider relevant policies which may be linked to health improvement".[1] Much of the core methodology of the report appears to have been selected with an emphasis on objective [A]. Yet much of what is presented in the report and many of the recommendations relate more to objective [B], for which there is no clear or appropriate methodology or criteria set out.

To address objective [B] would require an assessment of health in all policies, including those not implemented by Public Health Wales. The recent Consultation on the Health of the People Bill demonstrates the Welsh Government's commitment to addressing the wider determinants of health, however this Review fails to scrutinise the impact of other government departments on health outcomes. The review pays little or no attention to key areas of health that should be addressed in any review process meeting the ambitious scope of objective [B]. For example, mental health was only mentioned once in the final report, despite its significance and impact upon other aspects of public health.[2] Substance use is also missing from the report, even though it has an interactive relationship with other aspects of public health.[3]

Consequently the report's conclusions and recommendations are disconnected from the evidence reviewed. Many of them appear to be informed by an opaque cocktail of policy rhetoric and an inconsistent application of the evidence informed approach attempted in the review of health improvement programmes (objective [A]). For example, final recommendations focusing on areas of development such as community assets and social marketing have not been subject to the same scrutiny as PHW programmes such as the Cooking Bus. There may be good reasons to prefer a specific social marketing intervention to the Cooking Bus, but neither the broader theory, principles, evidence nor any other criteria are presented in this report for doing so.

2. Transparency & the use of evidence

The recommendations arising from the Programme Budgeting and Marginal Analysis (PBMA) report are confusing despite this information being imperative to the translation of evaluation outcomes into action. It is difficult to understand how conclusions have been reached and why certain intervention programmes have been recommended for discontinuation.

Two examples, in which DECIPHer has a particular interest, since we conducted the research and evaluation of the programmes, serve to demonstrate this puzzling inconsistency and lack of transparency: the Review recommends the partial disinvestment of the National Exercise Referral Scheme (NERS) despite high quality evidence of its effectiveness.[4] The Review also recommends that the progress of the ASSIST programme should be reviewed and monitored despite that fact that it is now recommended within the NICE guidance.[5] It is unclear how the findings from the PBMA report translated to these findings in the final Review. The PBMA final report clearly differentiates between the Designed to Smile and NERS programmes, assessing Designed to Smile as 'Amber' and the NERS as 'Green'. However, the overall report recommends partial disinvestment of both Designed to Smile and the National Exercise Referral Scheme without any explanation as to why a programme labelled as 'Green' is assessed in the same way as a programme labelled 'Amber'.

Each recommendation made by the report should be consistent with and traceable to a clear evaluation of the evidence within the report. But this is clearly not the case, as demonstrated by the examples above. The report also recommends 'social marketing and community engagement' despite the lack of any clear explanation, definition or evidence. Neither of these approaches is identified by the PBMA group as effective or potential investment areas. So where did this recommendation come from?

There are substantial risks associated with the inconsistent and opaque use of diverse criteria for making both general and specific recommendations. While the case for assets-based community-led programmes to tackle upstream determinants of health is strong, it should not be used to argue against efficient and cost effective behaviour change interventions. As understood well before it was codified in the Ottawa Charter, complementary and synergistic actions are required at multiple levels, which include (1) developing personal skills and (2) reorienting health services as well as (3) policy action, (4) supportive environments and (5) stronger communities. Many of the reports' recommendations seem to arise more from a desire to shift from 1+2 towards 4+5 rather than by developing evidence based recommendations using appropriate evidence in a transparent manner within a clearly defined set of strategic priorities.

3. Unclear definitions and categorisation

In Section 7, the definitions used to map health improvement spending are confusing. The inconsistent categories make it difficult, if not impossible to adequately make observations of the overall spending on health improvement. In the first chart in Section 7 many categories overlap and the labels used make it difficult to understand what areas have received spending. For example, the 'Designed to Smile' intervention is classed as a 'nutritional intervention' in the absence of a separate category for oral health. It could also be argued that since all dental public health is ring-fenced, what is the purpose of its inclusion in the review?

Moreover, the use of 'life course' as a separate category is unclear. It seems to be used as a very broad term which is not particularly helpful since there would be unlikely to be a recommendation for health improvement investment outside the life course. In the second graph the ages of the life course are broken down, however the specific categories are not described, leading to the questions;

- At what age do children and young adults become working age adults?
- When do working age adults become older people?
- What distinguishes older people from the elderly?

The budgets vary greatly between each stage of the life course, yet no evidence-based explanation or justification of recommendations are provided For example, it is extremely important to invest in the early years as this period of development is a determinant of health status throughout the life course[6] and can positively affect antecedents to health in later life.[7] However, this should not be implemented at the expense of investment throughout childhood and adulthood, which is equally important due to the high rates of obesity, and its associated comorbidities, observed in England and Wales among children and adults. For example, 23% of men and 25% of women in England were obese in 2002[8], a prevalence which is set to rise by 11 million by 2030 in the UK, with a cost to the NHS of 1.9-2 billion per year.[9]

Spending for prenatal/maternal health/early years has a budget of £4,115,113, which decreases to between £2 and £3 million for children to older people. Meanwhile, the elderly receive a mere £175,946 in spending, without any explanation if this is adequate to support a life-course approach. Far from being ignored, investments in the elderly, including social care, can lead to huge improvements in quality of life and save the NHS money, time and resources. For example, approximately 60,000 older adults fracture their hips every year and an analysis of 100 hip fractures found a mean hospital stay of 23 days with a mean cost to the NHS of £12,163 per patient.[10] After the incident, 51% of older adults over the age of 90 die within a year.[11] Small increases in physical activity can improve balance, physical function and prevent the deterioration of bone strength, factors which can both help to prevent falls and subsequent hip fractures and aid recovery. Physical activity has been

associated with a 20-40% decreased risk of hip fracture.[12] This emphasises the need to ensure that budgets are evidence-based and contextualised with other related policies and budgets.

4. Lack of on-going value

Overall, the review is high on rhetoric but lacks the substance of a forward facing implementation plan. For example, the Review states that Wales needs to *'work collaboratively and systematically plan action to reduce the health inequality gap'* and *'ensuring health improvement becomes everybody's business will be crucial to making this a reality'*. In order to work towards transforming health improvement in Wales, we need to create specific and detailed action plans of how and why changes will be implemented, rather than simply planning to make more plans. These should promote joined up working, be inclusive of a wide range of non-health policy areas and move away from the old-fashioned silo style of working.

A plan of action using joined-up policies should be implemented and tailored towards eliciting health improvement in the whole of Wales not just within the scope of Public Health Wales, as is recommended by the HOTP Bill. This could be implemented by the mainstreaming of NHS budgets, on-going monitoring of efficiency and evaluating the impact of non-health policies. By creating such a strategy, the 'tools' or interventions will be utilised more effectively.

The future of health improvement in Wales Review needs to be based on the creation and implementation of action plans that promote joined-up working and are inclusive of a wide range of non-health policy areas. These action plans should be based upon a rigorous and transparent evaluation of high quality evidence.'

Public Health Improvement in Wales is at a critical juncture and requires a forward looking strategic plan that develops effective systems and structures to maximise the health gain achieved from actions and expenditure across government policy areas. With respect to the wider determinants of health and the potential health improvements that can be achieved across other policy areas, the Green Paper for a potential Public Health Bill in Wales indicated many positive steps that can be taken to establish mandatory processes to assess and improve the health impacts of such policies.

Within the remit of the Department of Health, Social Services and Children (DHSSC), we believe that it is essential to develop processes to increase the proportion of expenditure allocated to health improvement and to drive up the efficiency and equity of health improvement. The current review is a rather unfocussed and poorly conducted cross sectional snapshot of a situation that has been influenced by opportunisms, historical contexts and haphazard planning. What is needed now is a dynamic process of continual evaluation and communication to develop detailed and relevant plans that are readily translated into action.

The recommendation to draw on NICE guidance to inform policy and practice is strongly supported by DECIPHer and should be routine and central to resource allocation decisions in

DHSSC. Such guidance provides critical ammunition to argue for a larger proportion of health spending to be allocated to prevention and public health, since from individually focussed behaviour change interventions to complex multilevel community interventions, the guidance and underlying effectiveness and cost effectiveness reviews typically find public health interventions and programmes to be more cost effective than the majority of health care interventions.

We would recommend an on-going process be applied to all decisions regarding the content and implementation of public health improvement programmes. Such a process would involve the identification of:

- Strategic priorities;
- Specific needs;
- Potential interventions;
- The resources needed to support their implementation.

Interventions would be taken forward if recommended by NICE guidance or clearly supported by high quality appropriate relevant evidence. Where this is lacking, the decision whether or not to take forward the intervention could be based on political or other factors, or could be taken on the basis of implementing it on an experimental basis within a high quality evaluation to develop the evidence base. The Public Health Improvement Research Network in Wales (PHIRN) and the work of DECIPHer has increasingly been recognised internationally for facilitating a number of innovative policy trials to provide high quality evidence of effectiveness within experimental implementation of new programmes (such as Free Breakfasts, Exercise Referral, Strengthening Families Programme). Wales is also fortunate in having one of the most extensive and integrated systems to track the impact of policies, and the distribution of interventions and exposures and their impacts on health and a wide variety of social outcomes in the form of the Secure Anonymised Information Linkage (SAIL) system.

The diagram in section 10.2 attempts to describe a set of criteria to inform a way forward and the list of bullets on p.42 to set out key functions. But neither of these is a process or system to be taken forward. And neither list seems to indicate that it may be a good idea to use the existing evidence base to decide what to take forward, which is a shocking omission. Indeed, much of the tenor of this section ‘the way forward’ seems to be dominated by the need to move towards rhetoric-driven rather than evidence-informed approaches. The emphasis on community empowerment and localism seems to be set up as salient and of greater importance than evidence, and nowhere does the report acknowledge the growing international evidence that supporting communities to engage with needs assessment and evidence informed decision making processes to maximise relevance, ownership, adoption implementation and sustainability of high quality effective programmes (rather than locally inspired square wheels) is the most promising way forward.

Therefore, although the report is generally very disappointing in setting out processes which can be applied to (1) increase the influence of the health lens outside the DHSSC, (2) increase the share of DHSSC expenditure on health improvement and (3) increase the efficiency of health improvement programme expenditure, we do welcome "Recommendation 6, Point 1: Public Health Wales and partners to develop Academic/Service Collaboration with Universities across Wales, Population Health Improvement Research Network (PHIRN) to strengthen academic expertise, facilitate research funding bids and improved the use of evidence in practice, including standardised evaluation frameworks". We are keen to contribute to developing processes to evaluate interventions taken forward on an experimental basis.

[1] Page 9

[2] E.g. Friedli L, Parsonage M (2009) *Promoting mental health and preventing mental illness: The economic case for investment in Wales.* http://www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20(English).pdf; Royal College of Psychiatrists (2010) *No health without public mental health: the case for action. Royal College of Psychiatrists Position statement PS4/2010*. London: RCP. http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf; Paluska SA, Schwenk TL (2000) Physical activity and mental health: Current concepts. *Sports Medicine* 29(3):167-180.

[3] E.g. DuRant RH, Smith JA, Kreiter SR, Krowchuk DP (1999) The relationship between early age of onset of initial substance use and engaging in multiple health risk behaviors among young adolescents. *Arch Pediatr Adolesc Med* 153(3):286-291; Bevan G (2009) Problem drug use the public health imperative. *Subst Abuse Treat Prev Policy* 4: 21.

[4] Murphy S, Tudor Edwards R, Williams N, Raisanen L, Moore G, Linck P, et al. (2012) An evaluation of the effectiveness and cost effectiveness of the National Exercise Referral Scheme in Wales, UK: A randomised controlled trial of a public health policy initiative. *J Epidemiol Community Health* 66(8):745-753.

[5] NICE Public Health Guidance (2010) *School-based interventions to prevent smoking. National Institute for Health and Clinical Excellence.* http://www.nice.org.uk/nicemedia/live/12827/47582/47582.pdf

[6] Halfon N, Hochstein M (2002) Life course health development: an integrated framework for developing health, policy, and research. *Milbank Q* 80:433-479.

[7] Hertzman C (1999) The biological embedding of early experience and its effects on health in adulthood. *Ann N Y Acad Sci* 896:85–95.

[8] Rennie KL, Jebb SA (2005) Prevalence of obesity in Great Britain*. Obesity Reviews* 6(1):11-12.

[9] Wang YC, McPherson K, Marsh T, Gortmaker SL, Brown M (2011) Health and economic burden of the projected obesity trends in the USA and the UK. *The Lancet* 378:815-825.

[10] Lawrence TM, White CT, Wenn R, Moran CG (2005) The current hospital costs of treating hip fractures. *Europe PubMed Central* 36(1):88-91.

[11] Keene GS, Parker MJ, Pryor GA (1993) Mortality and morbidity after hip fractures. *BMJ* 307(6914): 1248-1250.

[12] Gregg EW, Pereira MA, Caspersen CJ (2000) Physical activity, falls, and fractures among older adults: A review of the epidemiologic evidence. *Journal of the American Geriatrics Society* 48(8):883-893.