This is a repository copy of *Public health and the NHS at 70: Fit enough for the challenge of new enemies in a new landscape? An example of public health measures to address alcohol consumption*.

White Rose Research Online URL for this paper:
http://eprints.whiterose.ac.uk/147351/

Version: Published Version

Article:

Campbell, F. orcid.org/0000-0002-4141-8863 and Lee, A. (2019) Public health and the NHS at 70: Fit enough for the challenge of new enemies in a new landscape? An example of public health measures to address alcohol consumption. French Journal of British Studies, XXIV. 3. ISSN 2429-4373

https://doi.org/10.4000/rfcb.4282

Reuse

This article is distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs (CC BY-NC-ND) licence. This licence only allows you to download this work and share it with others as long as you credit the authors, but you can’t change the article in any way or use it commercially. More information and the full terms of the licence here: https://creativecommons.org/licenses/

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

eprints@whiterose.ac.uk
https://eprints.whiterose.ac.uk/

Revue Française de Civilisation Britannique
French Journal of British Studies

XXIV-3 | 2019
The NHS at Seventy: Framing Health Policy in Britain

Public Health and the NHS at 70: Fit Enough for the Challenge of New Enemies in a New Landscape? An Example of Public Health Measures to Address Alcohol Consumption

La Santé publique et le NHS à 70 ans : Capable d'affronter le défi de nouveaux ennemis dans un nouveau paysage? Un exemple de mesures de santé publique visant à réduire la consommation d'alcool

Fiona Campbell and Andrew Lee

Electronic version
URL: http://journals.openedition.org/rfcb/4282
DOI: 10.4000/rfcb.4282
ISSN: 2429-4373

Publisher
CRECIB - Centre de recherche et d'études en civilisation britannique

Electronic reference
Fiona Campbell and Andrew Lee, « Public Health and the NHS at 70: Fit Enough for the Challenge of New Enemies in a New Landscape? An Example of Public Health Measures to Address Alcohol Consumption », *Revue Française de Civilisation Britannique* [Online], XXIV-3 | 2019, Online since 30 August 2019, connection on 04 September 2019. URL : http://journals.openedition.org/rfcb/4282 ; DOI : 10.4000/rfcb.4282

This text was automatically generated on 4 September 2019.

Revue française de civilisation britannique est mis à disposition selon les termes de la licence Creative Commons Attribution - Pas d'Utilisation Commerciale - Pas de Modification 4.0 International.

Public Health and the NHS at 70: Fit Enough for the Challenge of New Enemies in a New Landscape? An Example of Public Health Measures to Address Alcohol Consumption

La Santé publique et le NHS à 70 ans : Capable d’affronter le défi de nouveaux ennemis dans un nouveau paysage? Un exemple de mesures de santé publique visant à réduire la consommation d'alcool

Fiona Campbell and Andrew Lee

Introduction

1 Public health focuses on health at the population level, seeking to reduce disease by improving and protecting health. When the NHS was founded in 1948 the most common cause of premature death and disability were infectious diseases, predominantly tuberculosis and polio. These were successfully addressed with comprehensive vaccination and screening programmes. The landscape has changed and the most common causes of avoidable death today are non-communicable diseases: cancers and cardiovascular diseases (ONS 2017). Health and the social and environmental environment are intrinsically linked, and this is evidenced by the impact of policies directly addressing inequalities, leading to improvements in the health of the population and particularly the health of the poorest. Improving health by creating environments where healthy choices are easy choices brings it directly in conflict with the interests of big business. We will focus on one example, that of minimum unit pricing (MUP) a policy initiative that the UK government had committed to, but at the last minute the government withdrew its support for the policy.

2 Industry approaches have included challenging evidence from scientific communities by funding 'counter science', directly influencing policy makers through lobbying and financial incentives or gifts in kind, seeking partnership arrangements with government bodies and direct legal challenge. Increasingly, those who seek to promote and protect health will need to be equipped with improved scientific literacy in order to be able to critically appraise and challenge information from all stakeholders, including industry. Contemporary public health academics have to be able to communicate across boundaries and package evidence in ways that policy makers can understand and access and there may need to be less naivety about the priorities and methods adopted when dealing with industry. Perhaps public health academics could learn to adopt strategies used by the most effective lobbyists in order to better disseminate and promote their academic outputs.

Founding principles of the NHS

3 The advent of the UK National Health Service (NHS) which came into effect in 1948 saw a monumental shift in British health policy and has influenced attitudes and expectations of health care provision ever since. The NHS made access to health care a fundamental human right, rather than a commodity to be purchased. Health care, free at the point of delivery, was radical in its ideology and its consequent impact on British society and population health, particularly for the poor for whom access to health care had been limited or unobtainable. The passage of the Act of Parliament that would invoke the NHS was contested and there was strong opposition to the idea of 'state medicine' (Seaton, 2015). Opposition came not least from the medical profession for whom it threatened a loss of income and autonomy, bringing doctors 'into the position of the civil service as full-time officers'. As Aneurin Bevan, the then Minister for Health, argued, 'A free health service is a triumphant example of the superiority of the principles of collective action and public initiative against the commercial principle of profit and greed (Bevan 1952). Opposition to the NHS continues, frequently portrayed in the media as being in a state of crisis and its ideological position challenged for limiting the involvement of the private sector in health care. Despite episodes of negative publicity, and opposition from those who seek a greater role for the private sector in health care public support for the institution has remained resolute over seven decades (Robertson et al 2019).

4 Public health, which seeks the improvement and protection of health over and above the treatment of disease, has been an important part of the NHS's role. The past 70 years have seen the health of the population in the UK go from an era where polio and TB caused premature death and disability on a large scale to one where free comprehensive vaccination and screening programmes have helped to prevent and detect these diseases. Improvements in health care, and rising standards of living have resulted in huge improvements in population health; life expectancy substantially rose from 66.4 years for men and 71.5 years for women in 1951, to 79.2 years for men and 82.9 years for women in 2017 (ONS 2017). Today, the major causes of premature death and morbidity are no longer the infections that reduced life expectancy in 1948. Instead, in the UK today non-communicable chronic diseases predominate: cancers and cardiovascular diseases and respiratory diseases are the main causes of death and disease (ONS 2017). Of note, many of these conditions are considered avoidable and are linked to unhealthy lifestyles and behaviours: 26% of adults are obese (Government Statistics Service 2018), 39% of adults

are physically inactive (British Heart Foundation 2018), 15% of adults still use tobacco (ONS 2017), and 31% of men and 16% of women drank alcohol above safe drinking limits (National Statistics 2018). Whilst people may live longer, they live in poorer health for longer, usually with multiple health conditions, and have a greater need for health and social care support (Barnett et al 2012).

5 However, in some respects the NHS has been a victim of its own success. Over the years, the range of health services and treatments afforded to the public have continued to expand. In turn this led to massive inflation of healthcare costs that successive governments have struggled to control. Rising demand for services, an ageing population and changing sociodemographic trends, as well as the rising costs of drugs and new treatment modalities continued to add pressure on limited healthcare budgets. Productivity and efficiency in health services became the key priorities in recent decades, especially following the economic crisis in 2009. Consequently, contemporary healthcare commissioning priorities have focused on managing this demand and costs, leading to an emphasis on issues such as cost effectiveness of therapies, value for money of services, and return on investment arguments (Lee et al 2012).

6 Belatedly, policymakers have attempted to refocus on population health outcomes and their determinants. This represents a shift away from just managing patient demand, waiting list and budgets. The NHS is increasingly seeking to help prevent conditions developing or to detect conditions early. Prevention was one of the three core themes in the NHS policy document, *NHS Five Year Forward View* (NHS, 2014), and is central to a new long-term plan for the NHS that is being currently implemented. In 2018, the Government set out prevention as one of three priorities for the health and social care system, followed by the release of the Department of Health and Social Care policy document 'Prevention is better than cure' (DHSC, 2018) and the Chief Medical Officer's annual report for England on 'Better health within reach' (Davies, 2018). The NHS England 'Long Term Plan', published a few weeks later included an entire chapter on prevention. This policy document also recognized the wide disparities in health that need to be addressed such as access to services by traditionally marginalised groups such as those with severe mental ill-health or learning disabilities.

Social determinants of health inequalities

7 Despite the aspirations for the founding of the NHS, which sought to provide comprehensive and equitable accessible health care based on clinical need rather than ability to pay, it is evident in the 70 years that followed that the provision of health care has not led to equity in the experience of health, ill health and access to health care. Differences in mortality and morbidity between social classes are well-documented (Townsend et al 1986, Whitehead and Drever 1997, Pickett and Wilkinson 2015). For example, there are significant differences in maternal, infant and child mortality between social classes (BMA 1999). The infant mortality rate (IMR), defined as the number of deaths under the age of 1 per 1000 live births, can be seen as a proxy for the health of a population (Reidpath et al 2003). The IMR is almost a fifth higher than the national average, in families where parents were in manual occupations (Dorling et al 2007). Children in social class V are five times more likely to suffer accidental death compared with those in social class I (Towner 2005)[1]. Children of unemployed parents are 13 times

more likely to die of external causes and injuries that those born in the top social class (Edwards et al 2006)

8 The ONS (Office for National Statistics) in 2019 reported that the life expectancy of women living in the poorest areas of England had fallen by 100 days in recent years. Between 2012-2014 and 2015 -2017, female life expectancy in the richest areas increased by 84 days, widening the gap between rich and poor by half a year. In men, the gap also widened but less dramatically. This marked an end to improvements in life expectancy seen since 1980. While the causes are contested, it is noticeable that these changes have coincided with the most prolonged and extreme austerity measures implemented since the 1930s. It reveals a growth in inequalities, where the gap in life expectancy for women living in the most and least deprived areas in England have widened to 7.5 years.

9 Health inequalities demonstrate the complexity of public health that is determined not only by health care provision, but is also influenced by powerful socioeconomic factors. Indeed, good health care is said to account for as little as 10% of a population's health and wellbeing (Pye 2018). The health behaviours and lifestyle choices that individuals make are shaped and informed by the social, cultural and environmental factors in which the individuals are embedded. Therefore tackling the causes of today's diseases necessitates addressing those lifestyle choices and behaviours and the wider factors that influence them. This however brings the commercial interests of corporations and industry and public health into direct conflict. The endeavours to protect and improve public health, particularly the health of the poorest, often clash with the commercial interests of industry and big business. Through the sale and promotion of tobacco, alcohol and ultra-processed food and drink transnational corporations are major drivers of global epidemics of non-communicable diseases (Moodie et al 2013). These corporate disease vectors implement sophisticated campaigns to undermine public health interventions. Industries' methods to affect public health legislation and avoid regulation with both hard power (building financial and institutional relations) and soft power (influencing culture, ideas and cognition of people, advocates and scientists) have been exposed with the release of industry documents as a result of tobacco and asbestos litigation (Lilienfeld 1991). The food, drink and alcohol industries use similar approaches to those of the tobacco companies in an effort to maximize profits and in so doing undermine public health interventions (Bond et al 2010). We are going to explore this in more depth by an examination of the way the alcohol industry has sought to undermine a specific intervention to address the effects on alcohol harm on the population in the United Kingdom.

Case Study of the Alcohol Industry vs. Public Health

10 The clash between public health and the interests of industry is very starkly exemplified by the alcohol industry's efforts to contest policies that promote health at the potential expense of industry profits.

11 Harmful use of alcohol is a causal factor in more than 200 disease and injury conditions (World Health Organization, 2005). Long-term alcohol use causes several diseases including alcoholic liver disease and encephalopathy, and increases the risk of many chronic disorders such as oesophageal cancers. Acute episodic consumption is associated

with acute adverse events such as road traffic accidents, falls and assault (Rehm et al., 2009).

12 The true impact of alcohol on the health of individuals and the wider community is difficult to estimate because of the many effects resulting from alcohol use (Gakidou et al., 2017). The cost of alcohol on public health is so significant that reduction in its consumption is an important global health goal, contributing to around 5% of the global burden of disease, disability and death (WHO, 2018). The resulting disease burden affects the quality of life for drinkers and their families and consumes substantial health care resources. Alcohol-related harm has a direct impact on the NHS, requiring therapeutic services for alcohol poisoning and addiction, and through wider consequences such as domestic and street violence. One study from Newcastle found that alcohol played a role in between 12% and 15% of those cases presenting for attention in A&E (Parkinson et al 2015 published in ch 3 McCartney 2016). In England the total yearly cost of alcohol related harm to the NHS was estimated at £2.7 billion in 2006/07 prices (Bhattacharya 2016). It is also estimated that in the UK, the annual cost to the economy of alcohol-related harm is £21 billion per year.

13 The factors that drive alcohol consumption are complex and interconnected: psychological, behavioural, social, economic, legal and environmental factors. These factors operate at the individual, community and population levels and are shaped by the actions of local and national governments, by consumers, and by alcohol industry practices (Petticrew et al 2017).

14 Interventions to reduce consumption of alcohol used in the UK have typically included education, screening and advice to people with harmful or hazardous drinking patterns, improved labelling of products, and recently the introduction of minimum unit pricing. The alcohol industry has countered this by advocating for the protection of maximum personal freedoms. It has also actively opposed interventions that work at a population level and those that 'make healthy choices, easier choices' (WHO). This was also the case for the policy of 'minimum unit pricing' and it serves as our example of how industry responds to policies that improve public health but may harm their profits.

15 In order to design and implement effective interventions, it is important to understand the factors that drive consumption. Focusing attention only at the individual level will have limited impact as it ignores the wider factors that also influence consumption. This includes understanding the ways in which the alcohol industry seeks to influence consumption by directly influencing policy, regulation and legislation. Their extensive financial resources, and the addictive nature of their products have enabled them to influence policies at the expense of public health in a number of ways. These include:

Direct and indirect lobbying of politicians and policy makers
Undermining scientific evidence
Legal challenge
Seeking partnership status with government agencies (Hawkins et al 2015)

16 We will explore how industry and corporations have responded to a policy initiative, minimum unit pricing (MUP), that has been shown to reduce alcohol harm and inequalities in health. Minimum unit pricing (MUP) of alcohol is a novel public health policy that seeks to reduce the adverse public health consequences of alcohol consumption (Katikireddi et al 2014). The policy links the price of wine, beer, cider and spirits to their alcoholic strength where a planned minimum price per unit would mean that low cost, high strength and cheap spirits would rise in price. This policy is expected

to not only lead to fewer deaths, hospital admissions and crimes every year, but also reduce inequalities, as it is the very cheapest alcoholic beverages that are disproportionately bought and consumed by the heaviest drinkers (Holmes and Meier 2017).

Direct and indirect lobbying of politicians and policy makers

17 Corporate lobbying of politicians and policy makers on the issue of minimum unit pricing used a wide range of methods, mirroring many of the direct and indirect approaches of the tobacco industry to influence policy at all levels of government (Hawkins et al 2012; McCambridge et al 2013). One integrative review that examined documentary evidence and interview studies described lobbying in the UK between 2007-10 by alcohol industry actors. The dominant approach used was to nurture and sustain long term relationships with policy makers, within which subtle forms of influence were exercised (McCambridge et al 2013). David Cameron, before becoming UK Prime Minister, said: 'We all know how it works, the lunches, the hospitality, the quiet word in your ear, the ex-ministers and ex-advisers for hire, helping big business find the right way to get its way' (cited in McCambridge et al 2013). The lobbyists from the alcohol industry had considerable access to policy makers, across all political parties and at all levels through a range of different channels, including party conferences and Parliamentary All-Party Groups. They were widely consulted and had access to policy makers at all stages of the policy making process.

18 Gornall's (2014) investigation into the role of the alcohol industry in influencing policy on minimum unit pricing found that the industry enjoyed far greater access to government departments than what was given to representatives from the health community. He also found that it was very easy for industry to build relationships because Members of Parliament (MPs) with constituency interests in alcohol companies as employers were advocates themselves on behalf of the industry. For example, the largest of the 472 All-Party Parliamentary Subject Groups is the Beer Group. Gornall (2014) describes how at the annual dinner for the Beer Group in Westminster, just three days before the announcement that minimum pricing was dead, the Chancellor George Osbourne was named Beer Drinker of the Year for his decision in the Spring Budget to scrap the beer duty escalator and to take a further 1p off beer duty (Gornall, 2014).

Undermining scientific evidence

19 Consumers of research findings, including policy makers, are unlikely to have either the time or the resources to undertake the critical appraisal that may be necessary to evaluate contradictory research evidence. A simple look to establish who funded the research evidence, while useful, may not always be evident. Tobacco and alcohol companies have recruited scientists to provide critiques with the purpose of sowing seeds of doubt regarding the validity and reliability of research that supports healthy public policies, such as traffic light labelling of unhealthy food (Sacks et al 2011). By using seemingly credible sources, such as doctors to undermine research creates a climate of doubt and this is further exploited to influence policy (Moodie, 2013).

20 One such example was the response of the alcohol industry to an economic model produced by the University of Sheffield's alcohol research department that had reviewed

existing data and modelled the health and social effects of raising alcohol prices. As early as 2008 the researchers in Sheffield had shown that the higher the minimum price, the greater the positive effect on alcohol consumption and health harms with relatively small effects on tax and duty income for the Treasury. It is a policy which has been shown to have a strong association of a beneficial effect on both citizens and the health service. This was through the potential to improve the health of the poorest in society. It is indeed rare to find such an effective policy that can directly reverse the pattern of health inequalities.

21 However, the findings were challenged by the Adam Smith Institute, a right-wing think tank and opponent of 'big government...regulating businesses [and] and interfering with lifestyle choices' with a long record of resisting regulation on behalf of the tobacco industry (Gornall 2014). They published a counter-report 'Minimal Evidence for Minimum Pricing' (Duffy & Snowdon, 2012) and declared the predictions based on the Sheffield alcohol policy model as 'entirely speculative and do not deserve the exalted status they have been afforded in the policy debate'. Another right wing think tank the Centre for Economics and Business Research, also attacked minimum pricing as a 'poor piece of policy that will do little to address the damage caused by alcohol misuse and much to exacerbate the financial challenge facing moderate drinkers on lower incomes'. The report was commissioned by SABMiller, a multinational brewing and beverage company (cited by Gornall 2014).

22 Another strategy adopted by industry are attempts to not only generate doubt regarding the reliability of non-industry sponsored research evidence but also deliberately seek to shape the evidence base itself. There are examples from the food industry where several food companies such as Mars Inc., Nestle, Barry Callebaut and Hersheys, who are amongst the world's biggest producers of chocolate, have funded research studies exploring the health benefits of cocoa. 98% of all studies funded by Mars have been shown to have a beneficial effect on health, and findings have made newspaper headlines claiming the health benefits of chocolate, that are purported to reduce and even reverse age-related cognitive degeneration, promote weight loss and lower blood pressure (Sokolov et al 2013, Bohannon et al 2015, Grassi et al 2005). Claims that chocolate could reverse cognitive decline were based on the findings of a study published in Nature Neuroscience (Brickman et al 2014). Not only was the study very small (n=37) but it was also only 3 months in duration, an insufficient duration to base claims that it might reverse cognitive degeneration. The study was also vulnerable to risk of bias, because it undertook 'outcome switching', a practice where the outcomes that are more favourable to the intervention get described in the published results. The resulting bias (selective reporting bias) is likely to distort the truthfulness of the findings. A Cochrane Review of the health benefits of cocoa in reducing blood pressure (Ried et al, 2012) concluded that the funding source of the trial influenced heavily the direction of the findings, heavily favouring the benefits of cocoa over an alternative.

Legal challenge

23 The effectiveness of industry at influencing policy is demonstrated in the case of attempts at setting a minimum alcohol price which the industry vigorously contested to preserve their commercial interests that conflicted with the interests of public health.

24 In 2012 and 2015, the governments of England and Wales set out plans to introduce minimum unit pricing. While the Prime Minister David Cameron acknowledged it might not be popular, he made a commitment to introducing it as "it was nonetheless the right thing to do" (Gornall 2014). In what was described as "an extraordinary U-turn", on the last day before the summer recess, the commitment was withdrawn.

25 In 2012 Scotland passed the necessary legislation with cross-party support to introduce a minimum unit price for alcohol. However, the initial legislative success was followed by a five-year legal battle with alcohol industry trade bodies. At the heart of the case was the question of whether the policy met the stipulation in EU law that public health policies restricting the free movement of goods must be appropriate to meet their stated aims and that there these aims cannot be achieved through existing measures that are less restrictive of free trade. The case went through the Scottish Outer House Court of Sessions (2012-13), followed by appeals to the Scottish Inner House Court of Sessions (2013-16), a referral to the European Court of Justice (2014-15) and finally an appeal to the UK Supreme Court (2016-17) which dismissed the industry's case. Scotland was the first nation globally to introduce a minimum unit price in 2018 (Meier et al 2017). It is estimated that for every year that that implementation was delayed at least 1,600 hospital admissions could have been avoided (Scottish Government Minimum Unit pricing cited by McCartney 2016)

Seeking partnership status with government agencies

26 Another strategy of the alcohol industry in recent years has been to position themselves as key partners with government agencies working to achieve policy goals of reducing alcohol-related harms (Casswell 2009, Hawkins et al 2012). This role includes providing information and expertise to officials, as well as policy delivery by undertaking various regulatory and governance functions (Adams et al 2010). By becoming embedded in the policy process as partners they can oppose and avoid effective health regulation as well as promote voluntary codes and partnerships with government.

27 Whilst these may appear on the surface as mutually beneficial arrangements, with industry sharing the burden of service provision with government, there is no evidence that these partnerships are effective. Indeed, the evidence suggests that these partnerships increase positive perceptions of the sponsors and the behaviours in question (Smith et al 2006). Paradoxically, the attitudes to the behaviours, rather than being challenged, are reinforced instead by these partnerships (Pettigrew et al 2016). Industry attempts to frame issues and influence agendas in order to shape their outcomes, and it is argued that they have been given too great a role in the development and implementation of alcohol policy (Baggott 2006, Baggott 2010).

28 Further evidence of the negative impact on public health of voluntary agreements and codes of practice with industry can also be seen through the UK government's partnership with the tobacco industry which continued for most of the second half of the century. It resulted in some of the tobacco industry's most impactful advertising campaigns, led to the delay in the introduction of comprehensive smoke-free legislation and the misleading promotion of low tar cigarettes as a healthier option (Gilmore 2018).

29 In 2018, in a development that has caused concern and opposition, Public Health England (an executive branch of the Department for Health and Social Care responsible for public health in England) entered into a partnership with DrinkAware, an organisation funded

by the alcohol industry. The partnership shared a campaign of 'Drink Free Days' that drew considerable criticism from public health practitioners and academics nationally (Petticrew et al, 2018). In an open letter, public health scientists argued that the partnership would undermine the reputation of and trust in PHE to provide impartial, evidence-based advice. Such a partnership was seen as incompatible with PHE's remit especially when the alcohol industry had a well-documented history of seeking to undermine public health science and reduce its influence on policy (McCambridge et al, 2014). It is the concerns with regards to the considerable risks of such partnerships, and the lack of evidence of their effectiveness, that has led the World Health Organisation to publicly state that it will not engage with the alcohol industry when developing policy or implementing public health measures (Torjesen 2019).

Ways forward

30 Health systems are inherently complex. Health itself too is complex with multiple determinants, of which socioeconomic factors are powerful. Individual behaviours are highly influenced by other actors and agents in society including industry. While access to good health care is important, it only accounts for as little as 10% of a population's health and wellbeing. A rising proportion of the UK population live with long-term conditions and the NHS spends considerable resources treating people with conditions that are the consequence of various social determinants. As Michael Marmot stated: 'Why treat people and send them back to the conditions that made them sick?' There is a significant mismatch between the multiple drivers of ill health and what the NHS is designed to deliver. If we truly want to improve population health and at the same time manage demand on healthcare services, we will need to address behavioural and lifestyle issues as part of disease prevention. So how does the NHS face the challenges of preventing and reducing the morbidity and mortality of lifestyle-related diseases when the policies that are needed bring the interests of public health directly into conflict with the interests of industry?

31 There is a clear need for health to be a priority across government departments and not just confined as the remit of the Department of Health. The impact of policies on health need to be considered by the Departments concerned with business, education, culture and the environment, i.e. 'health in all' policies. Cross-departmental working will allow conflicts of interest to be better understood and policy goals in terms of health outcomes to be prioritised. There is also evidence that policies targeting the reduction of health inequalities have, when measured over the longer term, led to improvements in health and reductions in health inequalities (Robinson et al 2019). There is no evidence that supports partnering with industry to pursue public health benefits. Indeed, such partnerships may be damaging to public health and there needs to be less naivety by policy makers of industry motives and the impact of their activities. Going forward, independence and transparency of reporting and declaration of all conflicts of interest in the shaping of policies and campaigns is critical (Hessari et al 2019).

32 There are no easy answers, and policymakers will need considerable skill and expertise to manage the multitude of considerations and to recognize the influence of various stakeholders. Key to better policymaking is the need for it to be informed by robust evidence. Policymakers need better scientific literacy in order to be able to critically appraise the information they receive from various stakeholders including industry, the

health professions and academia. Also needed are efforts to address existing evidence gaps and to focus the basis of policy discussions on the evidence. Academics are well placed to help bridge this gap as well as to facilitate and inform policy discussions. They will need to generate 'demand for evidence' by policymakers and promote its value to them over and above industry concerns and interests. This will require academics to learn to package the evidence better in a form that policymakers can access, understand and use. Arcane academic pieces are all too easily ignored.

33 If the NHS is to have a future, the demands upon it need to managed, its resources are finite and will always outstrip supply. Prevention is key to managing demand and to avoid ill health taking a toll on British lives as well as on its health services. However, prevention is not the sole domain of the health services but includes wider stakeholders such as local authorities who were statutorily tasked with prevention through the *Health and Social Care Act, 2012*. Effective disease prevention will require collaborative efforts to implement evidence-based policies that will improve population health that are likely to run counter to the strong vested interests of the food, alcohol and tobacco industries.

34 The NHS today is larger, older and more complex than when it was first set up. It remains vulnerable against the powerful actions of industries and businesses that are driven by profit who pay little heed and experience no consequence arising from the ill-health they generate in society. The NHS risks being a passive victim of circumstance. We need an NHS that is older and wiser that is able to robustly confront the key drivers of avoidable death and disease today. Public health leadership both from within the system but also in collaboration with wider stakeholders are needed, but it is unclear thus far where this will spring from.

35 **Andrew Lee is a Reader in Global Public Health at the University of Sheffield whose interests are in health inequalities, public health and health management. He is also a local director of primary care and population health in the National Health Service in the UK and a practicing primary care clinician.**

36 **Fiona Campbell is a Research Fellow at the University of Sheffield. She has an expertise in evidence synthesis to support decision making in health care and policy making and interests in public health, maternal and child health and nursing.**

BIBLIOGRAPHY

Adams, P. J., Buetow, S., & Rossen, F. J. A. (2010). Vested interests in addiction research and policy poisonous partnerships: health sector buy-in to arrangements with government and addictive consumption industries. *105*(4), 585-590.

Baggott, R. (2006). *Alcohol strategy and the drinks industry: a partnership for prevention?* : Joseph Rowntree Foundation.

Baggott, R. (2010). *Public health: policy and politics*: Macmillan International Higher Education.

Barnett, K., Mercer, S. W., Norbury, M., Watt, G., Wyke, S., & Guthrie, B. J. T. L. (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *380*(9836), 37-43.

Bevan, A. (1952). *In Place of Fear*: William Heinemann.

Bhattacharya, A. J. A. (2017). Which cost of alcohol? What should we compare it against? *, 112*(4), 559-565.

Bohannon, J., Koch, D., Homm, P., & Driehaus, A. J. G. J. o. M. R. (2015). Chocolate with high cocoa content as a weight-loss accelerator.

Bond I., Daube M., Chikritzsh T. (2010) Selling additions: similarities in approaches between Big Tobacco and Big Booze. Australas Med J, 3, 325-32

Brickman, A. M., Khan, U. A., Provenzano, F. A., Yeung, L.-K., Suzuki, W., Schroeter, H., . . . Small, S. A. J. N. n. (2014). Enhancing dentate gyrus function with dietary flavanols improves cognition in older adults. *17*(12), 1798.

Casswell, S., & Thamarangsi, T. J. T. L. (2009). Reducing harm from alcohol: call to action. *373* (9682), 2247-2257.

Casswell, S. J. A. (2009). Alcohol industry and alcohol policy—the challenge ahead. *104*, 3-5.

Davies, S. C. (2018). Annual report of the Chief Medical Officer 2018: health 2040 - Better health within reach. Accessible at: https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2018-better-health-within-reach

Department of Health and Social Care (DHSC) (2018). Prevention is better than cure. Accessible online at: https://www.gov.uk/government/publications/prevention-is-better-than-cure-our-vision-to-help-you-live-well-for-longer

Dorling, D., Shaw, M., & Davey Smith, G. J. C. H. I. F. A. t. C. H. (2007). Inequalities in mortality rates under New Labour. 31.

Duffy, J.C., & Snowdon, C. (2012). The minimal evidence for minimum pricing. Adam Smith Institute. Accessible at: https://www.adamsmith.org/research/the-minimal-evidence-for-minimum-pricing

Edwards, P., Roberts, I., Green, J., & Lutchmun, S. J. b. (2006). Deaths from injury in children and employment status in family: analysis of trends in class specific death rates. *333*(7559), 119.

Foundation, B. H. ((2018)). Physical Activity Report. Retrieved from https://www.bhf.org.uk/informationsupport/publications/statistics/physical-inactivity-report-2017. Accessed May 2019

Gilmore, I., Bauld, L., & Britton, J. (2018). Public Health England's capture by the alcohol industry. In: British Medical Journal Publishing Group.

Gornall, J. (2014). Under the influence. *Bmj, 348*, f7646.

Government Statistics Service (2018) Statistics on Obesity, P. A. a. D. (2018). Statistics on Obesity, Physical Activity and Diet.

Government Statistics Service (2018) Statistics on Obesity, P. A. a. D. ((2018)) Statistics on Alcohol 2018. In.

Grassi, D., Lippi, C., Necozione, S., Desideri, G., & Ferri, C. J. T. A. j. o. c. n. (2005). Short-term administration of dark chocolate is followed by a significant increase in insulin sensitivity and a decrease in blood pressure in healthy persons. *81*(3), 611-614.

Hawkins, B., Holden, C., & McCambridge, J. J. C. p. h. (2012). Alcohol industry influence on UK alcohol policy: a new research agenda for public health. *22*(3), 297-305.

Hawkins, B., Holden, C. J. P., & Politics. (2014). 'Water dripping on stone'? Industry lobbying and UK alcohol policy. *42*(1), 55-70.

Katikireddi, S. V., Hilton, S., Bonell, C., & Bond, L. J. P. O. (2014). Understanding the development of minimum unit pricing of alcohol in Scotland: a qualitative study of the policy process. *9*(3), e91185.

Lilienfeld D. (1991) The silence: the asbestos industry and early occupational cancer research - a case study. Am J Public Health 1991; 81; 791-800

Lee, A., Head, F., Packham, C., & Robinson, M. J. B. J. G. P. (2012). The challenge of commissioning for populations. *62*(598), e387-e389.

McCambridge, J., Hawkins, B., & Holden, C. (2013). Industry use of evidence to influence alcohol policy: a case study of submissions to the 2008 Scottish government consultation. *PLoS medicine, 10*(4), e1001431.

McCambridge, J., Kypri, K., Miller, P., Hawkins, B. and Hastings, G., 2014. Be aware of D rinkaware. *Addiction*, *109*(4), pp.519-524.

McCartney, G., Bouttell, J., Craig, N., Craig, P., Graham, L., Lakha, F., . . . Minton, J. (2016). Explaining trends in alcohol-related harms in Scotland 1991–2011 (II): policy, social norms, the alcohol market, clinical changes and a synthesis. *Public Health, 132*, 24-32.

Meier, P., Brennan, A., Angus, C., & Holmes, J. (2017). Minimum unit pricing for alcohol clears final legal hurdle in Scotland. In: British Medical Journal Publishing Group.

Mindell, J. S., Reynolds, L., Cohen, D. L., & McKee, M. J. B. (2012). All in this together: the corporate capture of public health. *345*, e8082.

Moodie, R., Stuckler, D., Monteiro, C., Sheron, N., Neal, B., Thamarangsi, T., . . . lancet, L. N. A. G. J. T. (2013). Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *381*(9867), 670-679.

National Health Service (NHS)(2014). Five Year Forward View. Accessible online at https://www.england.nhs.uk/publication/nhs-five-year-forward-view/

Office for National Statistics (ONS) (2017). Avoidable morality in the UK: 2017. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2017 Accessing May 2019

Office for National Statistics (ONS), (2017). Adult Smoking Habits in the UK

Petticrew, M., McKee, M. and Marteau, T.M., 2018. Partnerships with the alcohol industry at the expense of public health. *The Lancet*, *392*(10152), pp.992-993.

Pettigrew, S., Biagioni, N., Daube, M., Stafford, J., Jones, S. C., & Chikritzhs, T. J. A. (2016). Reverse engineering a ‘responsible drinking’campaign to assess strategic intent. *111*(6), 1107-1113.

Pickett, K. E., Wilkinson, R. G. J. S. s., & medicine. (2015). Income inequality and health: a causal review. *128*, 316-326.

Pye, S. (2018) Addressing social determinants of health through the NHS. Accessible online at: https://www.health.org.uk/newsletter-feature/addressing-social-determinants-of-health-through-the-nhs

Reidpath, D. D., Allotey, P. J. J. o. E., & Health, C. (2003). Infant mortality rate as an indicator of population health. *57*(5), 344-346.

Ried, K., Sullivan, T.R., Fakler, P., Frank, O.R. and Stocks, N.P., 2012. Effect of cocoa on blood pressure. *Cochrane Database of Systematic Reviews*, (8).

Robertson, R., Appleby, J., Evans, H. J. R., & Fund, t. f. t. B. s. a. s. L. K. s. (2017). Public satisfaction with the NHS and social care in 2016.

Robinson, T., Brown, H., Norman, P. D., Fraser, L. K., Barr, B., & Bambra, C. J. J. E. C. H. (2019). The impact of New Labour's English health inequalities strategy on geographical inequalities in infant mortality: a time-trend analysis. jech-2018-211679.

Room, R. (2004). Disabling the public interest: alcohol strategies and policies for England.

Room, R. (2004). Disabling the public interest: alcohol strategies and policies for England. *99*(9), 1083-1089. doi:10.1111/j.1360-0443.2004.00803.x

Sacks G, Veerman JI., Moodie M., Sinburn B. 'Traffic-light' nutrition labelling and 'junk-food' tax: a modelled comparison of cost-effectiveness for obesity prevention. Int J Obes (Lond); 35: 1001-09

Savell, E., Fooks, G., & Gilmore, A. B. J. A. (2016). How does the alcohol industry attempt to influence marketing regulations? A systematic review. *111*(1), 18-32.

Savell, E., Gilmore, A. B., & Fooks, G. J. P. o. (2014). How does the tobacco industry attempt to influence marketing regulations? A systematic review. *9*(2), e87389.

Seaton A. (2015). Duncan Tanner Essay Prize Winner 2014: Against the 'Sacred Cow': NHS Opposition and the Fellowship for Freedom in Medicine, 1948–72. *Twentieth Century British History.* 2015 Apr 27;26(3):424-49.

Smith, K., Dorfman, L., Freudenberg, N., Hawkins, B., Hilton, S., Razum, O., & Weishaar, H. J. F. i. p. h. (2016). Tobacco, alcohol, and processed food industries–why do public health practitioners view them so differently? *, 4*, 64.

Smith, S. W., Atkin, C. K., & Roznowski, J. J. H. c. (2006). Are" drink responsibly" alcohol campaigns strategically ambiguous? *, 20*(1), 1-11.

Sokolov, A. N., Pavlova, M. A., Klosterhalfen, S., Enck, P. J. N., & Reviews, B. (2013). Chocolate and the brain: neurobiological impact of cocoa flavanols on cognition and behavior. *37*(10), 2445-2453.

Torjesen, I. (2019). Exclusive: Partnering with alcohol industry on public health is not okay, WHO says. *365*, l1666. doi:10.1136/bmj.l1666 %J BMJ

Towner, E. J. I. j. o. i. c., & promotion, s. (2005). Injury and inequalities: bridging the gap. *12*(2), 79-84.

Townsend P., D. N., Whitehead M (1986). *The Black Report and the Health Divide*. Harmondsworth: Penguin.

Whitehead, M., & Drever, F. J. D. s. L. Office for National Statistics (1997). Health inequalities.

NOTES

1. In 1911, the Registrar General introduced a classification system to categorize the British population by social standing on the basis of their occupation. This was later renamed in 1990 as *Social Class based on Occupation*. This range from Social Class V (Unskilled occuptions) to Social Class I (Professional occupations).

ABSTRACTS

Health for the many, and particularly the health of the poorest, has often been vulnerable to the commercial interests of powerful actors such as corporations and industry. This is exemplified by the efforts of the alcohol and tobacco industries to fight public health policies aimed at curbing alcohol and tobacco consumption: through the publishing of poor science, political lobbying and finally through legal action at national and international levels. There is clear evidence that better public health cannot be achieved solely through the promotion of healthy behaviour but also requires active efforts to counter those powerful entities with vested interests in commercial profit. The manner in which the British government’s commitment to introducing a minimum unit price (MUP) for alcohol in England and Wales saw an extraordinary U-turn has been described as a cautionary tale of the power of the alcohol industry to influence public health policy. In Scotland, where the bill was passed, legislative success was followed by a five-year legal battle with alcohol industry trade bodies. MUP as a policy exposed just how strategically and earnestly industry will fight to preserve its profits and its interests at the expense of public health.

La santé de la population, et en particulier celle des plus pauvres, a souvent été vulnérable aux intérêts commerciaux d’acteurs puissants tels que les entreprises et l’industrie. Cela est illustré par les efforts des industries du tabac et de l'alcool pour lutter contre les politiques de santé publique visant à réduire la consommation d'alcool et de tabac, que ce soit par moyen de la publication d'informations scientifiques médiocres, le lobbying politique ou enfin par des actions en justice aux niveaux national et international. Il est clairement établi que l'amélioration de la santé publique ne peut être obtenue par la seule promotion d'un comportement sain, mais nécessite également des efforts actifs pour lutter contre les intérêts commerciaux lucratifs. La manière dont le gouvernement britannique s’est engagé à introduire un prix minimal unitaire (MUP) pour l’alcool en Angleterre et au Pays de Galles a connu un tournant extraordinaire et a été décrite comme une mise en garde concernant le pouvoir de l’industrie de l’alcool d’influencer la politique de santé publique. En Écosse, où le projet de loi a été adopté, le succès de la législation a été suivi par une bataille juridique de cinq ans avec les organismes du commerce de l’alcool. La politique de prix minimal unitaire a montré à quel point l’industrie allait se battre de manière stratégique et sérieuse pour préserver ses profits et ses intérêts, au détriment de la santé publique.

INDEX

Keywords: NHS, Alcohol Policy, Minimum Unit Pricing, inequality, Health policy
Mots-clés: NHS, Service national de santé, Politique relative à l'alcool, Prix unitaire minimal, inégalités, politique de santé

AUTHORS

FIONA CAMPBELL

University of Sheffield

ANDREW LEE

University of Sheffield