The Wanless report and decision-making in public health

Sara Allin, Elias Mossialos, Martin McKee and Walter Holland

The 2004 Wanless report expressed disappointment with the substantial gap that exists between evidence and policy in public health, emphasizing in particular the importance of evidence to make the economic argument for investing in public health. The report recommended setting quantified national objectives for all important determinants of health for the medium and long term. Furthermore, it highlighted the need to develop an evidence base on the cost-effectiveness of existing interventions that could inform future developments.

To inform the Wanless report, we were commissioned to review the public health decision-making processes in eight industrialized countries: Australia, Canada, Denmark, Finland, France, Germany, the Netherlands and Sweden. As expected, significant differences in the organization of public health were found among these countries. These differences can be largely attributed to: differing challenges to population health; the political and historical context of public health decision-making, for example in the relative emphasis placed on individual and collective actions; the extent of centralization or decentralization of government; the extent of pluralism in policy-making; the role of nongovernmental organizations; and the important, but less well-documented role of informal mechanisms and interest groups in the policy process. Furthermore, there were significant differences in the reported level of spending on public health as a proportion of total health expenditure across countries, as reported by the OECD, ranging from 1.4 per cent in Australia to 7.3 per cent in Canada. However, these differences must be interpreted in the light of the challenges of defining the boundaries of public health with its multiplicity of funding sources.

Despite these differences, some common features emerge. Goals are typically aspirational. They often include issues such as tackling inequalities in health and reducing tobacco consumption. There is, however, little evidence of the use of the quantitative targets for public health that have characterized policy in the United Kingdom. An exception is Finland, where a government resolution on health included specific, measurable targets for the period 2001–2016. The Dutch strategy to reduce socio-economic inequalities in health also included quantified targets.

Although there is growing awareness of the need to develop a system for evaluating public health programmes, remarkably few policies have been subject to an evaluation of effectiveness and even fewer have been examined for cost-effectiveness. For example, the Netherlands is the only country among those examined that had a systematic, research-based approach to public health policy, in this case focussed on socio-economic inequalities in health. This is, however, changing as countries are formulating new national strategies and initiating new evaluations of current interventions.

Among the eight countries reviewed, only in Australia has cost-effectiveness analysis (CEA) been undertaken to a significant extent. The Australian Ministry of Health and Ageing assessed the economic return on investment of past public health programmes to reduce road injuries, HIV/AIDS, coronary heart disease, measles and tobacco consumption. In each case, they estimated the costs and health benefits attributed to the programmes, total return to society of investment in these programmes and more narrowly, savings to government. This research found that investments in all five areas yielded a substantial net benefit from a societal perspective. However, these evaluations were ad hoc and not part of a national programme to systematically and continually evaluate programmes. Similar cost-effectiveness evaluations have been conducted in the United Kingdom, however, they remain peripheral to the policy-making process.

There are many reasons why the use of economic evaluation in public health is limited. One is that the evaluation of complex interventions such as for public health issues is intrinsically difficult. In clinical medicine, evaluation has largely been limited to single interventions, such as drugs or medical devices, in highly controlled circumstances that often have limited generalizability. In the field of public health, the time taken to implement a project, coupled with the frequently long lag period before an outcome might be detected, means that by the time results are available the intervention has already moved on. There is also the...
difficulty in differentiating the effect of the intervention from underlying trends in, for example, diet or smoking. While in interventions directed at individuals it is usually straightforward to identify controls, this is much more difficult with some population-level interventions, especially those involving behaviour change, as news of the intervention may leak into the control population. This does not mean that rigorous evaluations cannot be done; it is just that they are often difficult.

There are also numerous difficulties in measuring both the costs and the benefits to health of prevention. While health policy makers will inevitably be most concerned about costs falling on the health sector, it is important that a societal perspective is also taken. Calculation of future benefits requires detailed knowledge of the natural history of diseases as well as the effectiveness of interventions; the former is greatly facilitated by the creation of population disease registries such as those in Denmark and Sweden, or the Oxford Record Linkage Study. Another significant obstacle is the lack of funding for such research. While pharmaceutical companies clearly have an interest in paying for large-scale and very expensive studies of drugs, governments have much less interest in paying for complex, large-scale, population-based interventions to improve public health. Finally, there is a need to overcome the often widely held view that many public health interventions are either rejected out of hand or accepted as common sense, without recognition of the need for evaluation.

What lessons did we learn? As the Wanless report noted, there are potential benefits from having specific, attainable, non-aspirational targets and an improved evidence base. However, there were several other findings that were equally important. First, even where the best possible economic evaluations are available, they are only one element in a complex process of decision-making that is also shaped by what is politically feasible. While there clearly is a need for a broader evidence base for public health, it should not be assumed that this will lead automatically to better policies.

Secondly, in order for the benefits of evidence-based policy to be realized, policy makers everywhere need to work more closely with and express their needs more effectively to researchers who must in turn be responsive to these needs.

Thirdly, for effective public policy development it is vital to have complete political commitment to public health from all levels of government and across all sectors. To this end, some recent reforms in France and Canada have strengthened national involvement in public health, creating strong national and regional leadership in this area. There is also a need for a clear legal framework within which public health can operate. While this is common in other European countries, such as France, the United Kingdom currently does not have a modern public health law.

Fourthly, measures must be in place for public health practitioners to be able to speak freely about the weaknesses and needs of the current system without prejudice. In the United Kingdom, prior to 1974, the security of tenure of public health professionals allowed them to express views that were counter to prevailing political views. While it can be argued that tenured status may create negative incentives for performance, the impact of this loss of security for public health policy needs to be considered. Thus, it is vital that public health maintains its independence from political and other pressures.

Fifthly, there is a need to confront explicitly the tension between individual liberty and shared action, with governments making the case for why the latter is sometimes important, forcefully rejecting the charges of fostering a ‘nanny state’ that are often levelled by the tabloid press. The need to do so is all too apparent in the current debate about a ban on smoking in public places. The recent White Paper consultation process has been an important first step in involving the population in the debate about public health but more needs to be done.

Finally, public health involves both individual behavioural changes and structural or environmental changes. It is especially important not to ‘blame the victim’, which appears to be the trend in many countries emphasizing altering individual lifestyles. While initiatives to tackle unhealthy behaviour are important, it is vital to recognize the determinants of these unhealthy behaviours, which are largely rooted in the social and economic context of the individuals. Thus, to tackle them, one must also work to improve the conditions in which people live – specifically, alleviating poverty. While encouraging lifestyle changes is important and, often, effective in improving health, it must not diminish the importance of directing policy to the broader socioeconomic determinants that might have an even greater impact on population health.

References