Course book

Public Health and Public Policymaking

SSC 2053

Academic Year 2017-2018

Coordinator: Prof.Dr. Dirk Ruwaard, MD

Faculty of Health, Medicine and Life Sciences

Department of Health Services Research

1. Summary of the course

This course is about two main topics: public health and public policymaking. Public health deals with various aspects of the health of the population or specific segments of it, e.g. health by gender, health by age, health by socio-economic status, health by region or health by minority. Other important themes are, among others, health behaviour and health determinants. The second topic concerns public policymaking whereby the emphasis lies upon public policymaking at the national level. Both topics will be presented in a combined way by highlighting the intricate relationship between public health and public policymaking as well as the meaning of public policymaking for public health. The course is set up as a multidisciplinary course. There are contributions from political science, public health, medical sociology, health economics, health ethics and public health genomics.

2. Objectives of the course

The objectives of the course are as follows:

Knowledge and insights

- Students should be familiar with key concepts and key problems of public health and main approaches to improve public health.
- Students should be familiar with key concepts of public policymaking and approaches to public policymaking.

Application of knowledge and insights

- Students are capable to apply key concepts of public policymaking in the field of New Public Health.
- Students are capable to form reasoned opinions (opinions based upon theoretical insights and empirical research) on real-world public health problems.

Communication and skills

- Students are capable to apply the knowledge and insights gained in this course in written form (paper) and orally (presentation).

3. Specification

This section is intended as a short introduction to public health and public policymaking.

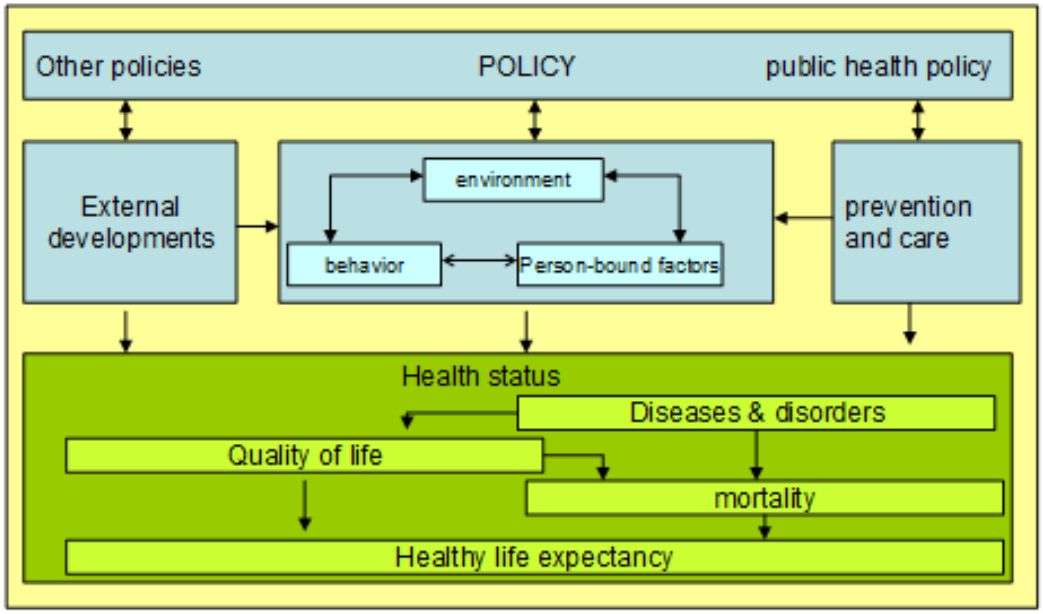
Public health

Before discussing the concept of public health, it is necessary to briefly elaborate the concept of health. The World Health Organisation defined health in 1948 as '*a state of complete physical, mental and social well-being and note merely the absence of diseases or infirmity'.* This definition was ground-breaking in its time because of its breadth and ambition. Yet, it also became a target of criticism. A first problem is that the breadth of health leads to medicalization, because it implies that most people would be sick most of their time. A second problem is that the demography and nature of disease have changed considerably. A central element of this development is the rise of the number of people with chronic disease. Thirdly, it is impossible to operationalise or measure the term 'complete'. For these reasons, there is a need for a new definition of health. Huber et al (2011) propose the following concept. Health is 'the ability to adapt and self-manage'. This definition allows for a much more flexible approach to health. For instance, it implies that people who suffer from chronic problems but yet are able to develop successful strategies for coping may consider themselves healthy. The focus in the physician-patient communication may shift from a mere focus on reducing symptoms to empowerment (based upon Huber et al).

Public health is also a concept that has been defined in many different ways. Pomerleau and McKee (2005) define public health as '*the science and art of promoting health and preventing disease through the organised efforts of society*' (p. 7). A key concept in their study, that also stands central in many other textbooks on public health, is the so-called *health field concept*. This model can be seen as the rejection of the medical model in public health that prevailed until the 1970s. It was published by the Canadian government in the well-known Lalonde Report. The essence of the report was to move away from the medicalization of health or 'old public health' and adopt a broader perspective, often referred to as the 'new public health'. The health of individuals and the population is not only influenced by the availability of health services (physicians, hospitals, nurses, and so on), but also by many other factors. The fundamental weakness of the medical model is that it only takes health services into consideration and neglects other important determinants of health. An important implication of the health field concept (see scheme below) is that policies to improve public health should not only address the availability and quality of health services, but other factors as well including environmental circumstances (e.g. housing, education, nutrition, poverty) and individual behaviour and lifestyle factors (e.g. smoking, physical exercise, sexual behaviour). The focus is also more on prevention and health promotion. The health field concept does not mean that health services are no longer important. It only implies that a single focus upon health services

fails as an organised activity to protect people against health problems and to promote public health. A much more comprehensive view is required to be successful.

Scheme 1: Health field model



Source: Van de Lucht & Polder, 2010.

In their book 'The New Public Health' (Academic Press, 2000), Tulchinsky and Varavikova describe the movement to the new public health as follows: '*Traditionally, public health has been defined as health of populations and communities. However, the New Public Health addresses the health of the individual, as any medical care provider, both directly with individuals and indirectly through communities and populations. The indirect approach is to reduce the risk factors in the environment, whether physical or social, such as in reducing exposure to contaminated water working or improving educational levels, while the direct approach works with the individual patient or client as does a doctor treating the patient or a program for vaccinating children.*'(p.2). The emergence of the New Public Health also went along with a significant expansion of public health activities. Globally speaking, one may say that in the past emphasis public health programs focused upon health protection whereas presently much attention is also given to health promotion.

Presently, public health includes a broad variety of topics, for example communicable diseases, non-communicable conditions, family health, nutrition and food safety, environmental and occupational health, health services and inequalities in health. The study of public health and development of public health programs has also given rise to new sciences such as epidemiology and health promotion. It is obviously impossible to

address all these issues in this course. The objective can only be modest: to make students familiar with some key ideas and problems in the broad field of public health.

We started this introductory section with the notion of public health and public policymaking as two interrelated concepts. It is now clear why they are interrelated: the resolution or decrease of public health problems requires effective public policymaking. This conclusion seems self-evident, but it raises many other interesting questions, for instance whether these problems *only* require effective public policymaking, whether there are serious *limits* to the effectiveness of public policymaking and, if so, what these limits are. Another interesting question relates to *dilemmas* in public policymaking. For instance, under what conditions and to what extent is it legitimate to restrict a person's freedom of choice in the name of public health?

Public policymaking

In the policy literature, one can find many different definitions of public policymaking. For instance, some scholars describe public policymaking as the *making and implementation of a policy plan consisting of a number of policy objectives and policy instruments.* Policymaking is about setting policy objectives and selecting policy instruments to achieve these objectives.

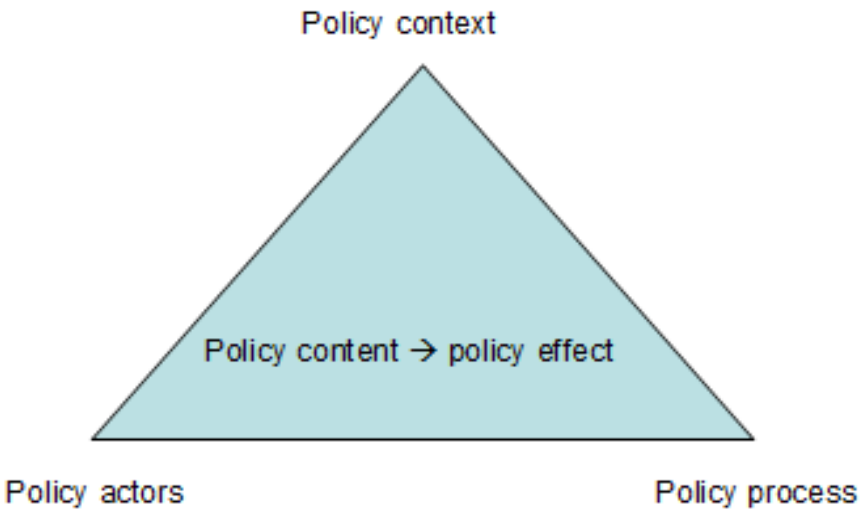
Other scholars prefer a somewhat broader description and conceptualise public policymaking as *an organised and purposeful activity to resolve public problems* whereby public problems are understood as problems which require public collective action of people and organisations for resolution. This description underscores that public policymaking starts with the framing of a public problem that must be addressed. Problem framing is a crucial aspect of any public policymaking, because the policy content is always strongly influenced by the way public problems are framed. For instance, it makes a big difference for policymaking whether abortion is defined as a policy problem from a pro-choice or pro-life perspective or whether health is seen as the result of individual lifestyle or the result of social circumstances (e.g. poor education, poverty). Another element of the second description of public policymaking concerns the term organised and purposeful activity. This terminology highlights that public problems do not disappear spontaneously, but require some activity. Furthermore, policymaking can only be effective when the activities of many people and organisations are organised (or coordinated) and purposeful: they must be directed at the achievement of certain policy objectives.

Another approach is to view public policymaking as *a series of activities to address public policy problems.* The basic idea behind this approach is that public policymaking often unfolds over time. Policymakers take some decisions at time t, followed by further decisions on t+1, t+2, and so on. New decisions are based upon new information upon the development of policy problems or upon an evaluation of the effects of earlier decisions. This approach conceptualises public policymaking as a process of successive policy

decisions over a certain period of time. This approach has important implications for the study of public policymaking: Public policy analysis cannot be restricted to the study of a single policy document stating the policy goals and instruments, but rather requires the study of a series of policy decisions over a longer period of time.

The scheme below represents a slightly adapted version of the so-called *policy triangle* taken from Buse, Mays and Walt (2005). It is a highly simplified model of the real world of public policymaking and consists of a number of key concepts that function as an analytical guideline for health policy analysis. Buse, Mays and Walt rightly emphasise that these concepts should not be considered separately but studied in connection with each other.

Scheme 2: The policy triangle



The term *policy content* refers to the plan of action (or policy) consisting of policy objectives and policy instruments. Buse et al (2005) define a policy as a '*broad statement of goals, objectives and means that create the framework for activity*'. Policies '*often take the form of explicitly written documents, but may also be implicit or unwritten*'. A policy can contain different types of objectives: well-known are the distinction between short-term and long-term objectives and the distinction between intermediate and ultimate objectives. An example of the last distinction is to educate people (intermediate objective) to improve health (ultimate objective). The policy means or instruments can be classified as follows (Howlett & Ramesh, 1995). The first category consists of authority-based instruments (regulations, instructions, commands, threats, and so on). The second category consists of treasury-based instruments (subsidies, taxes, allowances, pensions, and so on). Organisation-based instruments make up the third category. Policymakers need an organisational apparatus for institutional capability. The final category includes

information-based instruments (public campaigns, information exchange, marketing and propaganda, performance measurement, and so on).

The purpose of public policymaking is to resolve public problems or, to put it differently, to bring about certain *policy effects*. These effects can be seen as the intended effects of public policymaking. Importantly, however, public policies often have unintended effects as well. For instance, a frequently reported unintended or side effect of policies to improve the health of the population is that they may increase health differences, because well-off people tend to benefit more from these programs than people living in poor circumstances. The effectiveness of a policy is the extent to which it brings about the intended effects.

The term *policy actor* or stakeholder refers to individuals, groups and organisations that are somehow involved in the public policymaking process. A key actor in public health policymaking is the government, but it is important to realise that usually a multitude of actors or *stakeholders* are involved at various levels of public policymaking (macro, meso and micro). Buse et al (2005) define a stakeholder as '*an individual or group with substantive interest in an issue, including those with some role in making a decision or its execution*' (p. 175). The influence stakeholders have on public policymaking widely differs. While some stakeholders do have a strong influence on agenda setting and problem framing, other stakeholders are much less successful in influencing the policymaking process. In this course we will see that public health policymaking most of the time requires the involvement of a wide array of stakeholders which often have conflicting interests. There are many examples of economic interests conflicting with public health objectives.

The term *policymaking process* (Buse et al speak here of the policy process) gives expression to the view that public policymaking must be conceptualised as a process consisting of several stages. Buse, Mays and Walt (2005) differentiate here between the following stages: problem identification and issue recognition, policy formulation, policy implementation and policy evaluation. The stage of *problem identification and issue recognition* is often referred to as *agenda setting*. An important question in this respect is which problems are recognised as problems that require public action and how they are framed. As already mentioned, problem identification is crucial because of the strong interdependence between problem formulation, the definition of the policy objectives and the choice of policy instruments. *Policy formulation* is about setting policy objectives and selecting instruments to achieve these goals. In democratic societies policy formulation includes the approval of a policy by the Parliament representing the population. To be effective, policy formation is not enough. Policies must also be implemented or put into practice. 'The proof of the pudding is in the eating'. *Policy implementation* often turns out to be highly problematic, for instance because of lack of sufficient resources or resistance among the population. Therefore, policy implementation has been called 'the Achilles Heel' of public policymaking. The final stage is policy evaluation. Some questions that play an important role in this stage are: Has the

policy been a success or a failure? Which policy lessons can be drawn from the experiences so far?

Usually, a policymaking process does not consist of a single policy cycle but of a series of such cycles. Policy evaluation may give rise to a reformulation of policy problems, to a revision of the policy goals and instruments or to a reorganisation of the organisational structure for implementation. There may also be complicated relations between the stages of public policymaking. The real of public policymaking is far more complex than the linear model of the policymaking process as a set of successive stages suggests.

Furthermore, it is important to note that political decision-making does not only take place during the policy formation process. Political decisions are taken in each stage of public policymaking. The identification and framing of policy problems is a political process. Political decision-making also plays a role in policy implementation and evaluation.

Public policymaking should not be studied in isolation, but in its broader *policy context*. It is an embedded activity that cannot be well understood without taking its context into consideration. Following Buse, Mays and Walt, the policy context refers to '*systemic factors – political, economic and social, both national and international, which may have an effect on health policy'* (p. 11).

Public health policy analysis can be shortly described as the systematic analysis of the content and effects of health policies, the actors involved, the policymaking process and the policy context that impacts upon the policymaking process. One of the objectives of this course is to train students in this type of analysis and to make them familiar with several theoretical models (or approaches) of public health policy analysis.

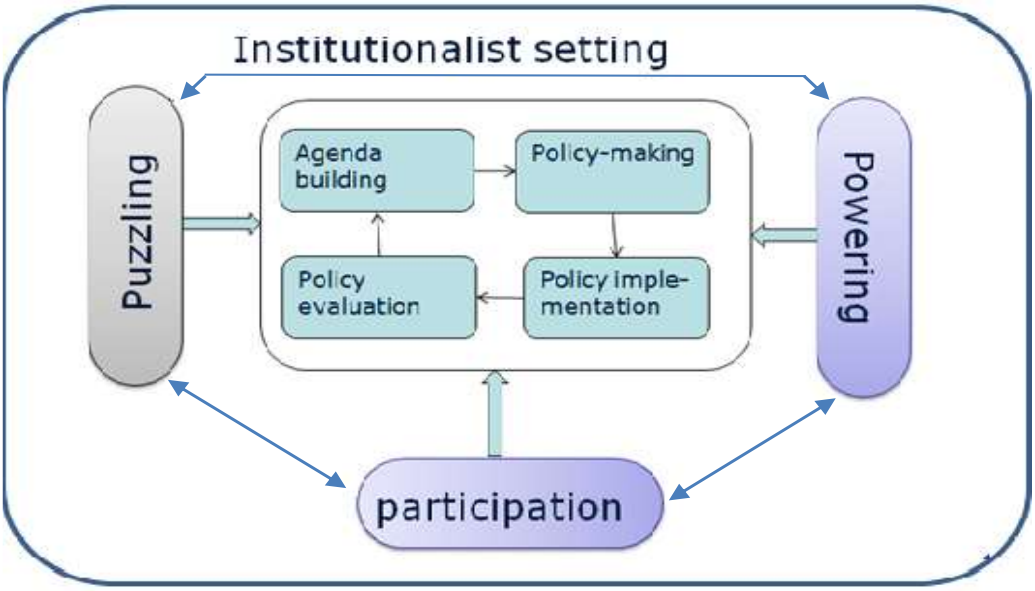
Four perspectives

In the public policy literature one finds various analytical or conceptual perspectives for doing public health policy analysis. In this course the focus is upon four perspectives: puzzling, powering, participation and institutions. Each perspective concentrates on different aspects of the public health policymaking. The four perspectives are interconnected.

The *puzzling* perspective draws attention to the fact that policies are explicitly or implicitly based upon normative ideas (values) and ideas about 'how the real world works'. Policies are based upon what may be called a *normative and cognitive belief system.* Public policymaking requires the designing of policy, deliberation, values, evidence, uncertainty reduction, risk avoidance, and so on. From the puzzling perspective public policymaking is a process of seeking the optimal approach

From the *powering* perspective public policymaking is conceptualised as the outcome of a bargaining process between the stakeholders participating in the policymaking process.

Stakeholders are not only politicians and governmental or bureaucratic agencies (e.g. the Health Department), but also non-state agencies such as interest groups. A key concept here is power.



From the *participation* perspective emphasis is on the participants or stakeholders which are involved in the policymaking process. Some important questions here are: Who are they, what is their role, which interest do they articulate? The role of stakeholders is strongly influenced by the type of political system (e.g. liberal-democratic or authoritarian) and the formal and informal rules of the game.

Participation, puzzling and powering do not take place in a vacuum but are influenced by the institutional setting which can be defined as the set of institutions that influence public policymaking. There is no single definition of institutions. Scharpf defines an institution as a 'system of formal and informal rules that structure the course of actions that a set of actors may choose'. Nobel Prize winner North speaks about '*humanly devised constraints that structure political, economic and social interaction*' and the sociologist Scott about '*cognitive, normative and regulative structures that provide stability and meaning to social behaviour*'. Institutions influence behaviour, but do not determine it. They create stability in social and cultural patterns.

A central theme in the institutional analysis of public policymaking is the concept of institutional impact: whatever definition of institutions is chosen, a common element is that institutions influence public policymaking. For instance, the rules of the game influence who can participate in public policymaking and who is excluded from it. In a similar way deeply rooted cognitive and normative beliefs make radical policy changes unlikely. Public policymaking reflects the legacy of the past and is characterised by a high degree of path dependency: '*each step along a particular path produces consequences which make that path more attractive for the next round*' (Pierson). Only under specific circumstances, referred to as critical junctures, radical policy changes are possible.

Given the legacy of the past and the mechanism of path dependency institutional analysis stipulates that most policy changes are evolutionary or incremental. This is even true for reform programs the rhetoric of which often suggests radical change. If reforms alter a system (e.g. health system), the pattern of change can best be depicted as gradual transformation.

4. Literature

Information about the literature is provided below each assignment and also in Student Portal.

5. Teaching activities

The course includes the following activities:

- Lectures
- Tutorial groups (PBL)
- Paper writing
- Presentations

6. Examination

Grading policy
Presentation: 20 per cent
Paper: 30 per cent
Written test: 50 per cent
Students must pass for each element separately.

Paper

Each student is required to write an individual paper about a self-selected topic directly related to public health policymaking. This paper must combine knowledge and insights in the field of public policymaking with knowledge and insights in the field of public health gained during the course. Example topics from previous years will be available in Student Portal at the beginning of the course. The paper must be submitted **in SafeAssignment not later than Friday 25-May 23:56**. The required word count is about 2500 words. The paper should have the form of an essay. Regarding the format, please consult the UCM Style Manual, which can be found at MyUCM. The paper will be graded by the tutor. The grading of the paper will reflect the adequacy of the paper given the above formal requirements, as well as the clarity of the paper, the depth of policy analysis presented, the soundness of the conclusions and recommendations, the consistency of referencing style. In case of questions, the tutor can be consulted throughout the course.

Presentation

To facilitate the preparation of the paper and to broaden the course perspective, each student is required to present the topic selected for the paper. The following presentation slides are suggested: 1) overall topic; 2) relevance of the topic to public health policymaking and society; 3) research question and objectives; 4) methods; 5) structure of the paper. The presentation should be max 5-8 min. This is usual for conference presentations. The presentations will take place on **Friday 20-April during the tutorial meeting**. This means that it is important to select a topic for the paper as soon as the course starts. The presentation will be graded by the tutor. The grading of the presentation is based on the student's presentation skills and the quality of the presentation (layout and content). In case of questions, the tutor can be consulted.

Written test

The written test will take place in the last week of the course. It will be a closed-book exam containing several open-questions with sub-questions.

Resit: In accordance with the regulations in the UCM teacher handbook

7. Attendance policy

In accordance with the regulations in the UCM teacher handbook

8. Contact information

Coordinator: **Prof.Dr. Dirk Ruwaard, MD**
E-mail: d.ruwaard@maastrichtuniversity.nl
Department of Health Services Research,
Faculty of Health, Medicine and Life Sciences

Dr. Olga Zvonareva
E-mail: o.zvonareva@maastrichtuniversity.nl
Department of Department of Health, Ethics & Society
Faculty of Health, Medicine and Life Sciences

Dr. Andrew Roy
E-mail: a.roy@maastrichtuniversity.nl
Department of Department of Health, Ethics & Society
Faculty of Health, Medicine and Life Sciences

Dr. Milena Pavlova
E-mail: m.pavlova@maastrichtuniversity.nl
Department of Health Services Research
Faculty of Health, Medicine and Life Sciences

9. Time table

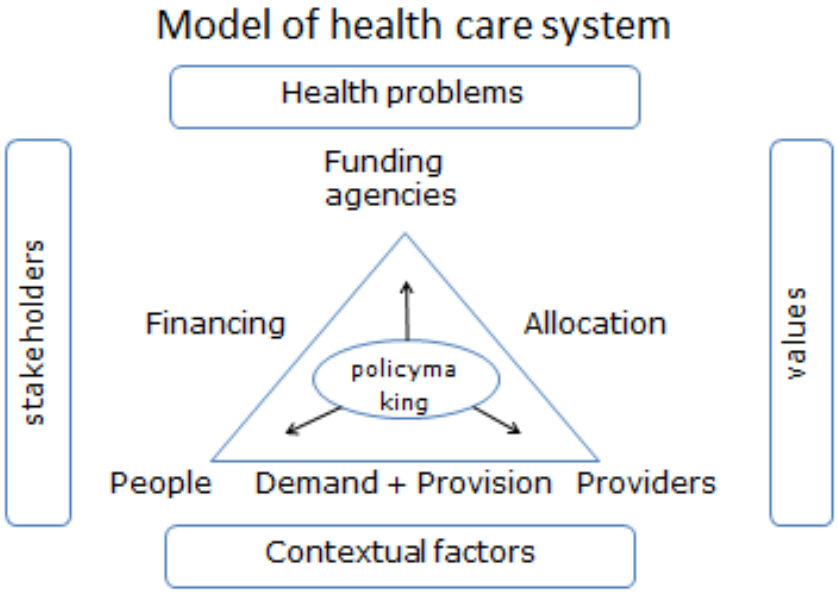
	Lectures	Tutorials	Paper and presentations
Week 1			
	Title: Health system analysis Lecturer: Hans Maarse	Pre-discussion assignment 1	
		Post-discussion assignment 1 Pre-discussion assignment 2	Selection of paper topic
Week 2			
	Title: Issues in public health Lecturer: Dirk Ruwaard	Post-discussion assignment 2 Pre-discussion assignment 3	Presentation preparation
		Presentation of paper topic	
Week 3			
	Title: Public health policymaking Lecturer: Hans Maarse	Post-discussion assignment 3 Pre-discussion assignment 4	
			Paper writing
Week 4			
	Title: Health inequalities Lecturer: Hans Bosma	Post-discussion assignment 4 Pre-discussion assignment 5	
		Post-discussion assignment 5 Pre-discussion assignment 6	Paper writing
Week 5			
	Title: Economic evaluation Lecturer: Mickael Hiligsmann	Post-discussion assignment 6 Pre-discussion assignment 7	
			Paper writing
Week 6			
	Title: Healthcare governance Lecturer: Wim Groot	Post-discussion assignment 7 Pre-discussion assignment 8	
			Paper writing
Week 7			
	Title: Public Health Genomics Lecturer: Elena Ambrosino	Post-discussion assignment 8 Evaluation	
			Paper submission
Week 8			
	Written Exam		

For timeslots and locations see MyTimetable in MyUM !!!

Assignment 1: My country's health care system

A health care system is the organization of people and institutions that deliver health care services to meet the population's health needs. There is a wide variety of health systems around the world, presumably due to differences in health needs and resources available. But even when comparing countries within the same geographical region, various types of health care systems emerge.

The health care systems have various objectives and functions. Access to medical care is one of them. Access to high quality medical care for individuals, groups and populations is however highly dependent upon the structure and strength of the specific health care system.



Use this scheme to analyse the structure of your home country's health care system.

References:

- Rothgang H et al. (2011). *The state and health care. Chapter 2 (p.10-22)*. Palgrave Macmillan UK.
- Böhma K et al. (2013). Five types of OECD healthcare systems: empirical results of a deductive classification. *Health Policy* 113: 258– 269.
- Dúran A, Kutzin J, Martin-Moreno JM, Travis P. (2012). *Understanding health systems: scope, functions and objectives (p.19-36)*. In: Figueras J, McKee M. (eds.) Health systems, health, wealth and societal well-being. Assessing the case for investing in health systems. Open University Press.
- Walt G (1994). *Health Policy. An introduction to process and power. Chapter 1 (p.1-10) & Chapter 2 (p.11-34)*. Zed Books.

Assignment 2: Does health care matter in public health?

The following section is taken from Pomerleau J, McKee M. (eds), Issues in public health, p. 106-107. Open University Press, 2005.

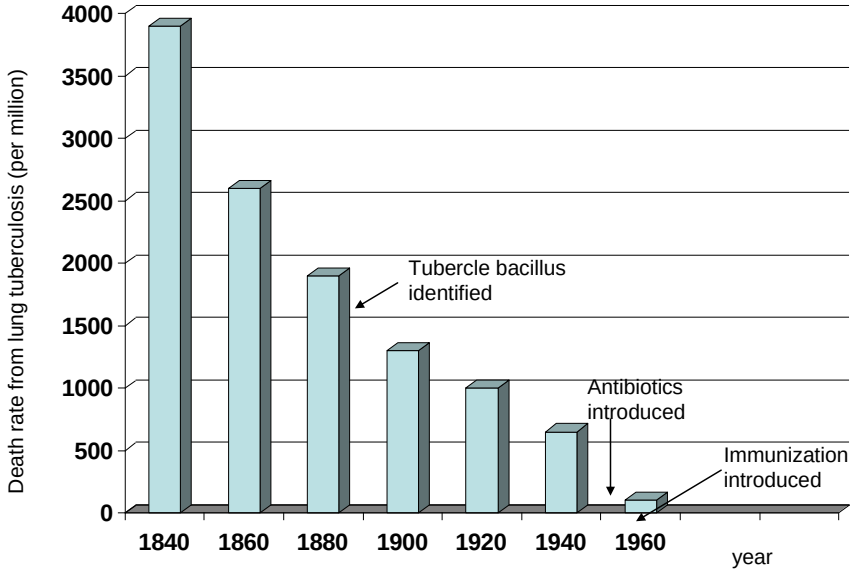
'Prior to the twentieth century, it would have seemed ludicrous to most people that health services could contribute to better health at a population level. Whether one survived or died was seen largely as a matter of divine will. This began to change when, for instance Florence Nightingale (1820-1910) showed that it was possible to reduce substantially the mortality among soldiers injured in the Crimean War by applying strict sanitary routines in a hospital in Turkey. Ignaz Semmelweis (1818-1865), a Hungarian physician, also showed that something could be done when he instituted hand (and later equipment) washing with chlorinated water and reduced the death rate among mothers following childbirth.'

Until then, with no anaesthesia, and inadequate understanding of infection, and only a very few pharmacologically active drugs, going into the hospital was, quite correctly, seen as a process that made death rather more likely. By the beginning of the twentieth century, however, things had changed. Anaesthesia was relatively safe. Aseptic techniques were in use, as were new drugs such as sulphonamides.

Throughout the twentieth century, scientific knowledge, and with it advances in health care, steadily grew. The Second World War provided a major impetus for innovation in health care (…..) It also led to a vast expansion in the number of people with surgical training, who subsequently pushed surgical techniques even further. By the 1960s many commentators, viewing the shining new hospitals and health centres that were springing up in industrialised societies, were caught up in unprecedented optimism about what health care could achieve, predicting the end of, for example, infections and cancer.

In the mid-1960s, however, some contrary voices began to be heard. Thomas McKeown, Professor of Social Medicine in Birmingham, looked at the large decline of mortality that had occurred over the previous 100 years and argued that it had largely been due to broader social changes. For example, he showed that the largest declines in mortality had taken place before the introduction of effective treatments. One of his best examples is that of tuberculosis, where he could plot mortality against the introduction of specific interventions (see figure). He argued that the reduction in mortality was largely a function of improved nutrition during the nineteenth and early twentieth centuries.'

(…) 'Inevitably, the views of McKeown (…) have been highly controversial.'



Decline in mortality from tuberculosis in England and Wales over time

Source: Thomas McKeown, *The role of medicine*, Oxford: Blackwell, 1979

References:

- Pomerleau J, McKee M. (2005). *Issues in public health. Chapter 1 (p.7-23) & Chapter 5 (p.105-126)*. Open University Press.
- Huber M et al. (2011). How should we define health?. *British Medical Journal* 343: d4163.
- Mackenbach J. (1996). The contribution of medical care to mortality decline: McKeown revisited. *Journal of Clinical Epidemiology* 49: 1207-1213.
- Fries J. (1980). Aging, natural death, and the compression of morbidity. *New England Journal of Medicine* 303: 130-135.
- Omran A. (1971). The epidemiological transition: a theory of the epidemiology of population change. *The Milbank Memorial Fund Quarterly* 49(4): 509-538**.**
- van der Lucht F, Polder JJ. (2010). *Towards better health. The Dutch 2010 public health status and forecasts*. *Executive summary: towards better health (p.5-9).* Bilthoven: National Institute for Public Health and the Environment.

Assignment 3: Public health policy or simply politics?

Some theoretical definitions describe policymaking as a problem-solving process which is expected to be rational, balanced, objective and analytical. Evidence however suggests that such definitions are far from reality. Seen from outside, policymaking appears a rather chaotic procedure, dominated by political, practical and socio-cultural factors. The analysis of policymaking is therefore essential to outline gaps between theory and practice, the policy actors involved as well as their motivations, roles and interactions.

The politics of smoking?

Source: Scollo MM, Winstanley MH. Tobacco in Australia: facts and issues, Chapter 10. Melbourne: Cancer Council Victoria; 2012. Available at: www.TobaccoInAustralia.org.au

(…..) Exerting effective influence on government decision making in Australia, and elsewhere, is an ongoing concern for the tobacco industry. Once legislation is in place, it is difficult to overturn. If shown to be effective in one part of the world, tobacco control legislation is often replicated in other jurisdictions. It is a general rule of thumb in tobacco control advocacy that the more effective a particular initiative is going to be, the more aggressively the industry will oppose it—often referred to as the 'industry scream test'. Regulation that gains industry support is not likely to be any serious threat to the industry.

The history of industry opposition and lobbying in regard to legislation initiatives in Australia has been well documented. The earliest battlefields related to the introduction of restrictions on advertising and later, health warnings on tobacco packages. Regulatory initiatives to introduce restrictions on smoking and increase tobacco taxation have also provoked vigorous response. This strategic opposition continues, as evidenced by the well-funded tobacco industry campaign against plain packaging reforms.

(……..) In the US during the 1990s, the tobacco industry countered major National Cancer Institute initiatives promoting community-based tobacco cessation projects. The program, American Stop Smoking Intervention Study (ASSIST), was the largest and most comprehensive tobacco control program launched in the US, and was strongly oriented to interventions and activities at a local level. The tobacco industry response was thorough. The industry monitored the projects; attempted to infiltrate them, obstructing them in some communities; and seeded negative media stories. A network of allies to assist in lobbying was organised. The industry attempted to have pre-emptive legislation introduced to protect tobacco advertising. The industry also attacked the basis of the project as a misuse of taxpayers' money to unfairly target the tobacco industry and launched a number of law suits, which disrupted and delayed program implementation. Litigation has also been used by the industry as a tool against other tobacco control

campaigns in the media, such as those run by the American Legacy Foundation and the California Tobacco Education Media Campaign.

(…..) Philip Morris USA took a different tack in 1995, undermining public health initiatives by appearing to offer them its support. As part of 'Project Sunrise', Philip Morris identified and then actively sought dialogue with public health advocates that it deemed to be 'moderate' in view and likely to be persuaded to see advantages in forming cooperative policies on tobacco control (such as concentrating on harm reduction strategies rather than on policies that would impact more negatively on industry profitability and survival). The benefits of any alliances would be multiple: they would buy Philip Morris social credibility; they could act as a conduit for Philip Morris's views in arena in which Philip Morris would normally be excluded; and they might help ensure that any programs supported or regulation developed was acceptable to Philip Morris. But above all, Philip Morris could argue that people who did not wish to associate with them were 'prohibitionists' or 'extremists', establishing useful schisms between tobacco control advocates and diluting their effectiveness.'

Food politics: how industries influence eating

The following quotes are taken from Marion Nestle (2002) Food Politics. How the Food Industry Influences Nutrition and Health.

'(….) I have wondered what role the food industry might play in creating an environment so conducive to overeating and poor nutritional practices and so confusing about basic principles of diet and health' (p. vii).

'(….) I eventually came to the conclusion that food companies – just like companies that sell cigarettes, pharmaceuticals, or any other commodity – routinely place the needs of stockholders over considerations of public health. (….) Food companies will and market any product that sells, regardless of its nutritional value or its effect on health. (….) Like cigarette companies, food companies co-opt food and nutrition experts by supporting by supporting professional organizations and research, and they expand sales by marketing directly to children, members of minority groups, and people in developing countries – whether or not the products are likely to improve people's diets' (p. viii).

'Addressing cigarette smoking requires only a single change in behaviour: Don't smoke. But because people must eat to survive, advice about dietary improvements is much more complicated: eat this food instead of that food, or eat less. (…) the "eat less" message is at the root of the controversy over nutrition advice' (p. 3).

'(…) the food industry's marketing imperatives principally concerns four factors: cost, convenience, and (…) public confusion. (….) Confusion: keep the public puzzled' (p. 16-17).

'(…) the "paradox of plenty". (….) Wealthier people usually are healthier, and they choose better diets. They also tend to avoid smoking cigarettes, to drink alcohol in moderation if at all. (….) low-income groups seem to have the same amount of nutrient intake as people who are better off, but they choose diets in higher calories, fat, meat, and sugar, and they display higher rates of obesity and chronic diseases. The gaps in diet and health are economically based, but they also derive in part from the social status attached to certain kind of foods'. (p. 27).

There is 'the conflict between scientific and other kinds of belief systems. Although most scientists view scientific methods (….) as inherently valid and truthful (…), many people regard as just one of a number of belief systems of equal validity and importance. Religious beliefs, concerns about animal rights, and view of the fundamental nature of society, for example, influence the way people think about food. So do vested interests. Like any other kind of science, nutrition science is more a matter of probabilities than of absolutes and is, therefore, subject to interpretation. Interpretation, in turn, depends on point of view. Government agencies invoke science as a basis for regulatory decisions. Food and supplement companies invoke science to oppose regulations and dietary advice that might adversely affect sales' (p. 27-28).

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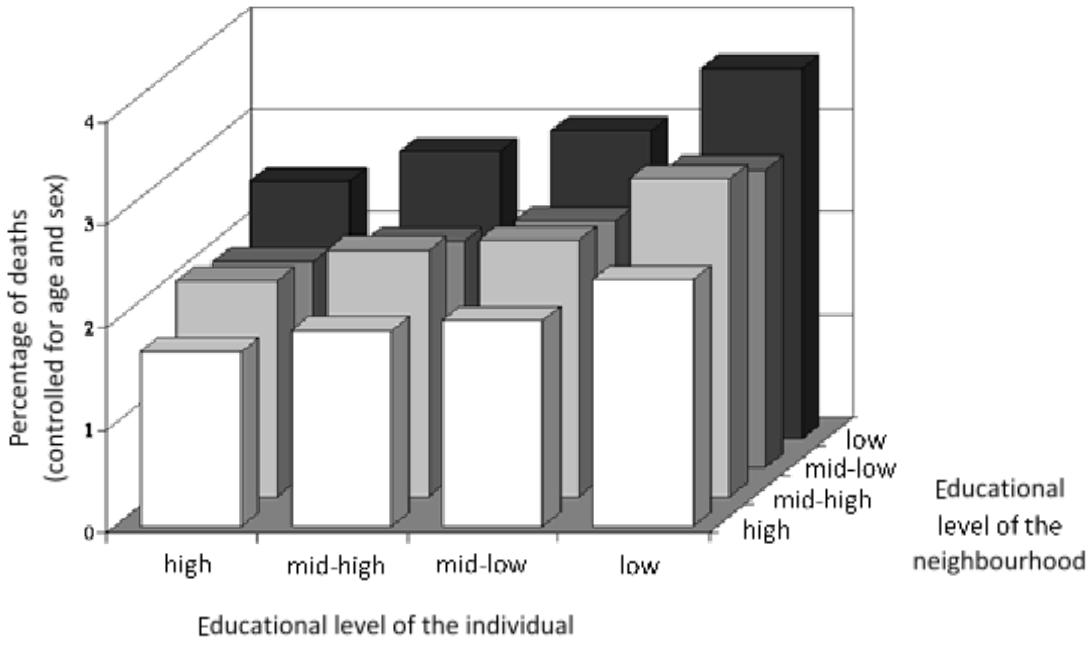
Assignment 4: Is death the big equaliser?

For your traineeship, you have been assigned to the regional public health service in Maastricht. You are handed over a recent report which demonstrates that some areas and neighbourhoods in Maastricht report worse health than other areas. You find out that these "unhealthy" areas are also the areas with high percentages of unemployed people, a lot of poverty, many people with a disability pension, many lower educated people, and many persons with migrant backgrounds. Simultaneously, within the same area, it is also apparent that people with a lower socioeconomic status fare worse concerning their health than their socioeconomically better-off counterparts. The report cites a recent study from another Dutch city (Eindhoven) with comparable findings, even regarding premature mortality (see Figure). You are breaking your head over where these differences come from and what could be done about them.



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Assignment 5: Should an individual have the freedom to undergo a total body scan?

Executive summary

Health Council of the Netherlands. Checking checked: appropriate use of health checks. The Hague: Health Council of the Netherlands, 2015; publication no. 2015/05

In this advisory report, the Health Council of the Netherlands' Committee on Population Screening highlights the benefits and risks of health checks and makes recommendations concerning the associated protective role of the government. Health checks are medical tests that are intended to detect diseases (or the associated risk factors) in individuals without any relevant medical indication. One example is a total body scan. Some health checks are governed by the Population Screening Act (WBO) and at present cannot be carried out without a permit. The Minister of Health, Welfare and Sport wants to maximize people's freedom to choose whether or not to undergo a health check. She has asked the Health Council about the required conditions. What criteria must health checks meet and what requirements should the government impose to protect people against the risks involved in tests of this kind?

The impact of health checks on individuals

The benefits of health checks are often taken for granted. In scientific terms, however, these cannot so easily be established. Studies have shown that no health gains are to be expected, as far as reduced mortality and/or reduced morbidity are concerned at population level. However, this is not necessarily the case for specific subgroups. Furthermore, individuals may feel that reassurance (if no problems come to light) or merely useful information suffices to undergo a health

check. There hardly is any scientific evidence that this is indeed the case, and whether or not individuals actually benefit from such checks.

Yet the old adage "it doesn't hurt to try" is hardly applicable to health checks. They certainly involve various major risks and drawbacks, although little is known about the extent to which these actually occur. For instance, a health check may well uncover an anomaly that would never have caused problems (overdiagnosis). Also there can be incidental findings whose implications, in terms of treatment and prognosis, are unclear. Furthermore, as with any type of medical treatment, there is a risk of complications and of erroneous results. In the latter case, false positive results can lead to further tests (possibly invasive in nature) and unnecessary treatment, while false negative results can lead to unwarranted reassurance and potential delays in the diagnostic process.

The impact of health checks on regular care and on society at large

The Minister has asked the Health Council for details of the conditions under which health checks might be offered by hospitals and other regular healthcare providers. One advantage of conducting health checks within the context of regular health care is that it might then be possible to dovetail them into the rest of the healthcare system more simply and effectively. Given the huge differences between indication-driven healthcare and health checks, however, the drawbacks involved might well be too large. For instance, specialists would have to take dedicated refresher courses to enable them to perform qualitatively responsible health checks. If patients are not fully capable to distinguish between indication-driven healthcare and health checks, they would likely tend to overestimate the value of hospital-based health checks. This effect would be further enhanced if insurers – as agents of care with a favourable price-quality ratio – were to include health checks in their supplemental insurance policies. This would boost demand for health checks, resulting in higher healthcare costs and problems of undercapacity. Accordingly, in its advice to the Minister, the Committee recommends that health care and commercial health checks be kept separate.

One leading question is what impact the increasing use of health checks will have on the healthcare system. It is plausible to assume that health checks tend to generate follow-up costs and waiting lists. Nevertheless, there is a lack of quantitative data about the potential scale of these consequences in case of a more generous policy concerning health checks. That would also depend on the specific details involved, for example on whether insurers were to include health

checks in their supplemental policies. The Committee recommends to perform research into these effects. Increase in healthcare costs and waiting lists as a consequence of health checks might undermine the foundation of justice and solidarity on which our healthcare system is based.

The government's responsibility

According to the Constitution, the government is required to take measures to promote public health. This includes the duty to ensure responsible provision and appropriate use of health checks. The government must provide protection against the drawbacks and risks of health checks without interfering unnecessarily in the individual's freedom of choice. The government's duty of protection consists of three elements.

Firstly, the government should ensure that health checks are provided and implemented responsibly, and should prevent the use of irresponsible health checks. In addition, the government should help to ensure that people are provided with good quality, comprehensible information that will enable them to make an informed choice about whether or not to undergo a health check. The need for information about the appropriate use of health checks is not restricted to potential participants. Training should also be given to medical professionals to enhance their knowledge of this area, and to teach them how to transfer that knowledge to others. An appropriate information system about the range of health checks on offer would be an important means for increasing people's knowledge of such matters. This would require the active support of the government. Finally, monitoring and enforcement is a government responsibility. With regard to the provision of health checks, the importance of monitoring and enforcement in this area is increasing in step with people's growing freedom to choose whether or not to undergo such checks.

The Health Council's report received several critical reactions in the social media.

One person wrote: 'What gives the state the right to deny me access to undergo a total body scan?'

Another person wrote: 'For undergoing a total body check you must now travel to Germany. The scan costs you 1500 Euro. That is unfair. Everybody should have the right to undergo such a check and insurers should pay for it.'


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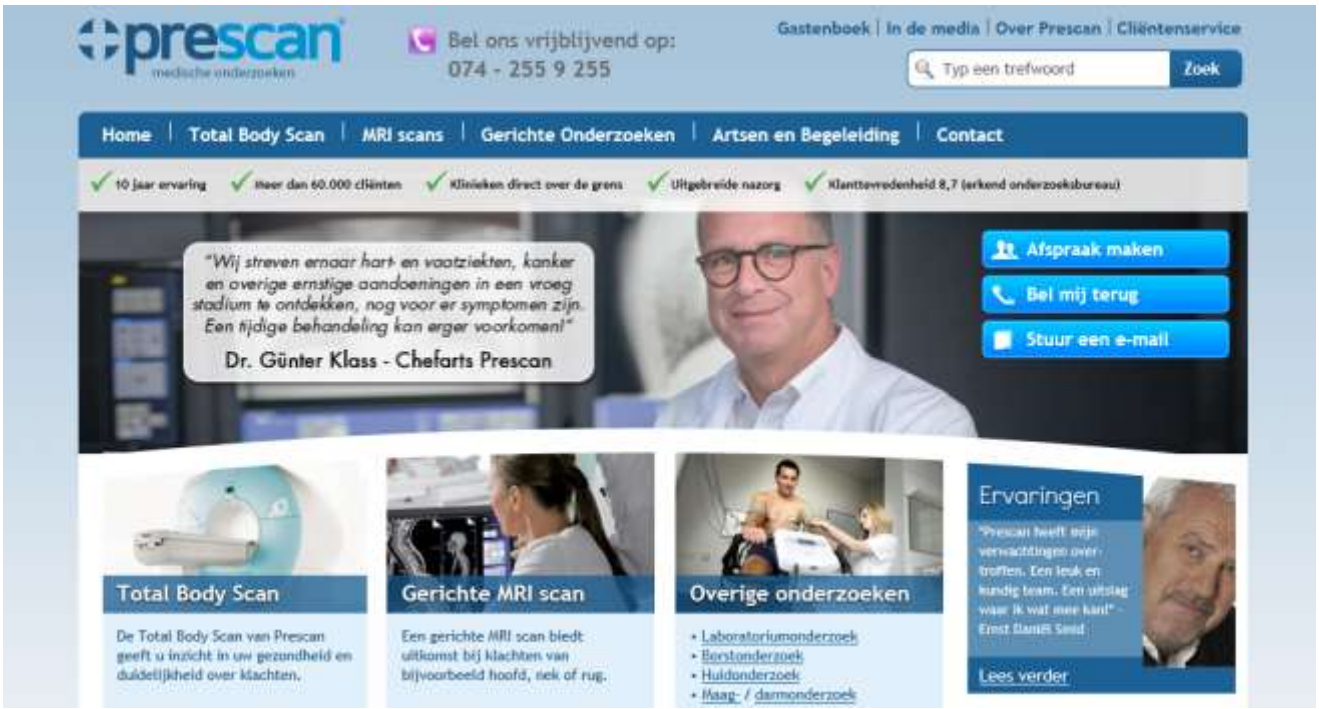
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Uitgebreide nazorg
Klanttevredenheid 8,7 (erkend onderzoeksbureau)
"Wij streven ernaar hart- en vaatziekten, kanker en overige ernstige aandoeningen in een vroeg stadium te ontdekken, nog voor er symptomen zijn. Een tijdige behandeling kan erger voorkomen!"
Dr. Günter Klass - Chefarts Prescan
Afspraak maken
Bel mij terug
Stuur een e-mail
Total Body Scan
De Total Body Scan van Prescan geeft u inzicht in uw gezondheid en duidelijkheid over klachten.
Gerichte MRI scan
Een gerichte MRI scan biedt uitkomst bij klachten van bijvoorbeeld hoofd, nek of rug.
Overige onderzoeken
• Laboratoriumonderzoek
• Borstonderzoek
• Huidonderzoek
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Assignment 6: The economics of (un)healthy behaviour

Susan, George, Mike and Josh are having dinner. Well dinner….They are having French fries and double hamburgers with extra bacon, chocolate cake for dessert and beer and wine and some cigarettes in between.

Just before desert, Ken joins them. Ken, who is Josh's roommate, just returned from his third fitness class this week.

"Hello Pal. Do you want a hamburger and a beer? You must be hungry after so many fitness exercises". "No, thank you, I don't like junk food and alcohol", Ken replies. "O, you're one of those health freaks, aren't you? You probably are one those persons who favours a 'snack-tax' or who likes the idea that people who eat fa(s)t food, should pay higher health insurance premiums".

"Well", Ken argues, "Partly, I do. Comparable to alcohol and smoking, also fa(s)t food should be taxed: obese people have more health problems. This increases the costs for society, leads to productivity losses and raises health care costs. For this should pay! At least such a tax will function as an incentive to develop a healthier life-style and prevent further harm".

Josh disagrees with this argument. Since smoking, drinking and eating are usually addictions; often people do not have a choice. Why then, should they be taxed or face control policies or other costly interventions? Which benefits are expected from this? Wouldn't it be better to stimulate prevention? Mike disagrees with the last argument: Prevention is also costly and has unsure benefits. Moreover, there are different factors that determine whether or not people opt for prevention. "I wouldn't even go to fitness if they paid me for it. So whether stimulating prevention is better than taxing unhealthy behaviour is still an open question to me".

George raises his eyebrows and hopes that the others don't start with a long discussion again. He would like to have a nice piece of chocolate cake right now! Be it good for his health or not!

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Assignment 7: Does the financial crisis influence public health?

Mathijs van Dijk, Endowed Professor of Financial Markets at Rotterdam School of Management, Erasmus University (RSM) held his inaugural address, entitled "The Social Value of Finance", on Friday, 7 March 2014. The topic of Professor Van Dijk's address was the value for society of finance as an academic field as well as the value for society of finance in the sense of a financial system (that is, banks and financial markets). He argued that average life expectancy declines by nine months in the six years after the start of a financial crisis.

Professor Van Dijk presented the results of new research on the impact of financial crises on society, aiming to help all stakeholders to better understand and deal with the societal consequences of financial crises. In his address, he explained that this impact goes far beyond well-known economic consequences such as reduced economic growth and increased unemployment. In particular, his research suggests that the health of the population of a country deteriorates significantly in the aftermath of a banking crisis. Most notably, average life expectancy tends to decline by around nine months in the six years following a crisis. Other aspects of society are also affected: primary school enrolment drops by 3.5% and fertility falls by 5.5%, but adolescent fertility rises by 4.5%. Less-developed countries are most vulnerable to the effects of financial crises.

Stress levels

Using data on 187 banking crises in 126 countries from 1970 to 2009, Professor Van Dijk finds that financial crises can have adverse consequences on people's health. He will argue that one of the potential underlying causes is an increase in stress levels as indicated by a higher incidence of cardiovascular disease, increased suicide rates and increased addiction to alcohol and drugs. Similarly, Van Dijk finds a considerable increase in HIV prevalence. In the wake of a financial crisis, people also tend to eat less healthily and there's an increase in poverty levels, especially in less-developed countries. Another likely cause of the health effects is that government budgets come under pressure in times of financial crises; budget cuts often affect government spending on healthcare, which may harm the availability and quality of healthcare. In addition, private spending on healthcare tends to decrease, for example because people postpone visiting the doctor.

Fertility

Other health effects include a considerable decrease in average fertility, measured in births per woman, but a marked increase in adolescent fertility by 4.5% relative to the global average, which is 62 births per 1,000 women aged between 15 and 19. Reducing adolescent fertility is one of the Millennium Development Goals formulated by the United Nations.
Van Dijk also argues that financial crises can affect education, especially in less-developed countries, with primary school enrolment decreasing 3.5% during the six years after a crisis. This suggests that parents keep their young children out of school in times of crisis, perhaps to save money or to let them help in making a living.

When distinguishing between different groups of countries, Van Dijk finds that the impact of a banking crisis on economic growth and unemployment is at least as large for developed countries as it is for less-developed countries, but less-developed countries bear greater social costs.

Investigating the development of social indicators around financial crises broadens our understanding of how societies are affected by such crises, says Van Dijk. A better understanding of which parts of society are hit hardest by financial crises will help governments to develop policies to alleviate their societal impact. The goal of Van Dijk's research in the coming years is to help people and policy makers to better understand and deal with the societal consequences of financial crises.

Source: http://www.erim.eur.nl/centres/finance-group/news/details/3395-inaugural-address-the-social-value-of-finance/

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Assignment 8: From genome to public health

The Dean of the Faculty of Health, Medicine and Life Sciences (FHML) is discontent with the food served in the cafeteria at UNS 40. He has asked his experts from the research school Nutrim for advice. The results are presented to all relevant stakeholders. In a public hearing, Professor Heinz, expert in internal medicine, suggests stopping serving fried dishes; he proposed instead to use fresh ingredients with olive oil. Professor McCain, a newly hired expert in nutrigenomics, warns the Dean and asks him not to follow the advice. He claims that olive oil is very healthy for 90 % of the Dutch population, but would create substantial health risks for the remaining 10%. Due to the interaction between the genome and the food, the risk for hypertension and stroke might be increased in this group. Assistant Professor Schmidt, from the department for Public Health Genomics, is aware of this issue. She claims that the whole confusion is caused by the delayed translation of genome-based knowledge into Public Health interventions. FHML has students and employees from 120 countries and no study has been conducted which assesses the effects on such a genetically heterogeneous group. She proposes to do such a study with the students of FHML as a cohort. Pim, a student, argues that students are happier if they are allowed to eat fries and other fried food. He assumes the happiness has also positive effects on the health of students. Marta, a PhD candidate from Spain who spends a year in Maastricht, suggests that all students and employees should undergo a genetic test which clarifies their genetic constitution. People from the 10 % group should be forbidden to eat the olive oil food and should be served an alternative. Karla, a cook at the cafeteria, argues that fried food is cheaper to produce and that the cafeteria would have to raise prices.

At the end of the hearing the Dean is very frustrated. He asks you, his Food Policy Advisors, for advice how he should decide. He feels UM needs a new food policy which takes the latest evidence from science into consideration. He is afraid UM gets into trouble if the food puts students or employees at risk. Please discuss a new food policy for the cafeteria at UNS 40.

Background information

Public Health Genomics (PHG) is an emerging translational multidisciplinary research field which builds on the expertise from various sciences and research networks, whose final aim is integrating the genome-based knowledge in a responsible and effective way into public health. Due to its multidisciplinary approach Public Health Genomics is ideal to stimulate the cooperation and collaboration amongst scientists from different backgrounds. It is also a field which works on the well-known bottlenecks of translational research. In a meeting in 2005 at the Rockefeller Foundation in Bellagio, PHG has been defined as**:** “The responsible and effective translation of genome-based knowledge for the benefit of population health.”

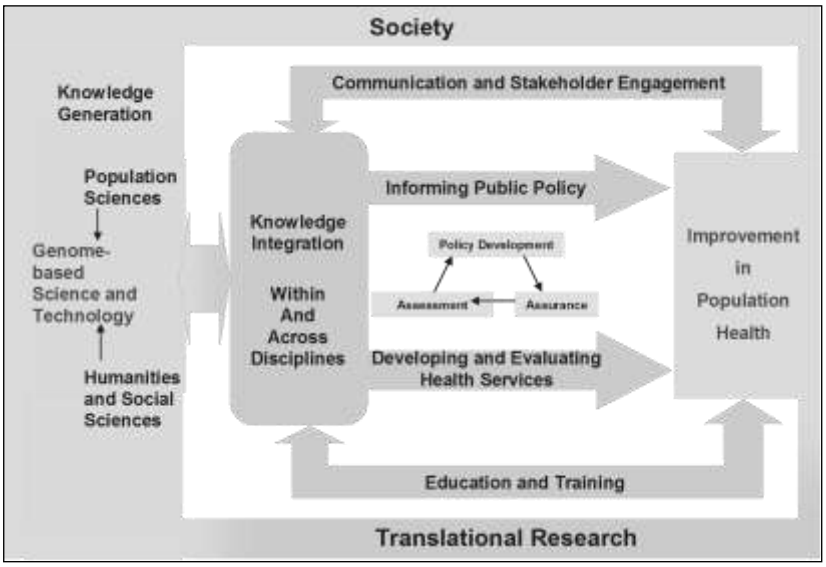

Figure 1 The Public Health Genomics Enterprise (according to the 'Bellagio' Model). The figure displays the core tasks of PHG between the "Knowledge Generation" and the overall goal "Improvement in Population Health". (Source: Bellagio Statement, 2005).

The integration of genome-based knowledge into Public Health requires different steps:

(a) *Informing public policy*. 'Policy' here includes a variety of public policies and programs. Activities include legal, philosophical and social analysis at an applied level; development of regulatory frameworks; engagement in the policymaking process; promoting relevant research; seeking international comparisons; and working with governments.

(b) *Developing and evaluating health services – both preventive and clinical*. This activity includes development of policies, programs and services in the health sector; strategic planning; service organisation, manpower planning and capacity building; service review and evaluation; and guideline development.

(c) *Communication and stakeholder engagement*. Relevant activities include public dialogue; 'marketing' the enterprise; and engaging with industry, which is seen as a key player in the development of new genomics-based clinical interventions.

(d) *Education and training*. This will involve promoting programs of genetic literacy for health professionals and generally within society; specific training for public health genetics specialists; and development of educational materials, courses, workshops and seminars (Bellagio Statement, 2005).

The concept of Public Health Genomics builds on the Lalonde Model from 1974 which introduced the field of genetics / genomics to the Public Health domain.

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