A HEALTHIER NATION

Policy Green Paper No.12

Conservatives

YEAR
FOR
CHANGE

Contents

Foreword

There are two ways to respond to a problem. You can simply clear up the mess as best you can, or you can also work out why the problem happened in the first place – and take steps to stop it from happening again. Across our policy plans, we have chosen the common sense of the second option. It is our aim to treat the causes of our national problems as well as their symptoms.

In our economy that means not just dealing with our debts, but setting up an Office of Budget Responsibility to help keep public borrowing at sensible levels in the future. In the fight against poverty it means not just moving money around in weekly benefit cheques, but radically reforming education so that people have the opportunity to break out of the circumstances they were born into. And in healthcare it means drawing on one of the oldest pieces of medical wisdom: prevention is better than cure. So we will not just improve our NHS so that everyone who is unwell can get the best treatment possible, we will also bring in a new focus on public health to keep people well in the first place.

Today, we can't escape the fact that today many of our most severe health problems are caused, in part, by the wrong personal choices. Obesity, binge-drinking, smoking and drug addiction are putting millions of lives at risk and costing our health service billions a year. So getting to grips with them requires an altogether different approach to the one we've seen before. We need to promote more responsible behaviour and encourage people to make the right choices about what they eat, drink and do in their leisure time.

Government can't pull a lever to change behaviour. Neither should we dictate how people should live their lives. Instinct and experience tell us that bossiness doesn't work. Instead we must think practically about how to help people take more responsibility for their own health. That means an entirely new approach.

Ours is an approach that is much more local, recognising that the social causes of ill health vary widely throughout the country. Local authorities will have the job of prescribing the right solutions for their area – and we'll reward them for the results they achieve. It is an approach that is more focussed, with the creation of a new Department of Public Health to enshrine prevention at the heart of our plans for healthcare. And it is an approach that will cut right across the work of government, whether that is promoting sport in schools or bringing in a tougher licensing regime to help reduce binge drinking.

I believe we must act urgently to improve public health. Far too many people are losing loved ones to illnesses that could have been prevented. The plans in these pages are designed to increase personal responsibility, help change behaviour and therefore save lives – and nothing can be more important than that.

Executive Summary

No public service matters more to people than our NHS, which is why for Conservatives the NHS is our number one priority. We have made the commitment to provide it with the funding and reforms needed to deliver world-class standards of care within a service that remains free and based on need. Because the NHS is the bedrock of a fair society, we will cut the deficit, not the NHS.

Our vision is to sweep away government micro-management and target-setting, and instead make doctors accountable to patients not politicians. New funding incentives linked to quality of outcomes and greater powers for patients to choose between care providers will raise standards radically. The need for bureaucratic government control will fall away.

We recognise that positive change and improved performance within the NHS are necessary but not sufficient to raise health outcomes. From its creation, the NHS was always meant to prevent illness. But today, lifestyle-linked health problems, like obesity and alcohol abuse, are putting huge demands on health services, causing costs both to the NHS and wider society – as well as creating a great deal of unnecessary illness. At the same time, health inequalities between different social groups and different parts of our country are growing wider.

A Conservative government will be able to focus on public health and preventable disease – the surest route to improving the health of the nation. We understand the critical importance of importance of public health and are committed to improving health outcomes across the board – from improving the quality of maternity care, to lowering rates of childhood obesity, and cutting rates of smoking and alcohol abuse later in life.

People are demanding increasing degrees of control over the health services they use, and are more critical of the top-down guidelines and advice they receive from government. This is a trend in every area of social life (part of what we call the 'post-bureaucratic age') so if we are to improve personal responsibility, government must change this approach fundamentally.

This is why we need an overhaul of the way we go about promoting better public health:

- There must be a focus on **reducing health inequalities**, in a locally led public health strategy and throughout government - from the strengthening of support for families with young children to reducing preventable winter deaths among elderly people.

- Some parts of public health policy need to be led nationally - immunisation programmes, emergency planning or behaviour change campaigns. Wherever possible, these should be evidence-based and linked to the latest advances in **social psychology and behavioural** economics, so that they work intelligently with the way real people live their everyday lives.

- Responsibility for improving public health, and the budget to do so, must be **decentralised** as far as possible - away from central government control and out to local communities.

- Councils, communities and independent providers should be **rewarded for reducing health problems** like obesity, teenage pregnancy and alcohol abuse – when they make serious savings for the NHS and the taxpayer, they should be rewarded for it.

The challenge we face

Many of our worst public health problems have already reached crisis point. Britain now has the highest obesity rates in Europe; we have among the worst rates of sexually transmitted infection; and we are seeing rising rates of alcohol and drug problems.

Despite attempts by the Government to improve our health, a quarter of adults and a sixth of children are now obese - up from one in seven adults and one in ten children in 1993. More than ten per cent of the population - 7.6 million people - are drinking at hazardous levels. The death-toll from tobacco use is also immense; smoking is responsible for around 84,000 deaths every year in the UK.

Labour's approach to managing healthcare has not allowed a proper focus on these problems. Activity is increasingly being focused on achieving bureaucratic targets for acute services, like operations, leaving too little room for preventative care that could cut down the need for treatments in the first place. This is one reason why our national health trends, such as cancer survival rates, still seriously lag behind the European average, despite that fact that we spend the European average on our healthcare.

But there is also a more 'cultural' aspect to this problem: people's personal choices - to drink to dangerous levels, for example - are driving up ill health and its public costs. Britain fares worse than other countries in terms of lifestyle problems that lead to major causes of premature death, like heart disease, cancer and stroke.

Britain has become one of the least cohesive and most socially divided countries in Europe. The decline of our community and civic life has been made worse by cuts to local services that are essential to well-being (like health visitors) and by policies such as 24 hour alcohol licensing. Rising rates of family breakdown, teenage pregnancy, and drug and alcohol abuse among children have not been tackled properly.

When government allows society to weaken, we see a damaging decline in social responsibility. Troublesome binge drinking is fuelled by irresponsible alcohol marketing; rising child obesity is encouraged by the decline in the number of families eating proper meals together at home.

It is our public services, and the NHS in particular, that take much of the fall-out: A&E units are dealing with rising numbers of drunks, and doctors report soaring obesity-related illnesses like Type 2 diabetes. The overall effect is that, despite the existence of a universal healthcare system which is free at the point of need, inequalities in ill health and infant mortality between rich and poor persist and are now at levels not seen since the Victorian era.

The change we need

Government cannot improve public health through crude attempts to dictate the way people should behave. People are often sceptical about the guidelines and advice they receive from government and other officials. They prefer to rely on information about their health from sources that they choose themselves. Our approach to improving public health is based on strengthening society and helping people take more responsibility for their own health. This is one reason why we believe that greater personal control of health records could lead to significant benefits, by helping people to take more responsibility for their health through sharing information with third parties if they choose to do so.

But government cannot sit back and watch ill health and healthy inequalities rise, in spite of all the information and healthy choices available.

We need a fresh approach to solve this conundrum.

1. Decentralisation: councils and independent providers rewarded if they improve local health

The first step towards a properly functioning system of public health is to recognise that the cultural and social causes of ill health and health inequalities vary between different groups of people in different parts of the country. We need a system in which local communities – working with other institutions (employers, charities, social entrepreneurs, private providers, schools and local doctors and nurses) – can identify local needs and provide rigorous solutions that are tailored to local circumstances. We will therefore give the job of improving our nation's health to local communities and create the opportunity for them to take ownership of their communities' health and wellbeing. We will not dictate how they achieve better public health outcomes. We will, however, reward them for the results they achieve.

Local authorities have already been assigned statutory duties to work towards improving public health, and some work well in partnership with Primary Care Trusts (PCTs) and others to achieve this. But these duties are not enough – they are not backed up by the powers or budget to bring about real improvements in local public health.

We will take immediate action to empower local communities to take real control:

- **Localised funding.** We will separate the public health budget from the budget for NHS services and devolve much more of the public health budget to local authorities and their health service partners. They will be paid a public health success payment for tackling problems like infant mortality, childhood obesity and sexually transmitted infections, and given financial rewards for reducing the future burden of disease and cost.

- **Freedom to innovate.** Local directors of public health will manage budgets and will be obliged to commission local bodies, like schools, businesses, councils and GPs, to promote healthy living. With money behind them, they will have the power to recruit and pay innovative local organisations, whether businesses or charities, to start to implement new ways of promoting healthy choices and behaviour.

- **Local action to tackle inequalities.** We will introduce a new 'Health Premium' to target resources towards areas with the poorest health to progressively reduce chronic health inequalities. The public health funding we devolve will give enhanced support and incentives to deprived communities, where health problems tend to be much worse. Based on the results achieved, the 'Health Premium' will incentivise and reward the improvements in the health of the poorest communities.

- **New roles for local GPs and pharmacists.** Pharmacists are many people's first stop for advice about their health, so we will encourage them to do more to promote better public health locally. We will also encourage GPs to deliver preventative health interventions that reduce the need for more serious treatment.

2. A new Department of Public Health focused on innovation and behaviour change

Our decentralised approach to NHS reform will completely redefine the role of the Department of Health. We will enshrine this change: it will be renamed the Department of Public Health and its role will be focused much more strongly on the prevention of disease, rather than just its cure. The Department will identify the specific health inequalities and preventable diseases we need to reduce, and will fashion the incentives framework for local authorities and their partners to achieve this reduction.

The Department will be directly responsible for the elements of public health provision that need to be addressed nationally, like immunisation, population-wide screening and major public health campaigns. We want this activity to be linked to the advances in behaviour change science:

- **A new information and evaluation strategy.** Countries like Sweden, Finland and the Netherlands are better than the UK at improving public health. This is in part because they are far more rigorous at monitoring and evaluating the direct impact of policies. We will embrace this good practice, but will go further by mandating the publication of the results of all national and local public health strategies online, along with tools which allow people to compare and benchmark performance.

  We will also use an "open-source" approach to get the best ideas, awarding a prize for the most effective campaign, and we will work with retailers to understand the impact of campaigns by tracking aggregate sales data.

  This approach will encourage far greater innovation – allowing people to see how behaviour can be successfully changed and spurring new providers to take over or replace failing programmes.

- **National campaigns paid by results.** Whenever possible, we will ensure that national public health initiatives funded by public money are paid for on the basis of the results they achieve. Cognitive science and behavioural psychology are being used increasingly in business to 'nudge' people towards making desired choices, because traditional ways of instructing or educating people are becoming less effective. Creating or changing 'social norms', for example, is very effective because people are powerfully influenced by the behaviour and choices of others. The approach has been shown to help people drink less and take up exercise, for example. By paying organisations running national campaigns by the results they achieve, we can encourage such innovation and improve the value we get from the money spent on public health.

- **Integration to meet changing major national public health challenges.** New patterns of infectious disease are emerging all the time, such as the spread of multi drug-resistant tuberculosis and Hepatitis C. A key role for central government will be to spread insights and best clinical practice from new science and research on these new, major threats. Emergency planning for the potential bird flu ('H5N1') pandemic influenza, which remains one of the greatest public health threats, also demonstrates that alongside decentralised decision-making in relation to public health lifestyle challenges we need to retain and enhance the ability of the Secretary of State to organise national prevention measures to deal with major threats. This means establishing clear lines of accountability from local directors of public health to the Secretary of State, so that there is an integrated system capable of initiating common preventative responses to sudden and unpredictable public health challenges, and carrying out an integrated response to outbreaks of emergent or re-emerging infectious diseases.

3. An approach that promotes personal responsibility and informed choices

We also need to recognise that the commercial world has a huge influence over the choices we make as consumers. We want to work with business to eliminate negative commercial influences and reward positive ones:

- **A responsibility deal with business:** We will ensure that business, alongside public authorities, plays its part on improving people's health. We will work together to extend to all media voluntary restrictions on marketing to children to all media, including online advertising, and also support industry-led initiatives to promote better health, such as reducing food portion sizes and reformulation. Building on the solid work of the Public Health Commission's report, '*We're all in this together, improving the long-term health of the nation*', we will ensure that businesses, alongside the public and voluntary sectors, are joint owners of a long-term public health strategy.[1]

- **Promoting informed choices:** In addition, we will discuss with industry how we can improve the consistency of information available to consumers, such as in fast-food outlets, restaurants, cafes and bars. We will work with the food and drink industry to improve the clarity of information on food packaging, such as 'Guideline Daily Amounts' (GDAs) and will improve on the 'units' labelling system for alcohol which is often difficult for people to understand.

4. A focus on public health throughout government

Our plans for improving public health will be linked to a wider strategy to make Britain a healthier nation:

- **New health visitors.** Children's experiences in their earliest years affect how well they do at school, and affect their physical and emotional health right into adulthood. We will provide a health visiting service and provide an additional 4,200 Sure Start health visitors, based in Children's Centres, who will help families provide support from before birth to primary school. This will enhance existing health provision to families and reduce the social costs caused by Labour's inadequate provision.

- **Preventative interventions around the time of birth.** We want to give every mother and mother-to-be world-class care, and to ensure that every child gets the best possible start in life. So a Conservative government will give mothers a real choice over where to have their baby, with NHS funding following their choices, and allow new providers to deliver maternity care – especially services like ante- and post-natal support. And we will introduce local 'maternity networks' to ensure that mothers can safely access the right care, in the right place, at the right time.

- **Encouraging sport and activity.** We want to increase sports played in schools and will promote this through a new annual School Olympics: a national competition between schools that will climax with finals held in the Olympic Stadium.

- **Tough action to reduce binge drinking.** To help tackle binge drinking and all the social problems it causes we will introduce a ban on cheap alcohol being used as a loss leader in shops and supermarkets and tax problem drinks like alcopops and super-strength beers more heavily. A tougher licensing regime will also be introduced so that problem venues which encourage irresponsible drinking can be tackled.

1. The rising rates and rising costs of poor public health

Chronic conditions such as heart disease and chronic obstructive pulmonary disease are among the most prevalent and costly health conditions. Half of chronic disease is attributable to lifestyle factors such as a lack of physical activity or smoking.

Many of our worst public health problems have already reached crisis point. Britain now has the highest obesity rates in Europe; we have among the worst rates of sexually transmitted infection; and we are seeing rising rates of alcohol and drug problems. Each year, smoking-related disease claims over 84,000 lives. Dealing with sickness among people of working-age costs the taxpayer over £75 billion every year; the loss to the economy at large is almost £130 billion.[2]

1.1 Increasing health inequalities[3]

Although life expectancy has been rising over the last decade, differences in the life expectancy between social groups have persisted and worsened. For example, the gap between the life expectancy of 'routine and manual' groups and the population as a whole has widened over the last ten years. The gap in men's life expectancy in the period 2005-07 was 4% wider than between 1995 and 1997, while for women, this gap was 11% wider.[4] This is not because the poor are becoming less healthy; the life expectancy of the poorest quintile of the population is now as high as that of the richest quintile 30 years ago. However, richer people are getting healthier more quickly. [5]

In England, the gap in infant mortality between the poorest and richest households has widened since Labour took office in 1997. In the period from 1997 to 1999, the infant mortality rate among the routine and manual group was 13% higher than in the total population, whereas in the period from 2005 to 2007, it was 16% higher.[6] And there are also wide variations in the mortality rates and the number of babies born with a low birth weight in different regions. The Government is on course to miss its target to reduce inequality in infant mortality by 2010.[7]

Poor people not only live less long than the rich, they also have more years of poor health.[8] Women in the most deprived areas of the country on average succumb to poor health 13.6 years earlier than their counterparts in the least deprived areas.[9]
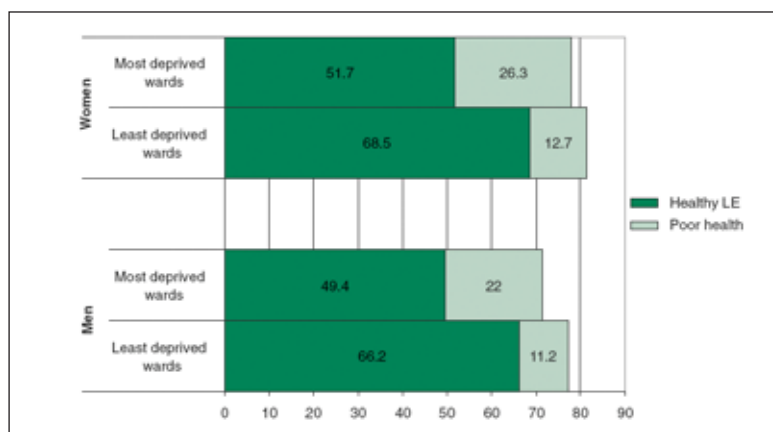
Years of healthy life expectancy (LE) and poor health by deprivation level[10]

The Health Select Committee argued that "there are many reasons why the poorest in society are less likely to adopt beneficial health behaviours. Firstly, information about how to behave healthily may not reach some groups of society; secondly, they may lack the material resources to live healthily, and the environments in which they live may make this doubly hard; behaviours such as smoking tend to be more heavily entrenched in those from lower socio-economic groups which makes positive change harder; and finally, for people living difficult lives, who may be faced with pressing problems with income, employment or even personal safety, changing health behaviour is unlikely to be a major priority."[11] Health inequalities are not only apparent between people of different socio-economic groups—they exist between different genders, different ethnic groups, and different ages.
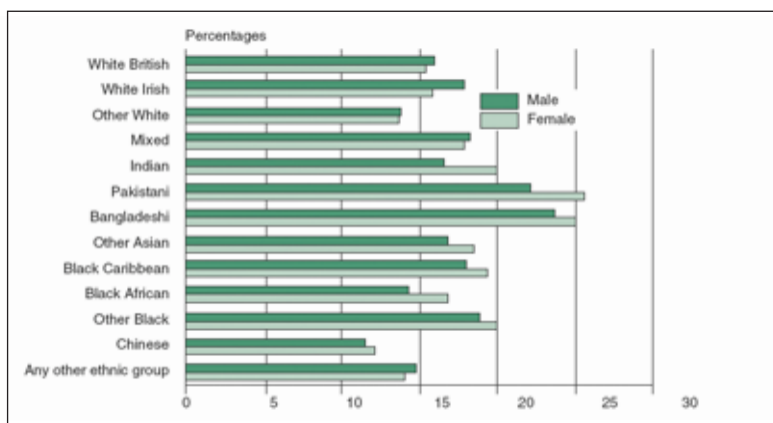
Percentages of people in different ethnic groups suffering from poor health and limiting illness in 2001[12]

The Health Select Committee also argued that people "suffering from a range of physical and intellectual impairments and disabilities also experience poorer health outcomes than other parts of society. Those with schizophrenia are 90% more likely to get bowel cancer, are 42% more likely to get breast cancer, have higher rates of diabetes, coronary heart disease, stroke and respiratory disease, and on average die 10 years younger than counterparts without mental health problems."[13]

Lifestyle-related causes of health inequalities reflect what are frequently referred to as the underlying causes of poor health - income, socio-economic group, employment status and educational attainment. For example, the association between housing conditions and physical and mental ill health has long been recognised.[14]

1.2 Rising rates of obesity

Of all the public health problems facing Britain, obesity is the most exaggerated by intergenerational standards and is growing alarmingly.[15] The Government's recent Foresight report suggests that on current trends, 40% of Britons will be obese by 2025 and that without changes to our approach, Britain could be a "mainly obese society" by 2050.[16] In 2008, there were more than 2,000 people in Britain claiming incapacity benefit because of obesity.[17]

A quarter of adults and a sixth of children are now obese - up from one in seven adults and one in ten children in 1993.[18] Obesity-related hospital admissions more than quadrupled between 1996-97 and 2007-08; the most recent figures included 2,104 admissions for children under 16.[19]

1.2.1 Increasing costs of obesity

The Department for Culture, Media and Sport and Strategy Unit report - Game Plan: a strategy for delivering Government's sport and physical activity objectives - estimated that the cost to the UK economy of physical inactivity is at least £2 billion a year.[20] A government report, published in 2007, stated that: "The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050. The wider costs to society and business are estimated to reach £49.9 billion per year (at today's prices)".[21]

1.2.2 International comparison

The UK now has more obese people than any other country in the OECD except New Zealand, Mexico and the United States.[22]

1.3 Rising rates of alcohol abuse

Britain is now particularly afflicted by alcohol abuse and this, too, is a rising trend. More than ten per cent of the population - 7.6 million people - are drinking at hazardous levels; 2.9 million are showing evidence of harm to their own health, including 1.1 million people who have some level of alcohol addiction.[23]

A recent survey found that over a third (37%) of those aged 16 and over in Great Britain exceeded UK recommended guidelines for regular drinking in the previous week, and 20% of adults consumed more than double the guideline amounts on their heaviest drinking day of the week.[24] In 2007-08 there were 863,300 alcohol related admissions to hospital. This is an increase of 69% since 2002-03 when there were 510,200 alcohol related admissions.[25]

Young people are now drinking twice as much as they did in 1990.[26] UK teenagers are among the most likely in Europe to report heavy consumption of alcohol and intoxication.[27]

The number of deaths linked to drinking is rising. In England the number of deaths directly related to alcohol has increased by 19% between 2001 and 2007.[28] Of these alcohol related deaths, the majority (4,249) died from alcoholic liver disease.[29]

1.3.1 Increasing cost of alcohol abuse

The cost of alcohol misuse to society is between £17.7 billion and £25.1 billion per year.[30] Between 2001 and 2007, the direct costs to NHS from alcohol misuse nearly doubled, increasing from between £1.4 - £1.7 to £2.7 billion.[31]

1.3.2 International comparison

Adults in the UK drink more than in most other OECD countries.[32] On average we consume 11 litres of alcohol per capita per year (the equivalent of more than 500 pints of beer each), compared with just seven litres in Norway and Sweden, eight in Canada and nine in the United States.[33]

1.4 Rising rates of smoking related disease

Smoking is another major cause of ill health and premature death. In 2006-07 there were approximately 1.4 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking.[34] This figure has been steadily rising for ten years.[35] The death-toll from tobacco use is also immense; smoking is responsible for around 84,000 deaths every year in the UK.[36]

Six per cent of children reported that they smoked at least once a week.[37] People who start smoking at an early age are more likely than other smokers to smoke for a long period of time and are more likely to die prematurely from a smoking-related disease.[38]

1.4.1 Increasing cost of smoking

The direct cost of smoking to the NHS was £5.2 billion in 2005-06.[39] This is a huge increase on previous estimates – in 1991 smoking cost the NHS between £1.4 and £1.7 billion.[40]

1.4.2 International comparison

21% of the UK population are daily smokers - more than in many comparable countries.[41] In the United States, for example, just 15% of the population smoke every day, in Australia only 17% do so.[42]

1.5 Increasing rates of infectious diseases

Rates for certain Sexually Transmitted Infections (STIs) have also been rising: the Health Protection Agency has reported a six per cent increase in the total number of STIs diagnosed in 2007 compared to 2006.[43] Since 1998 the number of newly diagnosed cases of HIV in young people in England has increased threefold.[44] 83,000 people are now living with HIV in the UK.[45] Between 1999 and 2008, the largest increases in STIs diagnoses were of chlamydia which rose by 116%, genital herpes which increased 65% and syphilis by over 1000%.[46]

We cannot ignore the threat of other infectious diseases like TB and Hepatitis C. Drug resistant strains of infectious diseases are especially worrying. When a Health Protection Agency team examined 28,620 TB infections in England, Wales and Northern Ireland between 1998 and 2005, they found the proportion of cases resistant to any of the first-line drugs rose from 5.6% to 7.9%.[47] Last year, doctors diagnosed the first ever UK case of a virtually untreatable strain of tuberculosis - extreme drug-resistant tuberculosis (XDR-TB).[48]

1.5.1 Increasing costs of infectious disease

Specific figures about the costs to the NHS of treating Sexually Transmitted Diseases are not available. In 2004, the Health Protection Agency (HPA) estimated that the annual costs of treating sexually transmitted infections across the UK were in excess of £700 million, but this did not include treating their longer term symptoms.[49] The HPA also estimated that each HIV infection prevented saves between £500,000 and £1 million over a lifetime.[50]

Treatment of drug resistant infectious disease is also extremely expensive, for example, extreme drug-resistant tuberculosis takes 12 to 18 months to treat and costs more than £100,000 a patient.[51]

1.5.2 International comparison

The UK has some of the highest rates of Sexually Transmitted Diseases in Europe. We have more cases of HIV than most other countries, with 14 cases of HIV per 100,000 population compared to three in Germany and nine in France.[52] Our Chlamydia rate is higher than in all other European countries except those in Scandinavia.[53] And we have more cases of Gonorrhoea than any other European country except Russia and Romania, with 31 cases per 100,000 population, compared to just ten in Ireland.[54] More of our children have had sex before the age of 15 than in any other European country.[55]

1.6 Rising rates of drug abuse

Reported rates of drug abuse have increased in the UK in recent years. Recorded drug offences in England and Wales have gone up from 135,945 in 1998-99 to 242,907 in 2008-09, an increase of 79%.[56] The percentage of 16 to 59 year olds admitting that they have used Class A drugs at some point in the previous year has increased from 2.7% in 1998 to 3.7% in 2008-09; the proportion using cocaine has more than doubled.[57]

There were a total of 2,928 deaths from drug-related poisoning in 2008, up from 2,640 in 2007, an increase of 11%. [58] [59]

1.6.1 Increasing costs of drug abuse

The financial cost of drug abuse is huge. A report by the drug and alcohol treatment charity Addaction found that over the ten years from 1998 to 2008, drug-related health and crime costs to the UK totalled £110 billion.[60]

1.6.2 International comparison

Rates of UK Drug abuse are amongst the highest in Europe. A report by the independent UK Drug Policy Commission found that the UK has the highest level of problem drug use and the second highest level of drug-related deaths in Europe.[61]Drug abuse amongst young people is a particular concern. A report by UNICEF into child poverty in 21 industrialised countries ranked the UK third highest in terms of the proportion of 11, 13 and 15 year- olds who said they had taken cannabis in the last twelve months.[62] The European Monitoring Centre for Drugs and Drug Addiction compared drug use in 28 countries in Europe and revealed that the UK has the highest proportion of cocaine amphetamines, ecstasy and LSD use.[63]

1.7 Rising rates of poor mental health

One in four British adults experience at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time.[64]

The proportion of people aged 16-64 meeting the criteria for at least one common mental health disorder (CMD) increased between 1993 and 2000, but did not change between 2000 and 2007 (15.5% in 1993, 17.5% in 2000, 17.6% in 2007). The largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45-64, among whom the rate rose by about a fifth.[65]

1.7.1 Cost of poor mental health

The Sainsbury Centre for Mental Health estimates that the cost of mental ill health is £77 billion due to loss of earnings and associated treatment and welfare costs per annum.[66] They estimate that the human cost of prolonged mental ill-health is equivalent to £41 billion a year, the cost of care to the NHS, local authorities and others is about £12.5 billion each year while the economic cost of lost work is an additional £23 billion.[67]
Leading health mental health charities and health policy experts predict that direct health and social care costs, and the cost of lost employment through mental health problems in the workforce, will double in real terms over the next 20 years. [68]

2. Labour's record on public health

Labour's approach to managing healthcare has not allowed for a proper focus on these problems. GPs, doctors and nurses are increasingly having to meet bureaucratic targets for getting people through acute services rather than being able to devote attention to the preventative care that can help stop people needing treatment in the first place. The decline of our community and civic life has been made worse by cuts to local services that are essential to well-being (like health visitors) and by policies such as 24 hour alcohol licensing. Rising rates of family breakdown, teenage pregnancy, and drug and alcohol abuse among children have not been tackled properly.

When government allows society to weaken, there is a decline in social responsibility and personal responsibility is undermined. This is one reason why the outcomes the NHS delivers, such as cancer survival, still lag behind European average, despite that fact that we spend the European average on our healthcare.

Increasingly people's personal choices, to drink to dangerous levels, for example, are driving up ill health and its public costs as well as causing premature death, heart disease, cancer and stroke.

2.1 Public health funds not getting through

Funding intended to improve public health has been diverted to cope with the NHS financial crisis.

The Independent Advisory Group on Sexual Health and HIV has said that a substantial part of the £300 million set aside for improving sexual health has been absorbed by primary care trusts.[69] The British Heart Foundation have argued that funds intended for public health have been used to offset deficits in acute care budgets under Labour.[70]

As one newspaper investigation revealed: "NHS trusts across England have siphoned off almost £100 million from government funds intended to combat obesity, alcohol abuse and sexually transmitted infections as a panic measure to escape financial crisis. Data provided by 103 primary care trusts (PCTs) showed that half axed almost all the projects promised by the government in the Choosing Health white paper in 2004. Less than 10% of PCTs used the full public health allocation for the intended purpose."[71]

2.2 Restrictions on public health spending

In 2002, the Chief Medical Officer for England, Sir Liam Donaldson, outlined his concerns over our 'obesity time-bomb' with increasing numbers of children and adults weighing more than in previous generations.[72] But in 2005, Sir Liam warned staff that they would face disciplinary action if they committed new money to public health programmes.[73] This is despite the fact that around about four per cent of health expenditure is spent on prevention.[74]

2.3 Weak or perverse incentives

As GPs do not hold responsibility for healthcare budgets, they have insufficient incentive to focus on prevention. Health policy experts agree that the mechanism for GP payment – the Quality and Outcomes Framework (QOF) does not encourage doctors to focus sufficiently on preventative work. "The current arrangement of the QOF does not consider implications for providing long-term care; even though there has been an introduction of new registers for smoking and obesity, the current incentives do not exist for advice and follow up."[75][76] When third parties are contracted to run behaviour change campaigns, most are not rewarded for the impact they have but are simply paid for producing the campaign. [77]

2.4 Low numbers of public health experts and poor quality commissioners

There is insufficient focus on public health expertise either in the Department of Health or in PCTs. And many public health staff lack the necessary analytical skill to commission effective public health programmes.

Gordon Brown's independent reviewer of the NHS said that it is "indicative of the relatively low priority given to public health that, while non-public health medical staff numbers have increased by nearly 60% since 1997, the number of public health consultants and registrars has gone down overall."[78]

A survey by the Faculty of Public Health published in 2006 found that there were 22% fewer public health consultant doctors than there were in 2003.[79] In the same year, there was little confidence that there were enough public health consultants to do the job. In England only 36% of primary care trusts believed that they had sufficient capacity to deliver public health effectively - and in the East Midlands, the worst-affected area, the figure was only 21%.[80]

A decline in the number of health visitors is particularly worrying. Health visitors are specially trained to work with mothers and their babies, visiting them in their homes to provide advice and support on issues like diet and vaccinations. And they are there to help new parents with the huge challenge of bringing up children. The number of health visitors has been cut by 16% since 2004 – which means more than 2,000 fewer staff.[81] 29% of health visitors report that caseloads are so large that they are losing track of vulnerable families.[82]

Last year a report from the King's Fund suggested that "NHS staff may… lack the skills necessary to interpret (data) accurately and use it to develop or adapt behaviour change interventions. As well as drawing on local health professionals' knowledge (whether GPs, health visitors, or other primary and community care staff), PCTs should be making full use of available data on the local population from a wide range of sources. To do so, they should ensure they have the necessary skills to interpret this data and to develop targeted interventions using the insights provided by the data." [83]

2.5 Minimal evaluation of what works

In 2000, 0.4% of public health research involved evaluation of outcomes.[84] As the Wanless report argued, "The dearth of evidence is not unrelated to the lack of funding of public health intervention research – with funding from research organisations and the private sector heavily directed towards clinical, pharmaceutical, biological and genetic research – and the lack of a clear and coherent set of Government priorities for the public health research which does exist."[85]

There is no formal assessment process that prioritises investments in health interventions. Research undertaken by bodies such as NICE (National Institute for Health and Clinical Excellence) and NIHR (National Institute for Health Research) provide valuable evidence on the effectiveness and cost-effectiveness of interventions, but they fall short of a formal process for ranking interventions.[86] "For instance, while NICE evaluates interventions to determine whether they provide sufficient value for money to justify investment, the result of this process is a list of interventions that PCTs can invest in, rather than a comparison of the effectiveness of these interventions against one another. And this evaluation is undertaken against the relatively narrow criterion of cost per Quality Adjusted Life Year (QALY) gained." [87]

2.6 Little analysis of different drivers of behaviour

The challenge at the heart of all public health programmes is how to help people translate knowledge into changes in behaviour. The evidence suggests that different approaches are needed to help different groups. But all too often the Government has failed to complete robust analysis of the reasons why people do things that they know are bad for them. The Department of Health has not applied the best insights from social psychology and behavioural economics. Finding effective ways to change people's behaviour is a challenging task in the absence of "a properly developed theory as to why people engage in unhealthy behaviours, or do not undertake healthy ones".[88]

2.7 A flawed approach to public health campaigns and ineffective spending

Significant effort and resource is spent on providing information on the assumption that it will automatically lead to behaviour change. The Department of Health invests heavily in publicity campaigns to promote healthy lifestyles – at least £50 million in 2007/08.[89] This money is spent despite evidence showing that in most cases information alone does not change behaviour, and when it does, it often changes behaviour in the "wrong" direction as it reinforces the behavioural norms that contribute to the problem in the first place. Often people want (unconsciously) to do what others do, particularly the "influential" others in their lives. So creating or shaping social norms can have major and pervasive impacts in positive or negative ways.

The Government has stubbornly stuck to its approach despite advice from their own Strategy Unit who argued that "the evidence suggests that, even when offered information and guidance, a significant proportion of people do not adhere to healthier behaviours", and from the King's Fund who have argued that "Government campaigns aimed at tackling our 21st-century health epidemics are old-fashioned and disjointed. As a result, ministers waste millions of pounds on ineffective advertising campaigns and fail to use the most effective weapons in the battle against obesity and substance abuse." [90][91]

The result of the Government's approach has been a series of ineffective campaigns with rising costs. For example, the number of people giving up cigarettes declined last year, despite millions of pounds being invested in NHS stop smoking services. A total of £74 million was spent last year, equivalent to a cost per quitter of £219, compared with £173 in 2007-08 and £160 in 2006-07.[92] Likewise, eight out of ten doctors and nurses believe public health campaigns to stem alcohol related problems have been insufficient.[93] Professor Ian Gilmore, President of the Royal College of Physicians and Chairman of the Alcohol Health Alliance UK, said: "While informing the public through health campaigns is important… front line doctors and nurses treating patients with drink problems do not believe that this is enough to reverse our binge-drinking culture."[94]

2.8 An addiction to short term initiatives

The Government's public health campaigns have been short-term and unsustained. The Health Select Committee report on Health Inequalities commented on the Government's record on public health initiatives, saying "Such wanton large-scale experimentation is unethical, and needs to be superseded by a more rigorous culture of piloting, evaluating and using the results to inform policy".[95]

Professor Ken Judge of the University of Bath, interviewed by the Health Select Committee, commented, "We end up with rich descriptions of what people are trying to do. These ... are then used as evidence of good practice because we do not have anything else and we slide inexorably from setting these things up essentially to the production of propaganda".[96] And Professor Hunter, head of Durham University public policy and health centre, argued that the Government's £75 million campaign Change4Life will fail to stop rising levels of obesity unless it commits to a strategy to change long-term behaviour.[97]

Campaigns that have come and gone over the last decade include:

- **'Healthy Schools'.** The Government have spent more than £50 million since 1999. But they have missed their own targets: in Tower Hamlets, figures show that nearly 40% of primary schools had not met healthy school standards by May 2008.[98]

- **'Health Action Zones'.** The government launched the Health Action Zone (HAZ) initiative in 1997. Twenty-six were set up as seven-year pilot projects 'to explore mechanisms for breaking through current organisational boundaries to tackle inequalities and deliver better services'. HAZs were meant not only to improve health outcomes and reduce health inequalities, but also to act as trailblazers for new ways of local working. The Health Development Agency's assessment of the usefulness of HAZs was that: "The HAZs felt that their direct impact on health inequalities was minimal – because of the short timeframe of the HAZ initiative and limited resources. Changes in national policy, including the NHS reforms and the emergence of local strategic partnerships, changes in HAZ priorities, and uncertainty about their future reduced the HAZs' ability to influence local policies. The following local factors affected their development: variable understanding of the problem of health inequalities affected coherence and ownership of HAZ strategies; changing organisational configurations locally caused problems, along with lack of co-terminosity of agencies."[99]

- **'Wired for Health'.** 1999. The Government set up a website to give teachers access to information to make their pupils healthier. Education Secretary Charles Clarke said the website would be 'indispensable' to teachers.[100] A few years later it had proved dispensable as it disappeared without trace.

Other initiatives which have lost momentum, disappeared, failed to impact or been superseded include:

- Healthy Teachers 1999
- Healthy Living Centres 1998
- Young and Active 1998
- Healthy Workplaces initiative 2005
- Small Change, Big Difference, 2007
- Healthy Further Education 2008
- Healthy Towns 2008
- Healthy Weight, Healthy Lives 2008

2.9 Little segmentation or targeting of programmes

The concept of targeting is based on the advertising principle of market segmentation, which seeks to find the right kinds of consumers for a particular product or service.[101] Targeting can be an important element of strategies to change behaviour and reduce health inequalities.[102] But the Government has failed to target public health campaigns on specific groups. Interventions that are not targeted may, in some cases, actually exacerbate inequalities, and waste valuable resources.

3. Our new approach to public health

In today's Britain, people have access to far more information about their health than ever before – information that was once held only by experts and bureaucrats – and they can have far more choice and control over how they manage their health as a result. They rightly demand increasing degrees of control over the health services they use, and are more critical of the guidelines and advice they receive from government. This is a trend in every area of social life (what we call the 'post-bureaucratic age') and it requires government to change fundamentally in order for policy to be effective. For example, greater personal control of health records could lead to significant benefits. It can empower patients, allowing them to share information with third parties if they choose to do so. Giving patients greater control of their data can also drive social and commercial innovation, and enable communities of patients to come together online and discuss their conditions and treatments. But up to now government has jealously guarded its control of patient data.

To achieve sustainable improvements in public health in a post-bureaucratic age, central Government needs to:

- decentralise control so that local communities and local providers can design public health measures to fit varying local circumstances;

- apply modern research to guide the national policy formulated by a newly focussed Department of Public Health

- promote social responsibility and informed choices; and

- take steps throughout Government (and not just in the Department of Public Health) to promote healthy lifestyles.

3.1 Decentralisation: councils will be rewarded if they improve the health of local communities

Local circumstances affect both health inequalities and the potential solutions which can be developed to deal with them. The most effective strategies for improving public health are ones that are designed and delivered direct in the community. For example, a strategy to reduce teenage binge drinking should be led and managed locally, not nationally, because the problem has a variety of causes. We therefore need to replace central-government-controlled public health strategies, wherever possible, with strategies that are conceived direct in the community and delivered in partnership with local institutions like local authorities, employers, social enterprises, private providers, charities, schools and local doctors and nurses.

Most public health work is carried out by those who do not have the word 'health' in their job title, and the importance of local authorities cannot be over-emphasised: almost all local government functions have a role in promoting the public health (including those concerned with the environment, education, social care and housing services.) Under current arrangements, good collaboration between all the relevant local bodies is possible but not guaranteed.[103]

It is accordingly no surprise that local authorities have already been assigned statutory duties to work towards improving public health, and some work well in partnership with PCTs and others to achieve this. But these duties are not enough – they are not backed up by the necessary powers or budget.

So we will empower local communities to take real control:

- **Localised funding.** We will separate the public health budget from the budget for NHS services and devolve more of the public health budget to support strategies agreed between local authorities and their health service partners. They will be financially rewarded for tackling problems like childhood obesity, teenage pregnancy, and sexually transmitted infections, and reducing the future burden of disease.

- **Freedom to innovate**. Local directors of public health will manage budgets and will be obliged to partner with local bodies, like schools, businesses, councils and GPs, to promote healthy living. And with real money behind them, they will have the power to recruit and pay innovative local organisations, like businesses and charities, to design new ways of promoting healthy choices and behaviour. To encourage a new market in innovative public health solutions is opened up in every part of the country, we will require local public health directors to ensure that an increasing proportion of contracts are awarded to providers from the private and voluntary sectors.

- **Local action to tackle inequalities.** We need to have resources far better targeted at the poorest if we are ever to eliminate our stubborn health inequalities. So the public health funding we devolve will – subject to the results achieved - work in such a way as to give relatively bigger future funding streams to deprived communities, where health problems tend to be much worse: this is our 'Health Premium'.

Rewarding success in improving public health

To incentivise local communities and providers to engage in improving the health of the people who live in each area, we will first establish a picture of the health of a community.

The incentive system will then reward communities and providers which make progress improving public health against a set of outcomes. The amount of money given to communities will be adjusted to reflect existing health inequalities. This 'Health Premium' means that the highest payments will be for the most deprived communities that currently have the poorest health outcomes.

Possible outcomes that will be used to determine improvements in public health include:

Obesity - Reduction in childhood and adult obesity; increases in physical activity levels.

Drinking - Reduction in incidence of alcohol-related diseases.

Drugs - Reduction in prevalence of illegal drug use.

Smoking - Reduction in prevalence of teenage smokers.

Infectious diseases - Reduction in numbers of infectious diseases cases; reduction in teenage pregnancy; reduction in prevalence of STIs and increase in immunisation rates.

- **New roles for local GPs and pharmacists.** Pharmacies and their staff are a vital resource for healthcare and condition management; they are close to the communities they serve and well placed to provide information about medical conditions, lifestyle choices and medicines management; they are many people's most frequent link to a knowledgeable health professional.

  There are some excellent examples of best practice that have been seen in some pharmacies, including offering cholesterol, chlamydia and blood sugar tests or providing computer terminals to enable people to research and print information on their condition and how it can best be managed. A Conservative government would support proposals to develop pharmacist involvement in the area of preventive care such as health checks. Once accepted, these measures would be integrated into the Pharmacy Contract.

  In pilot areas, we will develop the system that determines GPs' income, including fee-for-service and the Quality and Outcomes Framework, to align incentives with preventative health interventions, aiming to reduce people's need for more serious treatment. We will use these pilots to assess the effectiveness of such new public health incentives for GPs, and to help us design general changes to the Quality and Outcomes Framework that will ensure GPs play a full role, alongside PCTs, local government and other providers to improve public health.

3.2 A new Department of Public Health focussed on evaluation and behaviour change

While much of the responsibility for the design and delivery of public health improvements will be devolved to local communities, we need to be clear about the wider outcomes we want this activity to achieve nationally, such as reducing health inequalities and reducing preventable disease, so that we can lower the financial pressure on the NHS. We need clear means of identifying and rewarding progress towards these outcomes, as well as recognition right across government of the need to ensure that local efforts to improve health are supported.

3.2.1 A new Department of Public Health

The first step in sharpening national public health policy is to redefine the role of the Department of Health. It will be renamed the Department of Public Health and will shift its focus firmly to the prevention of illness rather than just its cure. We will carve out of the health budget and protect specific streams of public health funding, which (through our decentralisation process) will be used to promote real local innovation and to reward what works.

The Secretary of State for Public Health will lead a cross-departmental team of ministers focussed on public health - sending a powerful message that public health is the responsibility of all government departments. And we will ask the National Audit Office to review the effectiveness of the cross departmental working against the public health agenda.

The newly focussed Department for Public Health will take direct responsibility for key issues that need to be addressed nationally, like immunisation, population-wide screening and major public health campaigns. Under our proposals the Department would, for example, direct the emergency planning for a bird flu ('H5N1') pandemic influenza, and the recent swine flu ('H1N1') pandemic response. The Department will also lead national public health campaigns, like the campaign against HIV in the 1980s. We will want the providers engaged by the Department to undertake such activity to be paid by results; and we will insist that the methods used are linked to the recent advances in behavioural economics. There will be clear lines of accountability from local directors of public health to the Secretary of State so that we can provide common responses to national public health challenges, coordinate the prevention of specific diseases that pose an immediate national threat and provide an integrated response to outbreaks of emergent or re-emerging infectious diseases.

We will strengthen the Chief Medical Officer's department so that the Secretary of State receives clear and impartial advice about public health and there is an effective body to lead national action. And we will put parts of the Food Standards Agency which are responsible for the nutritional content of food and a slimmed down Health Protection Agency into the Department of Public Health so that public health strategies are consistent. Additionally, we will merge the Joint Committee on Vaccination and Immunisation and NICE to improve transparency and the consistency of decisions about the use of vaccines.

We are determined to make sure that we cut the number of patients dying needlessly from hospital-acquired infections: because we will re-prioritise the existing hospital capital budget there will be a significant increase in single rooms across the NHS specifically reserved so that patients who have, or are suspected of having, a hospital infection can be immediately isolated.

3.2.2 An improved information and evaluation strategy

Countries like Sweden, Finland and the Netherlands are better than we are at improving public health because they are far more rigorous in their monitoring and evaluation of the impact of public health policies. They take the trouble to find out what works best and promote this practice – and they use more decentralised approaches to policy delivery. We will embrace this good practice, but we will go further by publishing the results of all public health programmes online, along with tools which allow people to compare and benchmark performance. This will encourage far greater innovation – allowing people to see how behaviour can be successfully changed and spurring new providers to take over or replace failing programmes. In order to increase the transparency of efforts to improve health at a local level, a Conservative government will also mandate the publication of raw health outcome data in each local authority area.

We will:

- **Extend formal evaluation of existing programmes.** To ensure that the Department of Public Health is at the forefront of the latest thinking, we will extend funding for Health England's collaboration with the Matrix Knowledge Group. As part of this collaboration we will evaluate Change4Life and the Campaign for Smarter Drinking in terms of the results achieved.[104]

- **Develop a partnership with business to allow for continuous evaluation.** Evaluation of public health campaigns is poor or incomplete. We will work with retailers to understand the impact of campaigns by tracking aggregate sales data. The Public Health Commission describes this "agile evaluation" as "the use of consumer purchasing data provided and interrogated by business to create an immediate feedback loop on the impacts of public health interventions and to inform decisions on required action. Business and government can work together towards the creation of a virtuous circle of continuous, evidence-based improvement that will play a significant role in extracting maximum value from shared investment and maximum impact where it matters most, in people's lives."[105] Based on this Green Paper and ideas from the independent Public Health Commission report, *'We're all in this together'*, published in July 2009 we will establish a long-term partnership to deliver and evaluate our public health strategy.[106]

- **Build a network of experts.** We will also use an "open-source" approach to get the best ideas, awarding a prize for the most effective campaign – taking inspiration from Proctor & Gamble who are taking a similar open-source approach to their research. On top of the 75,000 scientists they directly employ in the traditional manner, they connect with more than 90,000 other scientists who are not directly employed through their InnoCentive network. Proctor & Gamble use this network of experts to help solve their R&D problems each year. Our network will be funded from the existing research budget.

- **Work with experts to carry out in depth demographic analysis to understand the impact of medical, socio-economic and geographic issues on behaviour** in order to build up a detailed map of the issues that matter to different target populations so that local public health directors can tailor and personalise policy interventions. This initial work will be funded by an allocation of £5 million from the NHS policy research budget.

3.2.3 Apply cutting edge science and research

We understand that people do not respond to government and other authorities simply telling them not to do something unhealthy. A key problem is that current strategies ignore what all the latest research is telling us about the way people make choices. In essence, this shows we are naturally very disinclined to avoid short-term satisfaction (such as eating something unhealthy) for a potential long-term gain (such as longer life), and are very likely to believe that bad health outcomes, such as disease and early death are things that will tend to happen to others, not ourselves.

But there are some hugely successful strategies now emerging from cognitive science and behavioural psychology which are increasingly being used in advertising to 'nudge' people towards making desired choices without dictating what they should do. Creating or changing social norms, for example, is a very effective way of changing behaviour because, contrary to classical 'rational choice' models of policymaking, people are powerfully influenced by the behaviour of others, in that they want (often unconsciously) to do what others do, particularly "influential" others.

Innovative business strategies are also emerging which show how direct financial incentives can yield strong behavioural changes that reduce costs without restricting choice – for example, the way health and life insurers offer free gym membership to increase their customers' fitness and thereby reduce both the likelihood and cost of claims.

We want to harness all this innovation to revolutionise our public health approach and we will use payment by results to ensure the adoption of programmes which have been successful elsewhere. This will be one of the driving forces through which we will ensure all our activity is focused on achieving real benefits for people: national public health initiatives commissioned by the Department of Public Health funded by public money will be paid for on the basis of the results they achieve wherever possible.

3.3 An approach that promotes personal and social responsibility and informed choices

The commercial world has huge influence over the choices we make as consumers. While we want to use successful marketing strategies and employee well-being schemes to promote positive behaviour, we know that in some cases, industry practices can exert a negative influence. We want to work with business to ensure we remove harmful influences and reward positive ones.

3.3.1 Agree restrictions on marketing and encourage the food and drink industry to make healthier products

To promote healthier living, such as the reduction of food portion sizes, we will:

- **Extend voluntary restrictions on marketing to children to all media (including online).** We will not seek to extend further restrictions on food advertising beyond those already implemented by Ofcom.

  The issue of advertising foods at the times children regularly watch TV continues to be contentious. There are existing restrictions on advertising foods high in fat, salt and sugar on television which are kept under regular review by Ofcom. Many food businesses also have voluntary marketing codes, both at UK and international level, which reinforce this and extend to other channels. There is, however, concern about marketing foods through "non-broadcast media" – such as the internet and mobile phones.

We would like to see the development of a self-regulatory code by food businesses extending their current commitments to restrict advertising to children across all media, together with an agreed form of robust evaluation to publicly demonstrate that the code is being complied with.

- **Agree further industry-led reformulation initiatives and reduction of portion sizes.** We welcome the progress that has been made on reformulation of products. For example, retailers, like Asda, Boots, Co-op, Iceland, Marks and Spencer, Sainsbury's, Tesco and Waitrose, have successfully removed all hydrogenated vegetable oils and fats (artificial trans-fatty acids) from all their own brand products, including the value ranges.[107]

We recognise that all aspects of food production, distribution and sale have huge implications for public health. We will encourage the food and drink industry to agree further objectives for the reformulation of products to reduce salt, saturated fats and sugar.

The rising prevalence of obesity has brought an increased focus on portion sizes, with pre-packaged foods and those served in some restaurants and high street 'fast food' outlets coming under particular scrutiny. We will encourage the voluntary reduction of portion sizes (particularly in high energy density foods) where increases have occurred both in retail and restaurant 'settings'.

3.3.2 Promote informed choices

We know that information needs to be personalised in order to have an impact on people's behaviour, the most successful behaviour change approaches personalise messages and methods of delivering these messages.

We believe that the provision of personalised data is the critical first step to change people's behaviour but that government in this country must learn from developments in the United States and elsewhere to translate personal information into action. Some of the world's most successful companies, like Tesco, Amazon and eBay, have been successful in part because of their ability to understand the needs of types of consumers. Healthcare maintenance organisations (such as UnitedHealth Group) have developed tools that can analyse existing healthcare information to identify patients' needs based on their history and clinical conditions. These organisations offer consumers and businesses personalised highly targeted campaigns. Personal information can be used to tailor messages and to create a network that will effectively support those individuals' attempts to lead a healthier life.

We will:

- **Improve information available to consumers both at home and when eating out.** We will work with industry to improve the consistency of information available to consumers both at home and in restaurants, cafes and bars. With so many meals being eaten outside people's homes, we will work with the catering and hospitality sectors to provide consistent and meaningful information about meals eaten away from home.

We will promote the display of consistent nutritional information in restaurants with more than 15 outlets. We will encourage the display of consistent nutritional information about the food people eat, and whether they buy it in a supermarket or in a restaurant or pub. We will focus efforts on extending nutritional information to restaurants in a manner consistent with the nutritional information baseline for on-pack labelling, including calories, sugars, salt, fat and saturated fat per portion.

- **Support EU proposals for a mandatory Guideline Daily Amount on front-of-pack food labelling. We will not add UK regulation to the existing rules. Additional traffic-light or colour-coded information will be voluntary.** A Conservative government will give backing for public awareness of Guideline Daily Amounts and how they can be used to build a better diet and support enhanced nutritional information and awareness. Front-of-pack nutritional information should cover calories, sugars, salt, fat and saturated fat. Information should be standardised to include kcal (for calories) and grams (for other nutrients) per portion against Guideline Daily Amounts.

We recognise that labelling changes are a major considerations for food retailers and producers. Businesses would be able to continue to apply nutritional evaluation systems, such as colour-coding and text, on a voluntary basis on top of the agreed standard baseline.

- **End the 'units' labelling system for alcohol content.** In 1998 a voluntary agreement was reached between the drinks industry and the government to introduce unit labelling on all products. In 2008 the drinks industry made further promises to improve alcohol labelling but recent research shows that many producers are falling short of their corporate social responsibility pledges. Only four per cent of products reviewed carried all five elements that make up the industry best practice label; only 18% of products carried information about sensible drinking levels and 56% carried unit information.[108]

  We will work with the drinks industry to improve labelling so that people are more aware of amount of alcohol in drinks (rather than the misunderstood 'units' system) as well as guideline limits. We will seek to agree the standardisation of labelling, where necessary at a European level, and will ensure that alcoholic products provide an indication of calorie content. (When surveyed earlier this year, four in ten did not know a glass of wine has the same calories (120) as a slice of cake, or that a pint of lager and a small sausage roll have 170 each.)[109]

  We will change labelling in order to take account of social norms and to abolish systems of labelling that do not help consumers understand the amount of alcohol they drink. For example, rather than just printing the number of units on a bottle of beer, we will add information about the number of bottles drunk by an average person each week and the volume of alcohol contained within that bottle.

Study after study has shown that social norms are much more important than policymakers have traditionally assumed; people are deeply influenced by the behaviour of those around them - and public policy should be taking this into account. For example, Northern Illinois University wanted to cut binge drinking amongst their students, so they advertised the fact in classified newspaper advertisements, a newspaper column, press releases, flyers, and posters that the average student at the university drank five or fewer drinks when they party, harnessing the power of social norms. Students went from a situation where they thought binge drinking was the norm, and everyone was doing it, to one where they understood that if they were getting drunk every night, they were completely abnormal and as a result, binge drinking fell significantly.[110]

3.3.3 Reward positive influences

Employers have a direct interest in boosting the health of staff, and this can have wider benefits which reduce public costs due to sickness and preventable disease. There are some excellent examples of how employers have improved the health of their staff and we will explore more ways of encouraging this through government incentives.

Encourage employers to invest in the health of their employees. "A recent report developed in conjunction with the World Economic Forum's *'Working Towards Wellness Initiative'* highlighted the growing need for businesses to engage in prevention measures in the workplace to avoid adverse effects on productivity, to remain competitive and to attract new talent."[111] A conservative estimate of the benefits of improving the general wellness of a workforce indicates an annual return of three to one or more.[112]

For example, Unilever measured the difference in productivity between its healthy and unhealthy employees and found that those who had a poor score on their health risk assessments also performed at a lower level over time. The company offered interventions to a group of staff to manage stress, cope with pain and sleep more soundly. They were found to be 8.5% more efficient at work and less likely to take time off. [113]

This benefit to employers has not led to sufficient occupational health provision. As Health England said, "Many employers in the UK do not invest in health because although they incur the costs in full, the benefits do not necessarily accrue to them. This in turn is because (a) they generally do not pay for their employees' healthcare costs, and therefore do not benefit from reduced use of the health services; and (b) employees often leave their employment before the health benefits are fully realised. Any economic incentive scheme needs to recognise this by helping employers to see the benefits more immediately, or by splitting the costs between all parties who benefit - the employer, the individual, and the (NHS)". [114]

We will consult on the right way to encourage employers to invest in health. The effectiveness of such measures would depend on the relationships developed with partners such as sport companies to offer services on site with trainers to offer health risk assessments, offer coaching programmes, or subsidise the development of activities offered on site."[115] We will work with business organisations, the NHS, Local Government and the Fitness Industry Association to establish 'turn-key' area occupational health schemes, which can be offered to small and medium-sized businesses. As discussed by the Public Health Commission, we will consult on further measures to incentivise preventative measures in occupational health, including offering access to Cognitive Behavioural Therapy (CBT) and counselling to respond to workplace stress, anxiety and depression.

3.4 A focus on public health throughout government

Our plans for improving public health are fully linked to a wider strategy to make Britain a greener, healthier nation. For example, our transport, regeneration and planning strategies all aim to make healthy activities like cycling and participating in sports far simpler. And our plans to strengthen families and promote better child development will include a health visiting service which will be able to help young families with a whole range of lifestyle, nutritional and developmental issues.

3.4.1 A healthy start in life

The quality of maternity care families receive can make a huge difference to the very earliest stages of a child's life. It can perpetuate inequalities in health and well-being or begin to narrow them. Helping parents to get our youngest and most vulnerable citizens off to the very best start in life will be a high priority for us.

The first stages in a child's development are crucial. Children's experiences in their earliest years go on to affect how well they do at school, and affect their physical and emotional health right into adulthood. Health visitors can provide valuable help to new parents with the huge challenge of bringing up children, but Labour have cut their number by 2,000 over the past four years alone.

We will tackle poor maternity services by instituting a culture shift in maternity care, using new incentives to drive up standards within an innovative family and community-based care approach. We will also institute structural reforms that will allow for a higher-achieving, more locally-based maternity networks to emerge and will ensure that all families get every aspect of care that they need.

We will:

- **Provide extra support from health visitors.** We will provide an additional 4,200 health visitors and base them at Sure Start Children's Centres. These health visitors will provide support on every aspect of child care from before birth to primary school.

  Health visitors will enable them to identify post-natal depression and infant health problems and they are the gatekeepers to a wide range of support for parents in the early years. New birth visits are popular with mothers, and effective public health checks. These visits aim to promote relationship development, assess the baby's growth and development and assess the family situation in order to make a decision about the most appropriate care requirements. But health visitors will continue to provide support on every aspect of childcare until that child reaches primary school.

- **Further preventative interventions around the time of birth.** We want to give every mother and mother-to-be world-class care, and to ensure that every child gets the best possible start in life. So a Conservative government will give mothers a real choice over where to have their baby, with NHS funding following their choices, and allow new providers to deliver maternity care – especially services like ante- and post-natal support. And we will introduce local 'maternity networks' to ensure that mothers can safely access the right care, in the right place, at the right time. Studies show that targeted support towards the most deprived families could achieve:

  - Reductions in the number of children born with disabilities. Parents with routine and manual occupations are twice as likely to have babies born with congenital abnormalities than those with managerial and professional occupations. A government study has found that: "Children with congenital anomalies have a significant impact on their family, the healthcare system and society: ten per cent of all disabilities are due to congenital anomalies; and it costs at least three times more to bring up a child with a disability than a child without a disability."[116]

  - Reductions in the number of children growing up in poverty and with poor health outcomes. A government study has found that: "Young women from the poorest backgrounds are ten times more likely to become teenage mothers than young women from professional backgrounds. Around seven per cent of babies born in England are to a mother under 20. These children are at high risk of growing up in poverty and experiencing poor health and social outcomes."[117]

  - Higher immunisation uptake, which would lead to better health. A government study has found that: "Immunisation protects children against diseases that can kill or cause serious long-term ill health. Babies routinely receive vaccines to prevent seven illnesses in their first year of life... Inequalities in immunisation uptake are persistent and result in lower coverage for poorer families."[118]

- Increasing the number of midwives. With the significant increase in the birth rate in recent years and the projection that around 50% of midwives will retire in the next decade, we will match the Government's commitment to increase the number of midwives by 3,000 between 2010 and 2014 to keep pace with a rising birth rate. We will therefore support the necessary additional midwifery education, funded from within existing plans for the Multi Professional Education and Training Budget in the NHS.

3.4.2 Encourage sport and activity in schools

Creating a competition that children at all levels can compete in would greatly raise the profile of sports played in schools and encourage team spirit. We will create an annual School Olympics: a national sports competition between schools that will climax with a finals session held in the Olympic Stadium. The School Olympics will see individual schools crowned as champions in a variety of different sports and age groups.

The School Olympics would use a similar mix of sports to the UK School Games but involve teams from schools rather than individual elite athletes. The list of sports could also be extended to include football, rugby, netball, golf, cricket, tennis or any other sport desired.

The Youth Sport Trust would establish a national framework for the Games setting out the sports to be played, the rules for each and the age groups involved. Schools would be free to enter as many or as few sports as they wish. This framework would then be used to organise city and county heats using the School Sport Partnerships infrastructure, in a similar fashion to the Kent School Games.

We would fund this policy through National Lottery reforms which would result in a greater share of Lottery funding (around an extra £30 million a year) going to sport.[119] We would give a maximum of £10 million a year of this to the Youth Sport Trust with a remit to run the School Olympics. To set this in context, the UK School Games costs approximately £3 million a year to run.

3.4.3 Encourage physical activity by improving the built environment

For two generations, we have seen too much urban space designed around the needs of motorised transport. It is now far too easy not to walk and cycle. A Conservative government will make these activities feel safer and more desirable than other forms of transport.

We will consult widely on how local businesses and organisations can maximise the opportunities to build health into the everyday working environments.

3.4.4 Tough action to reduce harm

To help tackle binge drinking and all the social problems it causes we will act to stop the sale of low-cost, high alcohol drinks. For example, we will introduce a tougher licensing regime so that problem venues which encourage irresponsible drinking can be brought to heel.

Properly structured financial incentives can yield strong behavioural changes; cost-effective way of reducing healthcare costs without restricting individual autonomy.

We will:

- **Change prices of alcoholic drinks and introduce a ban on alcohol sold below cost price coupled with a tougher licensing regime.** An Academy of Medical Sciences report found that increasing alcohol prices has the biggest effect on the heaviest consumers and on young people, who spend a relatively high proportion of their income on alcohol.[120] The British Medical Association has also found that heavy drinkers and young people are most sensitive to increases in price: "Increases in the price of alcohol not only affect consumption at a population level, but there is evidence that particular types of consumers (e.g. heavy drinkers and young drinkers) are especially responsive to price."[121]

  In 1997, the Labour Government scrapped the Conservative policy that the Chancellor should take into account public health issues when setting alcohol excise duties. We will treble duty on alcopops, we will significantly increase tax on super-strength beer and we will more than double tax on super-strength cider.

  According to the Competition Commission, supermarkets routinely sell alcohol below cost price. Their analysis shows that the four largest supermarkets sold nearly £113 million of beer, wines and spirits below cost during the 2006 World Cup, for example.[122]

  This practice has been heavily criticised by the Royal College of Physicians: "Supermarkets should not sell alcohol below cost price and preventive measures should be introduced if necessary."[123] The Institute of Alcohol Studies has linked supermarket cost-cutting to the phenomenon of "pre-loading", where binge drinkers get drunk on cheap alcohol before going to a club: "Potential binge drinkers seemingly choose to get intoxicated in the most cost effective way… the fashion has shifted somewhat towards high levels of initial home consumption." [124] We will ban retailers from selling alcohol below cost price. (Belgium, France, Portugal and Spain have already introduced policies to do this.[125]) To achieve this we will work with competition regulators and retailers to find a fair formula that could be used to judge whether a product is being sold below cost.

  We want local councils and the police to have a much clearer right of veto over a new license applications and to have the ability to amend existing license applications.

  Under the Licensing Act 2003, there is a fundamental presumption in favour of granting an application to sell alcohol, which makes it extremely difficult for local authorities to turn down applications.[126] We will radically overhaul the licensing system to empower local councils and the police to clamp down on binge drinking hotspots and irresponsible retailers.

- **Work to reduce tobacco smuggling.** Making an impact on tobacco smuggling will be one way we will reduce smoking rates. The UK consumption of some 5 billion cigarettes purchased internationally directly undermines the use of taxation to cut smoking rates. And the latest Government estimates of non-UK duty paid cigarette consumption amount to tax revenue losses of up to £4.1 billion, at a time we can ill afford them. We will examine new approaches to tobacco smuggling.[127]

  We will also consider changing how many cartons of cigarettes can legally be brought into the UK from other EU countries. It is often argued that that is a European issue. But other countries have a set this limit as low as 400 cigarettes. Our current level is 3,200.[128] We will also review the law relating to the 'proxy purchasing' of tobacco by adults for children as well as investigating the routes by which children access tobacco in order to secure better enforcement.

4. The academic research that underpins our approach to public health

By helping us to develop a more realistic account of human decision-making, cutting-edge academic research by social psychologists and behavioural economists can ensure that we achieve our policy goals in less intrusive ways. These insights from social psychology and behavioural economics show that people are not as rational as is assumed by traditional approaches to economics and policymaking. In fact, successive experiments and empirical evidence show that, while people do act rationally at times, we are often irrational in predictable ways. Understanding these 'predictable irrationalities' can help us to design policies that go with the grain of human nature, and therefore achieve our goals in less intrusive and bureaucratic ways. This approach to policymaking is commonly known as 'choice architecture', and it is central to the Conservative Party's policy agenda.

We have set up a team of experts to investigate the contribution of behavioural psychology to understanding how we can actually help change people's behaviour. Initial consultation suggests that programmes with (at least one) of the characteristics below will be most successful.

4.1 Presenting and organising information more clearly

Imprecise, cluttered, and misleading advertising or information often leads to poor choices. This argument is the driving force behind Conservative policies on standardising bank charges data allowing consumers to make quick and easy comparisons between providers. Clearly and intelligently presented information may have positive affects on people's behaviour. For example, standardising the presentation of statistics on food packaging will reduce the costs of comparing different products.

And one reason for overeating is a lack of awareness of the quantity of food consumed - we usually rely on a visual indication of how much we eat rather than sensing how hungry we are. Studies have shown that we typically eat about the same volume of food each day rather than considering the calorie intake, and that we eat until the plate is empty rather than until we are full.[129] On average, when questioned, people think they have eaten 20% less than they actually have done whilst other studies have shown that we consistently underestimate things as they get larger, including meals.[130] In keeping with this, we all underestimate calorie levels with mathematical predictability. This seems to be overcome to a degree when people can visually calculate the volume of food they are consuming – when people pre-plate their food they eat about 14% less.[131]

Case study: Clear information about calories in New York City
This approach has worked well elsewhere. In New York City (NYC), for example, chains with more than 15 stores have to post calorie counts next to item prices, in the same size font. This enables individuals to make informed food choices and mitigates against misleading health claims (e.g., "fat free" muffins that actually have more calories than normal muffins). The potential for savings are significant: NYC officials expect the laws to reduce obesity by 150,000 cases over five years, and prevent 30,000 cases of diabetes. And many other cities (such as Seattle and Philadelphia) have followed New York's lead. The costs of this change are often limited to changing menu boards and labels because large chains have already calculated nutritional information.

Case study: Improving hygiene ratings Los Angeles
"Los Angeles restaurants display hygiene grades in their windows. This scheme has increased A-grade ratings from 58 to 83%, resulting primarily from consumer choice. Additionally, the grading cards caused restaurants to make hygiene improvements. C graded restaurants began to lose revenue, and food-borne-illness hospitalisations decreased between 13-20%."[132]

Case study: Clearer information about prices across the Australian airline industry
The Australian government recently recognised that consumers were not taking advantage of lower flight costs offered across the airline industry, but tended to stick with one or two well-known airlines. As a result, competition in the airline sector was not working as effectively as it should have been.
Rather than introducing complex regulations to cap flight costs or introduce government monitoring of airline activities, the Australian government simply required airlines to publish their flight prices in a standardised format, allowing consumers to compare prices more easily.

4.2 Supporting the development of social norms

Creating social norms, changing social norms, or making existing social norms transparent are all powerfully effective ways of regulating behaviour without heavy-handed state regulation. This post-bureaucratic approach is made possible because, contrary to classical models of economics and policymaking, people's behaviour is often powerfully shaped by the behaviour of others.

Perception of social norms is what lies behind much of commercial advertising and it influences a great deal of our lives. So often people want (often unconsciously) to do what others do, particularly the "influential" others in their lives. So creating or shaping social norms can have major and pervasive impacts, and government has many of the resources to do this.

For example, studies show that where children have positive associations with healthy food it is a result of parents explicitly associating the foods with a positive benefit ("spinach makes you strong like Popeye").[133]

> **Case studies: Energy consumption, exercise and social proof**
> "A study of energy conservation in California found that social messages about neighbours' conservation behaviour spurred people to conserve more energy than did any appeals that are traditionally accorded motivational power, such as saving money, protecting the environment, or benefiting society".[134] The "results show that normative messages can be a powerful lever of persuasion but that their influence is underdetected," and that "communicating a descriptive norm—how most people behave in a given situation—via written information can induce conformity to the communicated behaviour."[135]
>
> Social comparisons ('social proof') are also highly effective. For example, Positive Energy trialled a system in the US that provided data on how a consumer compared to those in his neighbourhood in terms of energy usage. Consumers were told if they were above or below average; this resulted in a two to three per cent reduction of consumption.
>
> **Case study: Tax returns in Minnesota**
> The Minnesota state government had attempted various bureaucratic approaches to encourage people to submit their tax returns on time. They had threatened to introduce fines, published new guidance and various other bureaucratic regulatory approaches – but none of these were effective. What finally proved effective was the decision to publicise the simple fact that most Minnesotans had already filled in their tax returns.

4.3 Designing physical spaces to guide behaviour

The design and architecture of public (and private) spaces can have a significant impact on behaviour. For example, "increased density in New Zealand neighbourhoods with integrated parking and transport infrastructure has encouraged walking and cycling – resulting in 43% less fuel consumption."[136]

> **Case study: Cutting road accidents in the Netherlands**
> In the Netherlands, roads have been stripped of warnings and signs, making drivers more cautious and aware because they feel more responsible for their actions. This has been highly successful encouraging responsible driving without intrusive state regulation such as speed cameras or new legislation.
>
> **Case study: Encouraging cycling in Suffolk**
> In St Edmundsbury, in Suffolk, the number of cycling trips to work has increased by nearly 50% since 2001. This has been achieved by the borough council, the county council, local developers and the national cycling body, Sustrans, working in partnership, using currently available funding streams. A new, improved cycle route network has been designed and put into operation in Bury St Edmunds, while cycle routes have been improved in Haverhill.

The result of effective action to improve cycling safety is that the culture begins to change. Instead of the cyclist being seen as 'a nuisance' and by the planners as an afterthought, we can begin to move towards the Dutch model in which cycling becomes a standard part of everyday life.

4.4 Setting the default option in a set of choices

Many public health programmes are restrictive; they are intended to prevent individuals from making bad decisions – for example choosing unhealthy foods or high strength drink. Case studies from around the world have shown how it is possible to use default options to help people make better choices without restricting their options at all.

4.5 Offering 'self-contracting' to support commitment

'Self-contracting' allows one fix preferences over time. Research by social psychologists has shown that self-contracting is highly effective in regulating individual and organisational behaviour in a non-bureaucratic and voluntary way. This approach is effective because people tend to make better long-term decisions.

Case study: Gym membership in Germany
In Denmark a chain of gyms offers contracts for free membership, with the only caveat that members have to show up for it to remain free. If members fail to attend they are billed the normal weekly fee. Because people tend to fear losses more than they value gains, one can use this irrationality to design a system which motivates people to exercise (the fear of 'losing' the weekly membership fee is a stronger motivator than the hope of improving fitness).

Case study: Cutting problem gambling in Australia
Australian states have introduced programmes allowing gamblers to sign themselves to a 'self-exclusion' list that bans them from casinos. A review of this programme suggested that 30% of participants abstained from gambling completely.[137]

4.6 Providing targeted financial incentives

Providing simple financial incentives can encourage changes in behaviour. The government already does this through the tax system, but it may be possible to provide more targeted incentives.

For example, "there is a large volume of evidence that raising prices or taxes on unhealthy activities, or on the commodities associated with those activities, is an effective means of changing behaviour. Analysis of the impact on starting and quitting smoking using British data shows that a five per cent increase in tobacco duty would lead, on average, to a reduction in years of smoking between 2% and 3.5%."[138] [139]

In another example, private health insurers have offered reduced premiums to customers who participate in health-promoting activities (such as regularly attending a gym) or successfully manage their chronic conditions. Financial incentives have also been used successfully to increase savings in low-income households, reduce truancy and school absenteeism and promote educational achievement.

Case study: Cutting health insurance costs in Germany
Bonuses for healthy behaviour are a key feature of German health insurance systems. For example, bonuses are offered for taking part in check-up programmes, dieting, smoking cessation, participating in yoga sessions and active membership of a sports club. The bonuses are most often points that can be redeemed for a range of items including sports equipment and health books. Sometimes the points can be redeemed for cash or for a reduction in social insurance contributions. 'Secondary bonuses' are offered for adhering to previously agreed treatment plans and participation in special care plans. These bonuses usually take the form of reductions in copayments.

4.7 Summary case study: The Food Dudes Programme

The Food Dudes programme provides a good example of how many of the characteristics of successful behaviour change programmes can be incorporated in a single highly specific initiative:

Setting the default option. When running the school-based programme the organisers of this programme always prefer to have an opt-out system for parents and children; participation rates with an opt-in system would be just a fraction of what they would get with an opt-out policy.

Clearer information. How information is presented to children, teachers, and parents, is crucial. For example, boring information about food would kill the effectiveness of the programme for children. For teachers the organisers keep the instructions simple, and for parents they are positive and encouraging. Food Dudes has established as a strong fruit and vegetables 'brand' to compete with brands promoting foods that kids need to eat less of.

Social norms. The key aim of the Food Dudes programme is to change the culture of the school so eating good food, like fruit and vegetables, becomes the cool and socially acceptable thing to do, and eating junk food has less social cachet than it once had. The Food Dude characters (on DVD) provide the new social norms for the kids, and for their teachers and parents.

Targeted incentives. Research, however, shows that the Food Dudes messaging would have little impact on getting children to change their long-established eating habits were it not for the fact that whenever children begin to taste a "disliked" fruit or vegetable they receive a small Food Dudes prize. This is what really drives big initial changes in behaviour, though the role-modelling provides an excellent framework for the effects of the incentives to be intensified and sustained. It is important, however, that they are not seen as bribes or a form of coercion and that is where the use of social norms may be helpful, enabling incentives to be delivered as recognition for behaviour that has high social esteem.

5. Footnotes

1   Public Health Commission, We're all in this together, improving the long-term health of the nation, July 2009, http://www.publichealthcommission.co.uk/

2   Dame Carol Black, Working for a healthier tomorrow, 17 March 2008. Dame Carol Black estimated the total cost to the Government of working age ill health at up to £76 billion per year (composed of £29 billion in benefits, up to £11 billion in healthcare and up to £36 billion in foregone taxes). The overall cost to the economy is even higher, at up to £129 billion per year, more than the entire NHS budget.

3   Health inequalities are defined as "systematic differences in health status between different socio-economic groups" (Dahlgren and Whitehead, Levelling Up: Social inequalities in health concern systematic differences' in health status between different socioeconomic groups, World Health Organisation, 2007)

4   Health Committee - Third Report, Health Inequalities, Session 2008-09, House of Commons

5   Ibid

6   Health Committee - Third Report, Health Inequalities, Session 2008-09, House of Commons

7   Department of Health, Autumn Performance Report, 15 December 2008

8   Ibid

9   Evidence to the Health Select Committee from Professor Kay-Tee Khaw, Professor of Clinical Gerontology at the University of Cambridge

10   Health Committee - Third Report, Health Inequalities, Session 2008-09, House of Commons

11   Ibid

12   ONS data Age-standardised limiting long-term illness: by ethnic group and sex, April 2001, England and Wales quoted in Health Committee - Third Report, Health Inequalities, Session 2008-09, House of Commons

13   Health Committee - Third Report, Health Inequalities, Session 2008-09, House of Commons

14   NICE, Housing and public health: a review of reviews of interventions for improving health: Evidence briefing, December 2005

15   Obesity is defined as Body Mass Index (BMI) of 30 kg/m2 or over

16   Foresight, Tackling Obesities: Future Choices, 17 October 2007

17   HC Deb, 2 March 2009, c1308W

18   NHS Information centre, Statistics on obesity, physical activity and diet: England, February 2009

19   Ibid, p.153

20   DCMS / Strategy Unit, Game Plan: a strategy for delivering Government's sport and physical activity objectives, December 2002

21   Foresight, Tackling Obesities: Future Choices, October 2007

22   OECD Health data 2009

23   National Audit Office. Reducing Alcohol Harm: Health services in England for alcohol misuse, The Stationery Office, 2008

24   Lader D, Drinking: adults' behaviour and knowledge in 2008. Opinions (Omnibus) Survey Report No. 39., 2009

25   NHS Information Centre, Statistics on Alcohol: England, 2009, 2009

26   Smith LA, Foxcroft DR, Drinking in the UK: an exploration of trends. London: Joseph Rowntree Foundation, 2009

27   European School Survey Project on Alcohol and Other Drugs, 2003

28   NHS Information Centre, Statistics on Alcohol: England, 2009, 2009

29   Ibid

30   Tougher laws for drinks industry could be imminent, DoH press release, 22nd July 2008

31   Health Improvement Analytical Team, The cost of alcohol harm to the NHS in England, Department of Health. July 2008.

32   OECD Health data 2009

33   Ibid

34   NHS Information Centre, Statistics on Smoking, England, 2009, 2009

35   Ibid

36   NHS smoking information card (http://www.pharmacymeetspublichealth.org.uk/pdf/SMOKING_cards.pdf) quoting www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Tobacco/fs/en

37   NHS Information Centre, http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking/statistics-on-smoking-england-2009

38   Department of Health, Smoking Kills: A White Paper on Tobacco, 1998

39   Allender, S et al, The burden of smoking-related ill health in the United Kingdom, University of Oxford, 9 June 2009

40   Ibid

41   NHS Information Centre, Statistics on Smoking, England, 2009, 2009

42   OECD Health data 2009

43   Health Protection Agency, Sexually transmitted infections diagnosed in GUM clinics in 2007, 15 July 2008

44   Ibid

45   Health protection agency, HIV in the United Kingdom, 2009 Report, 2009

46   Health Protection Agency, STI Slide Set, http://www.hpa.org.uk/HPA/Topics/InfectiousDiseases/InfectionsAZ/1191942172144

47   BBC news website, Drug resistant TB 'rising in UK', May 2008 http://news.bbc.co.uk/1/hi/health/7379500.stm

48   The Guardian, Hospital confirms first UK case of extreme drug-resistant tuberculosis, March 2008, http://www.guardian.co.uk/society/2008/mar/21/health

49   HPA, Focus on Prevention HIV and other Sexually Transmitted Infections in the United Kingdom in 2003, An update: November 2004, 2004

50   Ibid

51   The Guardian, Hospital confirms first UK case of extreme drug-resistant tuberculosis, March 2008, http://www.guardian.co.uk/society/2008/mar/21/health

52   WHO/Europe Computerised Information System for Infectious Diseases (CISID), latest year available

53   Ibid

54   Ibid

55   UNICEF, An Overview of Child Well-Being in Rich Countries, 14 February 2007

56   Home Office, Crime in England and Wales 2008/09, 16 July 2009, Table 2.04

57   Home Office, Drug Misuse declared: Findings from the 2008-09 British Crime Survey, 23 July 2009

58   Office for National Statistics, Deaths related to Drug Poisoning in England and Wales 2008, August 2009, http://www.statistics.gov.uk/pdfdir/dgdths0809.pdf

59   These deaths include those related to both legal and illegal drugs - the number of deaths specifically attributed to drug abuse (drugs controlled under the Misuse of Drugs Act 1971) rose to 1,738 in 2008, the highest number since 2001 and 8% higher than in 2007.

60   Addaction, Cost of the UK's illegal drug problem, 25 February 2008

61   UK Drug Policy Commission, An Analysis of UK Drug Policy, April 2007

62   UNICEF, An Overview of Child Well-Being in Rich Countries, 14 February 2007, Figure 5.2c

63   European Monitoring Centre for Drugs and Drug Addiction, Annual Report, 2008

64   The Office for National Statistics, Psychiatric Morbidity Report, 2001

65   Adult psychiatric morbidity in England, 2007, Results of a household survey, NHS Information Centre 2009

66   Sainsbury Centre for Mental Health, The economic and social costs of mental illness, 2003

67   Ibid

68   The Future Vision Coalition, A New Vision for Mental Health: discussion paper, 2008

69   The Times, Sexual health funds used to cut trust debts, August 2006, http://www.timesonline.co.uk/tol/news/uk/article697093.ece

70   BHF submission to Conservative Public Health Consultation

71   The Guardian, Trusts raided public health cash in panic over funding, October 2007, http://www.guardian.co.uk/uk/2007/oct/19/health.politics

72   Sir Liam Donaldson, Obesity - what's in a word?, BBC News Online, December 2008, http://news.bbc.co.uk/1/hi/health/7785195.stm

73   The Guardian, Hewitt defends public health spending curbs, December 2005 http://www.guardian.co.uk/money/2005/dec/12/publicfinances.politics

74   Health England Report No 2, Prevention and Preventative Spending, 2009. In 2006/7 it is estimated that expenditure on prevention and public health services in England was £3.4 billion (excluding pharmaceuticals). The total health budget for England for the same period was around £92 million.

75   Health England Report No. 3, Incentives for Prevention, 2009

76   The QOF is a process for GPs in England and was introduced as part of the GP contract in 2004; the first year of operation was 2004/2005. Payments under the QOF amount to around 15% of expenditure on primary medical services. The QOF rewards practices in four domains of quality: for meeting clinical, organisational and patient-experience standards, and for offering additional services beyond the contractual minimum. The clinical domain covers 19 disease areas; the organisational domain rewards good practice; patient experience collects information on consultation length and patient surveys; and the additional services domain covers cervical screening (e.g. percentage of patients who received a cervical smear), child health surveillance, maternity services and contraceptive services. Practices earn entitlements to payment under the QOF by accumulating points for meeting national targets. The value of each point is determined nationally through a complex formula which rewards, generally, practice size more than it rewards prevalence of disease, but rewards are paid by local PCTs.

77   Health England Report No 3, Incentives for Prevention, 2009

78   The Times, Man who helped NHS to £46bn says it wasted the money and needs more, September 2007, http://www.timesonline.co.uk/tol/news/uk/health/article2433049.ece

79   The Times, Alarm over the state of public health, March 2006, http://www.timesonline.co.uk/tol/news/uk/health/article698039.ece

80   Ibid

81   NHS workforce statistics, 25 March 2009

82   Survey of Health Visitors by Amicus, 2007

83   Boyce, T, Commissioning and behaviour change, Kicking Bad Habits final report, Kings Fund, 2008

84   Millward, L, Kelly, M and Nutbeam D, Public health intervention research – the evidence, Health Development Agency, 2003

85   Wanless D, Securing Good Health for the Whole Population, Final Report. HM Treasury, 2004

86   Health England and Matrix Knowledge Group, Prioritising investments in preventative health, September 2009

87   Ibid

88   Health England Report No 2, Prevention and Preventative Spending, 2009.

89   King's Fund, Kicking Bad Habits Project, March 2009

90   Prime Minister's Strategy Unit, David Halpern and Clive Bates, Geoff Mulgan and Stephen Aldridge with Greg Beales and Adam Heathfield, Personal Responsibility and Changing Behaviour: the state of knowledge and its implications for public policy, February 2004

91   King's Fund, Kicking Bad Habits Project, March 2009

92   The Times, Fewer are quitting cigarettes despite millions spent on anti-smoking services, August 2009, http://www.timesonline.co.uk/tol/life_and_style/health/article6803947.ece

93   The Publican, Doctors say public health campaigns on alcohol are failing, April 2009, http://www.thepublican.com/story.asp?storyCode=63407

94   Ibid

95   Health Committee - Third Report, Health Inequalities, Session 2008-09, House of Commons

96   Ibid

97   Marketing Week, 'Change4Life at risk of failing' says public health expert, April 2009, http://www.marketingweek.co.uk/news/change4life-at-risk-of-failing-says-public-health-expert/2065230.article

98   71% of schools have met standard. (HC Deb, 15 January 2009, c932W. 19 Dec 2008) Gov aimed for 75% by 2009 (HC Deb, 20 November 2007, c62W) 64% primary schools in Tower Hamlets met standard. (HC Deb, 19 May 2008, c154W) HC Deb, 20 November 2007, c62W. Lord Adonis revealed in a written answer that from 2008-9 funding will move from the standards fund to the area-based grant. (HC Deb, 20 November 2007, c62W)

99   Health Development Agency, Lessons from Health Action Zones, June 2004

100   BBC news website, Schools wired for health, March 1999, http://news.bbc.co.uk/1/hi/education/294866.stm

101   Kreuter and Skinner, Tailoring: What's in a name? Health Education Research 15(1):1-4, 2000

102   Tammy Boyce, King's Fund, Commissioning and behaviour change, Kicking Bad Habits final report, 2008

103   ASH submission to Conservative Party Pubic Health consultation

104   Financial cost quoted by CEO of Matrix Knowledge Group in private communication

105   Public Health Commission, We're all in this together: improving the long-term health of the nation, July 2009

106   Ibid

107   BBC website, Retailers to stop trans-fat use, 31st January 2007

108   Alcohol Concern, Message on a Bottle, July 2009

109   BBC website, Many unaware of alcohol calories, April 2009, http://news.bbc.co.uk/1/hi/health/8002991.stm

110   Haines, M, A Social Norms Approach to Preventing Binge Drinking at Colleges and Universities, Northern Illinois University, 1996

111   PricewaterhouseCoopers, Working Towards Wellness: The Business Rationale, Geneva, World Economic Forum, 2007

113   Ibid

114   Health England Report No 3, Incentives for Prevention, 2009

115   Ibid

116   Department of Health, Review of the Health Inequalities Infant Mortality PSA Target, 7 February 2007 17

117   Ibid

118   Ibid

119   This is one third of the funding that the Big Lottery Fund currently gives to non-VCS sector projects plus one third of the extra money generated by moving the National Lottery to a gross profits taxation regime.

120   Academy of Medical Sciences (2004) Calling Time: The Nation's drinking as a serious health issue Academy of Medical Sciences. March http://www.acmedsci.ac.uk/images/publication/pcalling.pdf

121   BMA, Alcohol misuse: tackling the UK epidemic, 2008

122   Competition Commission, The supply of groceries in the UK market investigation, April 2008

123   Royal College of Physicians, Evidence to Competition Commission Inquiry into Groceries Market

124   Institute of Alcohol Studies Briefing Paper, Use of alcohol as a loss-leader, June 2008

125 Rand Europe, The affordability of alcoholic beverages in the European Union, 2009

126 DCMS, Amended Guidance issued under Section 182 of the Licensing Act 2003, July 2009, para 1.14.

127 Why I am unconvinced by the proposed ban on "point of sale" tobacco advertising, February 2009, http://conservativehome.blogs.com/platform/2009/02/mike-penning-wh.html

128 HC, 1 Dec 2009 : Column 605W

129 Wansink, B., Mindless Eating, Bantam, 2007

130 Ibid

131 Ibid

132 Fuller, J, et al, Heads, You Die: Bad Decisions, Choice Architecture, and How To Mitigate Predictable Irrationality, Per Capita

133 Wansink, B, Mindless Eating, Bantam, 2007

134 Fuller, J, et al, Heads, You Die: Bad Decisions, Choice Architecture, and How To Mitigate Predictable Irrationality, Per Capita

135 Nolan, J.M., Schultz, P.W., Cialdini, R.B., Goldstein, N.J. & Griskevicius, V. 2008, Normative Social Influence is Underdetected, Personality and Social Psychology Bulletin, Vol. 34, No. 7, pp. 913-923, http://www.csom.umn.edu/assets/118360.pdf

136 Fuller, J, et al, Heads, You Die: Bad Decisions, Choice Architecture, and How To Mitigate Predictable Irrationality, Per Capita

137 Blaszczynski et al, 2007

138 Forster, M. and A. M. Jones, The Role of Tobacco Taxes in Starting and Quitting Smoking: Duration Analysis of British Data, Journal of the Royal Statistical Society Series A (Statistics in Society) 164(3): 517-47, 2001

139 Health England Report No 3, Incentives for Prevention, 2009