Briefing paper

NHS
Health Development Agency

The evidence of effectiveness of public health interventions – and the implications

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Author: Michael P. Kelly
Director of Evidence and Guidance

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Introduction

This paper outlines the policy and practice implications, at national, regional, local and school level, of the evidence about effective public health interventions that has been collected, synthesised and reviewed by the Health Development Agency (HDA) since December 2000. It is based on the Evidence Briefings that the HDA publishes (www.hda.nhs.uk/evidence) and also on a range of other relevant published review and primary data. The argument is presented as a series of headlines oriented to practice and/or policy. The various qualifications and caveats, which may be made of these headlines and of the evidence underlying them are not described here, but may be found in the more detailed briefings, reviews, primary reports and methodological papers produced by the HDA (Kelly et al., 2002; Swann et al., 2003b).

Since December 2000, the HDA has developed a critical appraisal and review method and applied it to the world English language literature of systematic review evidence about public health interventions. The HDA takes a very robust approach to the production of its Evidence Briefings and other evidence products. Among other things, each Evidence Briefing identifies interventions or other activities that demonstrate strong evidence of effectiveness. However, this evidence of effectiveness only in very exceptional circumstances prescribes precisely which policies or practices should be implemented. The reasons for this are that interventions reported in the scientific literature and reviewed in systematic reviews are usually implemented under controlled scientific and well resourced experimental conditions. They may be considerably less effective when applied under non-experimental, routine service delivery circumstances. An evaluation of the likelihood of success of interventions has to be made and the policy and practice implications made clear.

This paper has selected, therefore, a number of public health interventions where not only is the evidence strong, but also where likelihood of success is high. Ways of making these interventions effective at national, regional, local and school level are then described. These judgements are made on the basis of the work the HDA has done when producing guidance for practice in the past, its ongoing work on getting evidence into practice (Kelly et al., 2003), and on the basis of accumulated other experience.

The evidence and its implications

The information presented on the following pages is on a topic-by-topic basis, disaggregated by national, regional, local NHS, and home and school settings.

ALCOHOL MISUSE

(see Mulvihill et al., forthcoming)

National

- Intensive, high quality server training accompanied by strong and active management support is effective in reducing the levels of intoxication in patrons. This should be developed in partnership with industry and local authorities.

Local NHS

- Extended brief interventions (ie several visits) in primary care concerning alcohol use and misuse should become a part of routine clinical management, particularly for women, delivered by healthcare professionals as they decrease alcohol intake.

TOBACCO

(see Naidoo et al., 2000, Naidoo et al., 2004; Silagy and Stead, 2000; Ashenden et al., 1997; Lancaster and Stead, 2001; Rice, 1999; Rice and Stead, 2000; McVey and Stapleton, 2000)

National

- Policies to continue to decrease the affordability of cigarettes should be vigorously pursued as a means of preventing initiation and consumption of cigarettes among young adults and children.
- Policies to reduce involuntary exposure to tobacco smoke through bans in public places and workplaces should be introduced.
- High profile mass media and public education campaigns on the dangers of cigarette smoking should be continued.
- The advertising ban on cigarettes should be enforced and loopholes closed in the current arrangements.
- Current provision of smoking cessation support including NHS smoking cessation services should be continued and improved.
- Brief interventions in primary care should remain a cornerstone of routine delivery of smoking cessation.
- The population group below the median income level should be the principal target as this group numerically provides the largest numbers of smokers.
- Government should implement in full the recommendations of the *Smoking Kills* white paper.
- There should be an increase in funding for tobacco control.
- The capacity and skill of the workforce for delivering all aspects of tobacco control need to be built up.
- An overarching framework for delivering effective tobacco control needs to be developed.

Local NHS

- Smoking cessation services among the more disadvantaged sections of the community must be maintained.
- Effective treatments for smokers in more disadvantaged sections of the community must be developed.
- The involvement of all health professionals in smoking cessation interventions including brief interventions should be encouraged.
- Primary care physicians should maintain and enhance brief interventions on smoking as part of routine general practice consultations.
- Formal smoking cessation must be a constituent part of ante-natal care to prevent low birth weight.

ACCIDENTAL INJURY

(see Millward et al., 2003a; Easterbrook et al., 2001; Mulvihill et al., forthcoming)

National

- Building regulations should be developed so that hard-wired smoke detectors are a compulsory adjunct to any rewiring upgrade undertaken by electrical contractors.
- Child resistant packaging should be made compulsory on all actual or potentially poisonous substances.
- Smoke detectors that are hard wired should be made compulsory in all new domestic dwellings and this provision should be incorporated into relevant building legislation.
- Selective breath testing and random breath testing sobriety checkpoints are both effective in preventing

alcohol-impaired driving, alcohol-related crashes, and associated fatal and non-fatal injuries. The development of such policies should be regarded as a high priority.
- 0.08g/dL Blood Alcohol Concentration (BAC) laws are effective in reducing alcohol-related crash fatalities. However, lower BAC laws are also effective in reducing alcohol-related crash fatalities among young or inexperienced drivers. The development of policies to reflect this should be regarded as a high priority.

Regional

- 20mph speed restrictions in urban residential areas should be actively pursued by local authorities in conjunction with their PCTs, paying special attention to issues of health inequalities in child pedestrian accidents.
- Comprehensive engineering schemes relating to kerbs, crossings, and tactile and auditory signals should become the norm.
- There should be comprehensive police enforcement of speed restrictions on all roads.
- A legal duty should be imposed on local authorities, housing corporations and private landlords to install hard-wired smoke detectors in all properties for which they are responsible.

Local NHS

- Trained staff should routinely deliver home exercise programmes to all persons over the age of 70 living in domestic or residential homes through the primary care system.
- Home, pharmacological, medical and occupational therapy assessment must be made compulsory for all patients over 65 treated at A&E for falls; local acute trusts and PCTs must introduce data linkage to support this.
- Comprehensive pharmacological osteoporosis prevention programmes should be introduced in general practice and primary care.

School

- Primary and secondary schools should implement integrated road safety education programmes. This should be assessed in Ofsted inspections and funding ring-fenced in local educational authority budgets.

MENTAL HEALTH

(see Barlow and Coren, 2002; Barlow et al., 2002; Dimond and Hyde, 1999; Barlow and Stewart-Brown, 2000; Bull et al., 2004; MacLeod and Nelson, 2000; Elkan et al., 2000; Zoritch et al., 2000; Lister-Sharp et al., 1999; Wells et al., 2001)

Local NHS

- Group-based parenting programmes for improving maternal mental health should be routinely available in primary care.
- Routine ante- and post-natal home visiting should be maintained.
- Physical activity should be encouraged as a significant intervention to promoting good mental health.

School

- Through the National Healthy School Standard, schools should be encouraged to play a significant role in positive mental health promotion.

OBESITY AND NUTRITION

(see Mulvihill and Quigley, 2003)

National

- The possibility of strict regulation or a total ban on the advertising and promotion of foods directly to children (including school manufacturer link-ups for the purchase of school equipment and learning resources) should be urgently considered. This should include taking forward the findings of the Food Standard Agency's research on the effects of food advertising to children.
- Tax incentives to employers to encourage exercise and physical activity at and while getting to the workplace should be introduced.
- There should be a statutory requirement for local authorities and planners to create a healthy environment by carrying out health impact assessments of planning proposals. The environment will promote activity, provide access to healthy food choices and limit availability to less healthy choices/outlets for all people – particularly disadvantaged and vulnerable groups.

- Within the current Food and Health Action Plan, a comprehensive and long-term nutrition strategy for England should be developed. This would require short, medium and long-term goals, supported by sufficient resources to deliver at local level and to provide the necessary research. This would include a national strategy on obesity.

Local NHS

- The use of brief interventions in primary care for obesity management and healthy nutrition should be a routine part of all medical consultations.
- Specialist obesity treatment services for children and/or adults to which GPs can direct patients should be universally available. These services must provide services that deliver to disadvantaged and vulnerable groups in the population.
- Family-based behaviour modification programmes, should be provided involving the whole family where appropriate, incorporating diet, child management, parenting and communication skills, and activity and behaviour modification.
- Adult-only services that include diet, physical activity and behaviour modification should be made widely available.

Schools

- Multi-faceted school-based interventions should be introduced. The interventions should be integrated with the curriculum and involve nutrition, activity, cooking, modification of school meals and tuck shops, teacher training, reduction in sedentary behaviour, behaviour therapy and the extension of the National Healthy School Standard to all schools in the country. They should also include the prohibition of all snack products except water, fruit, milk and juice on school premises.

PHYSICAL ACTIVITY

(see Hillsdon et al, 2004; Hillsdon and Thorogood, 1996; CDC, 2001)

National

- Incentives to employers to encourage walking and cycling to work should be introduced and the provision of existing local travel plans enhanced and encouraged through local authority grants.
- The development of a cadre of physical activity facilitators attached to primary care delivery agents should be established.

Regional

- Incentives must be introduced for local authorities to preserve playing fields and other open spaces and to address quality and safety concerns among users; safe play environments within open spaces, including ranger and park keeping schemes and safe walking environments, should also be introduced. This can be coordinated with local schemes to promote walking for health by signed routes, maps, local publicity and advice from health professionals.

Local NHS

- Brief interventions to promote physical activity should be a routine part of primary care using referral to properly trained and resourced physical activity and lifestyle coaches.
- Interventions that encourage walking and do not require attendance at a facility are the most likely to lead to sustainable increases in overall physical activity.
- There is strong evidence that individually adapted health behaviour change programmes are effective in increasing physical activity levels. These should therefore be used in primary care.
- Social support interventions in community settings are effective in increasing physical activity and therefore.

School

- School-based physical education should be maintained and enhanced.

DRUG MISUSE

(Canning et al., 2004; White and Pitts, 1998; Windle and Windle, 1999; Black et al., 1998)

Schools

- School-based interventions to embrace children, parents and teachers, specifically targeted at population groups and properly resourced, should be the basis of drug misuse prevention. The budget should be ring-fenced in local education authority spend.
- School-based interventions aimed at adolescents should be considered part of a comprehensive approach to the prevention.
- Universal prevention programmes should be part of a comprehensive approach to drug misuse prevention in schools.

Local NHS

- Interactive educative programmes using peers should be a part of comprehensive prevention programmes at local level.

SEXUAL HEALTH

(see Ellis et al., 2003; Ellis and Grey, 2003; Swann et al., 2003a)

National

- An integrated approach to the prevention of sexually transmitted infections (STIs) should be taken in which interventions are tailored and targeted to specific groups and are delivered by specialist services and emphasise skills training. STI budgets should be ring-fenced.

Regional

- Interventions should be encouraged that: are theoretically informed; are targeted and tailored; make use of needs assessment or formative research; provide basic, accurate information through clear, unambiguous messages; use behavioural skills training, including self-efficacy; emphasise risk reduction rather than promote abstinence-only; and use peers and community opinion leaders.

Local NHS

- For men who have sex with men, interventions should be implemented with reference to the range of factors that influence risk at both structural and personal levels (eg knowledge, skills, norms). Interventions should be tailored and targeted to specific sub-populations of men who have sex with men, for instance black gay men or men with lower educational attainment. Multi-component small group-work interventions, focusing on risk reduction, sexual negotiation and communication skills training and rehearsal, should be encouraged. The educational and delivery programmes should be ring-fenced in local spend.
- Including teenagers' parents in information and prevention programmes is effective and should be part of local strategies.

School

- School-based sex education programmes should begin before the onset of sexual activity.
- School-based, community based, youth development and family outreach programmes, which are linked to contraceptive services, which begin before young people become sexually active, and which are tailored, targeted and implemented by appropriately skilled workers, should be enhanced. The funding must be ring-fenced at local level.

CHILDREN AND YOUNG PEOPLE

(see Bull et al., 2003; Protheroe et al., 2003; Lumley et al, 2000; Lancaster and Stead, 2000; Lumley et al., 2001, Melvin et al., 2000; Dollan-Mullen, 1999)

National

- The Healthy Start Programme should be augmented with additional elements (such as those included within the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Expanded Food and Nutrition Education Program (EFNEP) programmes run in the US) to create a holistic food-based supplementation programme for pregnant women.
- The length of paid maternity leave should be increased to lengthen the duration of breastfeeding.

- Tax incentives should be provided for employers to support breastfeeding through the provision of a breastfeeding friendly environment for mothers returning to work (this would include breaks, facilities and childcare).
- CHAI's audit of hospitals should include the implementation of UNICEF's baby friendly hospital initiatives and the UNICEF seven-point plan for promoting breastfeeding in community settings.

Local NHS

- An integrated multi-faceted approach to increase the rate of breastfeeding must be undertaken. This will involve the integration of media campaigns, health education and professional training, combined with changes in organisational practices in antenatal, maternity and postnatal care. Funding must be ring-fenced at local level to support this, and local PCTs compelled to carry out performance management.

HOUSING

(see Thompson et al., 2001)

National

- Energy efficiency measures in domestic dwellings, such as installation of central heating and replacement windows, should be encouraged via policy initiatives. They are likely to result in improved respiratory problems and other symptoms, fewer days lost from school owing to asthma, and reduction in physical symptoms such as joint ache, headache and back pain.
- Rehousing and refurbishment initiatives are also likely to have beneficial health outcomes, including improvement in mental health, and should be supported.

WORKING WITH COMMUNITIES

(see Gillies, et al., 1997; NHS Centre for Reviews and Dissemination, 1997)

A number of features have been identified as effective when working with communities. These are:

- Local assessment of needs, and especially involving local people in the research process.
- Mechanisms that enable organisations to work together – ensuring dialogue, contact and commitment.
- Representations of local people within planning and management arrangements – the greater the level of involvement, the larger the impact.
- Design of specific initiatives with target groups to ensure that they are acceptable (ie culturally and educationally appropriate), and that they work through settings that are accessible and appropriate.
- Training and support for volunteers, peer educators and local networks, so ensuring maximum benefit from community initiatives.
- Visibility of political support and commitment.
- Re-orientation of resource allocation to enable systematic investment in community programmes.
- Policy development and implementation that brings about wider changes in organisational priorities and policies, driven by community approaches.
- Increased flexibility of organisations, so supporting increased delegation and a more responsive approach.
- Services need to engage actively with the mid-life and later life cohorts.

Commentary

Unequivocally, measured by occupation, there are marked differences in health from top to bottom of the social hierarchy. There are two different emphases that may be put on this observation. One focuses on the absolute difference between top and bottom. The other is an approach considering the whole spectrum, usually referred to as a gradient approach, which tends to be more interested in relative differences.

When the Black report was originally published (Townsend and Davidson, 1982) the debate that followed tended to focus on the absolute differences between the best and worst off, between the top and bottom of the social class scale. It was noted that there was a nearly two-fold difference in mortality between social class 1 and 5. This way of reading the data has contributed to an approach in which inequalities in health are defined primarily with reference to differences between the most advantaged and least advantaged. In turn, this inevitably forces attention on the most socially excluded, those carrying most risk factors and those most difficult to reach. In

policy and intervention terms this leads to approaches that attempt to lift the worst off out of the extreme situation in which they find themselves. If effective, such interventions deal with one relatively small part of the population. Such interventions do not greatly affect the overall health of the population.

A significant part of the Black report, which in the debates which followed its publication was much less prominent, was the evidence it presented showing a gradient in health moving up and down the social class ladder. It also showed that the difference in health of men compared to women, at all levels, was as great, and sometimes greater, than the differences between men in social classes 1 and 5. More recent evidence shows that the gradient (the relative differences) is getting longer or steeper (Acheson, 1998). So while the health of the worst off seems to be little better or perhaps worse than it was a generation ago, the differences right across the spectrum are stretching out to the disadvantage of all those below the average. Overall health levels in the population improve but the differences across the population seem to become more marked. In terms of figures, there are huge numbers of people who most certainly could not be described as socially excluded, but who in health terms are relatively disadvantaged. For these people, preventive and other interventions could produce massive improvement, and proportionate savings for the healthcare system.

The social gradient approach involves recognising the real health disadvantages of those below the middle of the spectrum and focusing interventions on them, as well as on the most socially disadvantaged. The kinds of approaches to prevention activity in this middle and lower group will be different to the most socially excluded. As the recent Wanless report acknowledged (Wanless et al., 2004), the ways in which different segments of the population respond to similar interventions is not well developed. There has been a long-term failure in public health to truly tailor and target interventions at the different segments of the population with their particular needs. All of the interventions described above, and the detailed evidence underpinning them, require tailored and targeted approaches, not only to be effective, but also to avoid the problem of making the gradient in inequalities steeper.

Conclusion

Overall, the evidence on effective interventions provides a framework within which a number of plausible intervention options may be described. The likelihood of success of any one of these options will be determined by factors located close to delivery. These factors include the local infrastructure of services, local decision making about resource allocation, staff attitudes and engagement with the intervention, relationships between local health service providers and others (such as local government, schools, voluntary organisations, and partners from NGOs), as well as local political 'buy in'. Likelihood of success will also be affected by political will at national and regional level, including adequate resourcing and an administrative mechanism to align national policy with local practice. The interventions listed above have been identified because it is possible to delimit the local and national likelihood of success factors and to describe arrangements and mechanisms to introduce them. They are not a panacea, but enough of the evidence points in the same direction to be reasonably confident of their effectiveness.

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Note that several papers are Cochrane Reviews – the references cited here are for the versions current at the time of the literature searches for HDA Evidence Briefings. Some of the reviews may have been updated. The Cochrane Reviews database is now published by John Wiley & Sons, Chichester, and the list of review titles is at: www.cochrane.org/reviews

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