

# **Expert testimony: Developing population level guidance**

**Klim McPherson – University of Oxford**

## **Introduction**

I was Chair of the PDG on preventing CVD in populations and also a Principal author of the Foresight report on 'Tackling Obesities', published in 2007. Both were components of UK science/health governance to develop, disseminate and implement public health policy. They were however very different in style and method and it might be interesting to compare the two and to try to learn some general lessons. I take it as axiomatic that the purpose of both was to change public health policy for the better. The following are my personal views based on that experience.

The first obvious thing to note is that effective public health policy tends to threaten several vested interests in UK socio political life, and this is important. Especially this is true obviously but nowadays somewhat less potently, with tobacco – but also increasingly with diet related disease. The parallels between big tobacco and big food have been much discussed (Kelly Brownell and Kenneth Warner in the Millbank Quarterly 2009 especially convincingly) and I fear we still know little of the real strategy of opposition to evidence based public health policy. But the recently reported successful expenditure on lobbying the European Parliament by components of the food industry of Euro1B to prevent mandatory colour coded front of pack labelling of food represent a possible iconic indicator. This is real, potent and successful and, as tobacco still illustrates, hardly at all constrained by evidence of massive numbers of attributable deaths. All of this is clearly based on (possibly wrong) perceptions of commercial success and a legal primacy of serving the interests of shareholders. Public health policy development in NICE is thus different from clinical guidance for obvious reasons. Reliable scientific evidence is dominant there because attributable health and ill health, and their costs to the taxpayer, are perforce the dominant considerations. The DH has no responsibility for commercial organisations, whatever their effect on health.

The second aspect to note is the 'Intervention Ladder' well described by the Nuffield Council of Bioethics (Public Health: ethical issues 2007). This is relevant because accusations of nannyism are also potent complexities in implementing public health policy. Getting the guideline into that context successfully, along with these other public pressures, is an important part of the nature of your task as well as the nature of future role of public health evidence in public policy as a whole. We all have a long way to go and it is an enormous task. But making comparison with the development of policy in other sectors should not be ignored. The financial sector is an interesting contemporary example.

## **The Foresight Report**

Foresight is an established component of the Government Office of Science – lead by the Government Chief Scientist (GCS). Its objective is to examine public scientific issues, suggested from an overarching Strategy Board, of the long term consequences especially from a policy perspective. It tends to take around 50 years ahead as its horizon. One issue at a time is tackled but with overlap and obesity was one such issue begun around 2004. The dominant milieu is science (and economics) but it heavily depends on forecasting, which is intrinsically uncertain.

In terms of policy implantation it is important to recognise that the GCS has a special place in Government. He or she has a weekly meeting with the Prime Minister. Also each project is governed routinely by a Steering Committee on which sit several ministers, in our case three, public health, children young people and families and sport. Thus the process is very close to Government throughout. It is thus difficult for any participating Government to ignore the final report, since they have important ownership

In my experience the process of preparing such a report was extraordinarily broad and detailed, involving many hundred international experts in developing a coherent report. Peer reviewed papers were commissioned on many aspects of the science of obesity, large scientific meetings were held with experts to devise for example the well known obesity systems map and experts in futurology commissioned to predict relevant political and social development. We, the Heart Forum essentially, were commissioned to develop methods of predicting the development of obesity in the UK and its consequences. In my humble opinion an extremely useful generic public health tool was developed under this heading by Martin Brown and Tim Marsh, which the health sector in all its manifestations, even research and development, had singularly failed to develop till then. That is the ability to predict and monitor changes in the prevalence of a dominant environmental risk factor, from Government surveys, and to measure reliably, using micro simulation, the health and economic consequences of such changes and of any effective policy to influence them.

The Foresight report was accepted essentially verbatim in all its detail by Government in its subsequent *Healthy Weight: Healthy Lives* strategy. The future of that strategy is currently unknown.

## **NICE prevention of CVD in population PDG**

These Guidelines were published last week – and the response has been excellent in my view. With one notable exception:

*A Department of Health spokesperson said:*

*"The best way to prevent cardiovascular disease is for people to eat better and be more active. The NHS provides high quality cardiac care and there has been a reduction in cardiovascular deaths of about 50 per cent over the last 15 years through better prevention and better treatment. "Today's recommendations are extensive and wide ranging but it is not practical to implement certain proposals in this guidance, for example on the mandatory use of traffic lights alongside GDA in food labelling. It is extremely important that work by NICE is methodologically robust and includes fully workable proposals."*

Clearly this is sub optimal from the point of view of the PDG but it did reflect the contribution of the DH to our consultation. We had we thought tried hard to work with the DH throughout. It contrasted unhappily for example with the Royal College of Physicians' response:

*Professor Sir Ian Gilmore, president of the Royal College of Physicians said in response to the NICE guidance on the prevention of cardiovascular disease (CVD):*

*"This year alone nearly two hundred thousand people in the UK are going to die prematurely from cardiovascular complications. In addition to its absolute effect, CVD will also have a devastating impact on efforts to reduce health inequalities, with those afflicted being more likely to come from some of our poorest communities. The NICE guidance demonstrates conclusively why we need to change radically our approach to this vast and silent killer. Ten years of personalised healthcare interventions have simply not made a sufficient dent in the overall toll. Simultaneously, major population oriented measures around advertising and smoking in public places have been shown to have a marked positive impact on public health."*

*"Many of the diet-related recommendations made by NICE have the added benefit of costing the public purse little to nothing, while creating an opportunity to reduce the tens of billions of pounds of associated costs the UK loses every year to heart disease. Banning trans-fats, reducing salt consumption and saturated fat levels in processed food*

*may initially pose operational challenges for manufacturers, but the profits of private firms ought not to take precedence when compared with the health of the more than four million people at risk in this country."*

We all clearly need to understand much better than we do where the link with the DH has possibly faltered. Our recommendations, as the RCP suggests, if implemented would save a large number of new CVD cases and deaths and consequently save the NHS enormous amounts of money, and yet the DH is quite dismissive. This is a true paradox, at least superficially.

## **Conclusions**

Clearly the context of Foresight and NICE in the development of health policy are different – very different. If Foresight is anything to go by scientific policy development is, or was in that instance, highly effective. Why the apparent difference?

NICE exists in a context where DH policy is to implement NICE recommendations via funding mechanisms at PCT level. That is treatment which are not recommended broadly will not be funded and detailed funding strategy is largely determined by NICE guidance. Not so apparently for Public Health Guidance but that is appropriate because public health policy necessarily inputs strongly into public policy – which is a Government responsibility alone. There is also some ambiguity around NICE's remit in this context, perceived as well as real. The accusation of 'exceeding its remit' can be levelled which can put it on a back foot, a position Foresight could never occupy. Foresight always had a cross Government and society wide remit and was addressing itself to society as a whole. But the role of evidence based policy development needs to be properly understood, especially at NICE where many public health recommendations ought to also have a wider authority, outside health, than they currently do. Has the broadening of health care interventions to public health yet taken on the full nature of public health recommendations, in an organisation linked so strongly to the DH, and all that that implies?

Clearly the embedding of Foresight in the corridors of power must make a major difference to its ultimate acceptability. But while I was studying the reaction to Foresight several features struck me. It was an unusual experience for someone working in public health. Firstly it's obvious expert scientific provenance – not different fundamentally from NICE – was important. But secondly the way in which costs were handled. This does differ. In our NICE Guidance there was no overriding simple number (of £Billion) that could be explicitly and unambiguously attributed to no action. That was firstly because it could only represent a saving on current expenditure – not an unaffordable increase in expenditure. Secondly the costs we quoted were partitioned across separate recommendations. Thirdly for reasons of (misplaced?) sensitivity we failed to compare with rigour the cost effectiveness of current policy on health checks with our own recommendations, for fear of annoying the DH !

In Foresight the £50Billion figure of the extra cost of obesity growth by 2050 at constant prices captured the imagination of policy makers – who ultimately could not ignore it, and certainly could not refute it. Our CVD recommendations had no such number for which any DH official could be held responsible if our recommendations were ignored. I think this emphasises the importance of proper public health modelling of populations at NICE, which would grow in sophistication and acceptability. The economics tends to be highly simplified and nonetheless unduly complex, which affects the potency of its message greatly. Public health modelling talks about actual lives and actual costs, changing over a period. This is what the Treasury does. It is what both Turner and Wanless badly needed, and represents in my view the one single improvement in NICE's methodology that would make a difference to the widespread acceptance of its public health guidelines in the future. 28/06/2010