**REFLECTIONS FROM UK PUBLIC HEALTH NETWORK SUMMIT 21 OCTOBER 2019**

1. **REFRAMING THE CONVERSATION ON PUBLIC HEALTH**

* Two aspects of communication were considered, that of how well the public understands health and how a section of the public perceives regulations.
* Evidence does not always speak for itself and often requires “heroic leadership” to bring it to public attention – as has happened with climate change. Public understanding of health presents a particular challenge since this is frequently viewed in negative terms as an absence of disease. Public understanding of factors affecting health are also often viewed as personal choices or genetics. Key insights from focus group work suggests that public health communications should:

Avoid acknowledging individual behaviours – people hear this as confirmation and do not hear the rest of the message.

Use the language of an emergency instead of a crisis in order to encourage action in place of paralysis.

Use words with a clear meaning – “education” for instance is heard as “education-about-being-healthier” and not attainment.

Explain the links between each determinant of health so that people are clear how education affects employment that has an impact on housing etc.

* Regulations can be perceived as helpful, providing they are pitched to an audience in the right way. Focus groups proved supportive of 1) regulations that protected them because they felt safe, 2) regulations that stopped others from doing something harmful because this supported individuals’ own high standards and protected the community, 3) regulations that stopped themselves from doing something because it supported self-control. Providing truthful explanations of the reasons for regulation mitigated negative reactions of feeling patronised or oppressed – for example the restriction on taking photos of their children in school was understood once explanations were given that it is to protect other children who might be at risk of abuse.
* Discussion considered:

1. How the public health community could think itself into the mindset that made “take back control” so effective and come up with an equivalent phrase.
2. The need for a set of communication principles by which the public health community can operate consistently and improve the choice of language.
3. The potential for speaking about regulation differently, using a call to fairness, public interest in being community-focussed, emphasising the sense of opportunity for improvement rather than the language of a ban, and appealing to “the angel on your shoulder” when it comes to regulations that might stop people from doing something.
4. **REFRAMING PUBLIC HEALTH POLICY**

* Two examples were considered, that of New Zealand’s wellbeing budget and work by The King’s Fund on framing population health.
* New Zealand developed its living standard in 2011, based on four markers of future wellbeing: natural capital; human capital; financial and physical capital; and social capital. A suite of 61 indicators is used to monitor how well people are able to use their resources in these areas and thus provide an indication of wellbeing. The 2019 budget focussed attention on: child poverty; family and sexual violence; work; Maori; climate; and mental health, with child poverty carrying specific, three-year targets. The aim is to increase cross-government working and longer-term thinking. Budget support for wellbeing initiatives only applies to new expenditure - currently 5% of the total budget - although new legislation is being considered to embed wellbeing in policy-making more generally.
* The population health framework was devised as a means of creating an inclusive approach to health. It aims to bring coherence to the health system. It identifies four pillars of wider determinants of health; our health behaviours; integrated health/care system; place and communities. The aim is to create balance between the pillars, identify what is happening locally and nationally, and determine what needs to happen at local, regional and national levels. This approach is helping NHS audiences to be more outward-looking and more focussed on achieving wellbeing of its population, but it requires local leadership to help shift thinking.
* Discussions considered:

1. Whether “wellbeing” is a more effective term than “health,” particularly as the public tends to explain health negatively as the absence of disease. “Wellbeing” is more aspirational, fits with a community / place-based approach and is already the language in Scotland and Wales. However, rather than finding one common definition of wellbeing, it may be more important to understand what it means to each department, local authority etc.
2. The need for a public health framework that sets out core goals for the public health system (for example on sustainable prosperity, social justice, and wellbeing), the way in which these should be communicated and how to gain traction with other sectors.
3. The need to fill the gap between interventions and policy action by investigating public support. Policy is based not just on evidence but on the things that matter most to people.
4. The value of measurement. Flawed measurements create the potential for policy actions to be flawed. Measuring wellbeing through GDP is problematic but, although there are alternative indicators, these are not an integrated dataset in the UK and a single measure has not been identified.
5. **WHAT HAVE WE LEARNED?**

* The language that public health currently uses is not reaching its audiences in the way that is intended. “Crisis” terminology may just panic people whilst “emergency” phraseology may help produce action. Acknowledging people’s views on personal responsibility is just gesturing and results in the message being diluted or not heard at all. Step by step explanations are needed on causal links.
* Some progress has been achieved by working more collectively; for example, the word “lifestyle” is no longer used by either the Association of Directors of Public Health or the Royal Society for Public Health.
* Influencing policy requires greater influencing of public opinion. This could be achieved through:

1. Learning from Scotland’s rights-based approach to exploit the concept of fairness more widely across the UK as a basis for talking about health inequalities and the factors that affect health.
2. Exploiting the protection / safety approach, using the example of not getting on a plane that had not gone through safety checks or the consequences of having insufficient workforce to enforce food hygiene standards.
3. Learning from the Wellbeing of Future Generations (Wales) Act to investigate whether “wellbeing” is more easily understood by the public than “health.”

* From a policy point of view, much is anticipated of New Zealand’s wellbeing budget but as it only applies to new spending, this is not going to be a panacea. However, it should encourage longer-term thinking and greater cross-government working.
* Explaining public health in economic language may be helpful, although using GDP to measure wellbeing is misleading because it does not measure the right things.
* Using the more inclusive approach of population health works at a local level, as it encourages people to see the health system as a whole and where they fit.
* If the public health community has to change its language, then it will have to do so consistently across all organisations in order to be effective.

1. **CONCLUSIONS**

* Consider a focussed debate on the language to use and not to use and establish a set of principles on public health language to create consistency of messaging.
* Map each organisation’s current contribution to reframing public health.
* Consider how better to capture the public’s voice in the public health system.
* Consider how the UK Public Health Network can facilitate further conversation on the topic.
* Investigate a public health framework to identify common language and cross-sector understanding of terminology.

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