UNDERSTANDING SOCIETY

A HEALTHY UNDERSTANDING?

Global attitudes to health

Foreword

Welcome to this international edition of Understanding Society, covering a wide range of health challenges – everything from service provision, behavioural interventions to promote public health, the importance of health literacy, the increasing reality of exporting healthcare, the opportunities and challenges of ageing populations to how Sustainable Development Goals (SDGs) tie many of these themes together.

This publication examines the state of health at both a national and global level, drawing together some of the research carried out by our Ipsos colleagues in 30 countries and across five continents.

Leila Tavakoli from the UK and David Ahlin from Sweden start with an overview of the different levels of expectations from healthcare services across countries and how they shift over time, pointing out that there is little correlation between public concern about the future of health services and objective indicators used to determine the quality of healthcare. Why do the "worried well" countries rate the quality of their healthcare highly but worry about it the most?

Sustainable development is a key area of research for Ipsos. Jonathan Glennie, Head of our Sustainable Development Research Centre, examines the successes and failures of the Millennium Development Goals set out by the UN and looks forward to the SDGs. What has changed, and what remains the same? Ipsos India's Tripti Sharma provides a case study in impact from her country.

To help us understand the next phase of global health challenges, we are delighted to have an interview with Dr Flavia Bustreo, Assistant Director for Family, Women's and Children's health, and the Italian candidate for Director General of the World Health Organization (WHO). Flavia gives us an account of how decision-making has shifted to a more collaborative approach that includes citizens, governments, businesses and health professionals. She also outlines the impact of ageing societies and the movement of people on healthcare systems and infectious diseases, and ways that the WHO are facing these challenges.

We are also delighted to have an interview with Duncan Selbie, Chief Executive of Public Health England (PHE), an executive agency of the UK's Department of Health that focuses on health improvement. Duncan outlines his vision for the future of the public's health, moving beyond doctors and hospitals, and towards social media apps and healthy life choices.

And we examine two of the most pressing public health challenges across many countries today – obesity and how we deal with the care needs of our ageing populations. By 2050, for the first time in history, people aged 60 and over will match that of those aged less than 15. An ageing population is often seen only as a challenge and concern, with many horror stories about how we care for our older citizens. The challenge is real but this isn't the whole picture, as data from the Your Care Rating survey in the UK shows, with many surprisingly positive perceptions.

Louise Park, Associate Director at Ipsos also looks at British perceptions of obesity, how much we underestimate it as a problem and how we might be able to shift behaviours. In the same vein, later in this edition, Chris Martyn from Ipsos in Canada outlines new research on how health literacy may also hold a large part of the answer to better outcomes.

And finally, Dan Evans, Director of Ipsos Australia, explores how the 'lucky' continent that ranks second on the UN's most liveable places needs to adapt to a new economic landscape. Dan looks at how Australia's health infrastructure, experience and skills can be traded to countries like China and Japan, to help the country to continue to earn its good fortune.

We hope you enjoy reading about the global state of health. Ipsos remains committed to disseminating the insights from our broad range of social and political research, in the belief that this leads to better policy and practice. If you would like to discuss any of the research here, please get it touch.

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The worried well

Our increasing expectations of health systems   Leila Tavakoli, UK and David Ahlin, Sweden

Look up the phrase the 'worried well' and you'll find the definition: 'people who are unnecessarily anxious about their physical or mental health'. Many of us are familiar with the term; we have friends or relatives who we would consider the 'worried well'. Perhaps some of us would even use the phrase to describe ourselves. And increasingly it seems to be a concept that could be applied to entire nations.

Our data shows that there are a few countries where people who rate the quality of their country's healthcare highly are also among those who are most worried about it. Two thirds or more of those in Australia, Canada, Great Britain, Sweden and the USA rate the quality of healthcare that they and their family have access to in their country as good (70%, 64%, 69%, 58% and 70% respectively). Yet healthcare also generally ranks in the top three topics people find most worrying in those countries. There are also inevitably countries where people have high levels of concern about their healthcare and also rate it poorly, Poland and Brazil being two examples. Yet it is still interesting that this 'worried well' contingent of nations exists.

So what are 'worried well' nations worried about?

There does not seem to be a convincing correlation between how worried people are about their country's healthcare and actual health indicators when you look at two indicators often used as a proxy for the quality of healthcare, life expectancy[1] and the number of doctors relative to the population[2]. Probably linked to this, concern in the 'worried well' nations also does not seem related to actual expenditure on health. The US spends 18% of its total annual GDP on health,[3] more than any other country in the world, while Great Britain spends half of that proportion,[4] and yet both are among the countries that are most worried about the future of their healthcare systems.

There is a relationship, however, between how much is spent on healthcare in a country and how people feel about how the system is currently performing. Broadly, the higher the proportion of its GDP that a country spends on healthcare, the more favourably it

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will be regarded by its citizens.

Looking at one country that is known for the pride it has in its health service in more detail, Great Britain, the majority of the population are satisfied with how it is run (68%).[5] Despite this, half expect the quality of healthcare that they and their family have access to locally to get worse over the coming years (47%), and only 8% expect it to get better. The Brits are the most pessimistic about the future of their healthcare system of all the 23 countries we surveyed, despite the fact that 77% of people in England say that Britain's National Health Service is one of the best in the world[6].

The reason for this concern is clearly linked to worries about future funding. Probably linked to the commentariat's repeated assertion that the NHS is in a state of perpetual crisis, 'lack of resources/investment' has been cited by the public as the biggest problem facing the NHS for a decade and 84% think the NHS will face a severe funding problem in the future.[7] Although the British public remain hugely positive about the current care they receive from their health service, almost daily headlines about its financial sustainability are taking their toll.

But context is king

Memorably described as 'the closest thing the English people have now to a religion' Britain's National Health Service is potentially unusual, if not unique, in how its citizens view it however. Health systems vary considerably around the world, and so making comparisons

Figure ONE.

Which three of the following topics do you find the most worrying in your country?
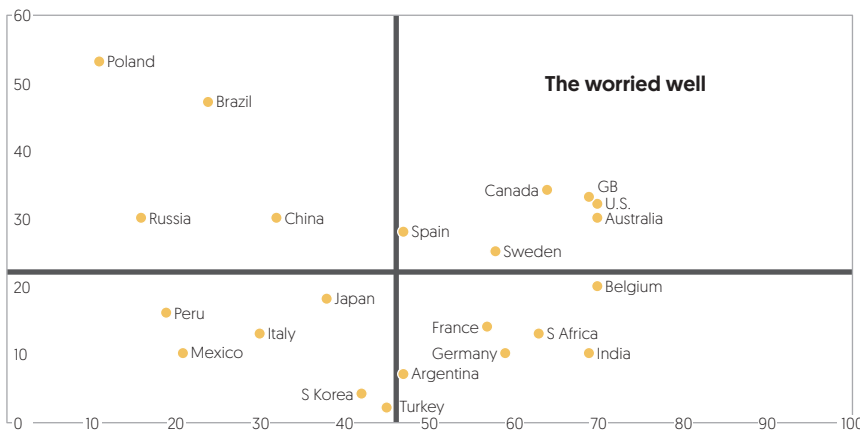
How would you rate the quality of healthcare that you and your family have access to in your country? By healthcare we include doctors, specialist physicians such as surgeons, hospitals, tests for diagnosis and drugs to treat various ailments.

The Brits are the most pessimistic about the future of their healthcare system of all the 23 countries, despite the fact that 77% of people in England say that Britain's NHS is one of the best in the world.

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Figure TWO.

What percentage of total annual Gross Domestic Product is spent on health expenditure each year?

How would you rate the quality of healthcare that you and your family have access to in your country? By healthcare we include doctors, specialist physicians such as surgeons, hospitals, tests for diagnosis and drugs to treat various ailments.

Figure THREE.

Over the coming years, do you expect the quality of healthcare that you and your family will have access to locally will improve, stay the same or get worse?
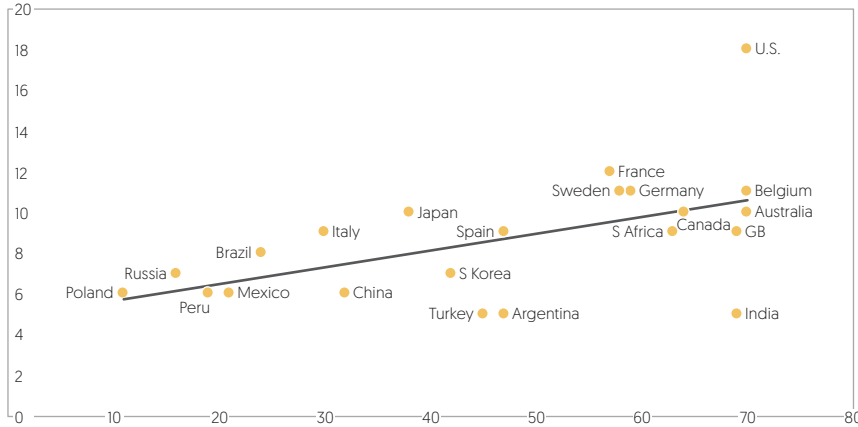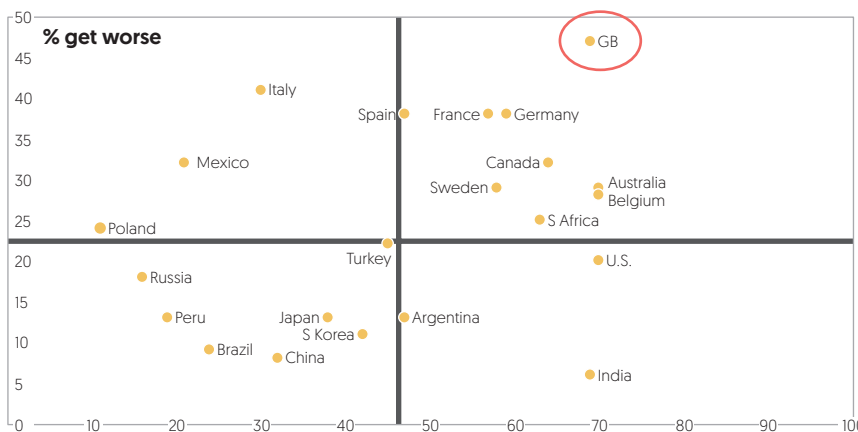

How would you rate the quality of healthcare that you and your family have access to in your country? By healthcare we include doctors, specialist physicians such as surgeons, hospitals, tests for diagnosis and drugs to treat various ailments.

between them is complicated. At the start of this century the World Health Organization made an attempt to rank health systems in its World Health Report 2000 based on a range of criteria including the level and distribution of the health of populations, and the responsiveness and fair financing of healthcare services.[8] The classification was subject to debate though and the approach has not been replicated.

The Commonwealth Fund in its regular report 'Mirror, Mirror on the Wall' compares the performance of health systems we might expect to be similar (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the UK, and the USA) and has found on several occasions that, though the US system is the most expensive in the world, it underperforms compared with those in other countries.[9] Of course, the USA is the only country in the study without provision of universal healthcare. So each individual country's context is crucial to bear in mind when comparing different health systems.

Regardless of context however, ensuring good health and promoting well-being is the aim of goal 3 of the 17 United Nations' Sustainable Development Goals (SDGs) and these apply to every country in the world. Although healthcare challenges and needs are clearly greater in developing countries than in developed ones (as discussed in this edition of Understanding Society by Dr Flavia Bustreo, the World Health Organization's Assistant Director-General for Family, Women's and Children's Health, and Jonathan Glennie, our new Head of Sustainable Development), public concern about future healthcare in countries where people are currently largely satisfied with the care they are receiving suggests even those with relatively established and well-functioning systems will remain under pressure to maintain them.

Plus ça change

The central challenge for global health remains stubbornly intractable   Jonathan Glennie, UK

The past two decades have seen great progress in many areas of human health. Not all the Millennium Development Goals will be met, and the progress could have been shared more fairly, both in terms of geography (Africa still lags behind) and in terms of social strata (inequalities are rising in many countries). Nevertheless, the statistics are impressive.

According to the World Health Organization (WHO), just under 13 million children under 5 died in 1990 compared with just over 6 million in 2013. That equates to tens of millions of children alive today who might otherwise not have survived. Immunisation coverage is perhaps one of the stand out successes, leading to dramatic falls in measles deaths. The number of women dying in childbirth has halved. Malaria kills only half as many people as it used to. The list of successes goes on.[10]

The causes of this progress are various. On the one hand, as Charles Kenny argues in his book "Getting Better: Why Global Development is Succeeding", it is partly simply that the cost of healthcare has reduced as technology has advanced around the world. Thus, some countries that are not much richer now than they were some decades ago have still benefitted from large-scale health improvements. Those countries which have experienced economic growth, of course, have benefitted even more. For some in rich countries, this may seem counterintuitive as health budgets struggle to meet the level of demand. But that is because more affluent communities demand ever more advanced health solutions – a world apart from the primary health interventions that are saving lives in poorer contexts.[11]

Of course, political will remains crucial and the international pressure generated by the Millennium Development Goals following on from a series of crucial global summits in the 1990s certainly helped. When I was studying Nepal's success in bringing down maternal mortality it was the dogged determination of politicians, bureaucrats and health workers, putting public money where their mouths were that more than anything explained progress. Support from the international community, both financial and in terms of research and analysis, was also critical.[12]

Then there are the innovative context-specific solutions that have arisen around the world, mapped and narrated in Amanda Glassman's "Millions Saved" work that documents this progress. As well as a focus on the latest science, political will, and partnerships to mobilise technical, financial and political resources, she identifies the use of data and evaluations to "adjust course" as a critical ingredient of progress.[13]

So is global health just one big success story? Unfortunately not. The central challenge in global healthcare today is the same as it was 20 years ago, despite a radically different, much more upbeat context. It would be churlish to over criticise GAVI (the Vaccine Alliance), the Global Fund and other large-scale

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Figure FOUR.

Comparison of health indicators

Country	Number of km² covered by one health worker	Neonatal mortality rate (per 1,000 live births)
Australia	24	2
Canada	26	3
Germany	0.3	2
Italy	0.5	2
Japan	0.2	1
Norway	4.6	2
Spain	1.2	3
Sweden	3.5	2
UK	0.3	3
USA	2.7	4
Mali	155	40
Niger	527	28
Guinea	46	33
Central African Republic	479	43
Ethiopia	47	28
Haiti	-	25
Afghanistan	28	36
Nigeria	3.3	37
Chad	568	40
Somalia	504	46

international health interventions, but the concerns raised as they were getting going in the early 2000s have largely been borne out, i.e. in an admirable effort to achieve results in the short-term for poor people, the structural underpinning required to build good health systems that can sustain for the long-term has been neglected.

In a report published in 2015, the international charity Save the Children argued that the main lesson from the Ebola outbreak in West Africa was that, for all the progress, health systems in poor countries remain fragile and vulnerable to shocks. The authors dub the episode a "wake-up call" to the international community, and in his foreword respected health academic, practitioner and one of the team to discover Ebola, Dr Peter Piot warns that there are many other countries with "dangerously weak health systems".[14] Many are understaffed and underfunded and this manifests in health outcomes, as shown in this table which compares health indicators for the bottom 10 of the 75 countries where more than 95% of all maternal and child deaths occur (monitored by the Countdown to 2015 movement)[15] with comparable indicators in high income countries.

This is not news to most, and the Sustainable Development Goals, in contrast to the Millennium Development Goals they replace, emphasise the need to deliver "Universal Health Coverage" (UHC), the mot du jour, and "the most important concept that public health has to offer" according to WHO's outgoing Director General, Dr Margaret Chan, and echoed by Dr Flavia Bustreo, the WHO's Assistant Director-General for Family, Women's and Children's Health in this journal. The Elders (a group set up by Nelson Mandela and comprising respected ex-politicians from around the world) has adopted UHC as its new campaign, joining the World Bank and many others. They don't all agree exactly what it means, but the WHO says health coverage is universal when everyone is able to access good quality health services without, crucially, falling into financial hardship.[16]

The temptation to engage in what is known as "vertical" programming, which could be characterised unfairly as helicoptering in supplies without dealing with underlying systemic issues, is great. Organisations and their funders (whether the general public through their taxes, or philanthropists and private organisations) want results fast – and it is hard to take a smiling photo of a more efficient and sustainable health system.

But that was the challenge twenty years ago, and it remains the challenge today. It will take even more money and even more political will to achieve.

Health systems strengthening

A case study from India   Tripti Sharma, India

As Jonathan outlines, enabling access to good quality healthcare services for everyone is one of the unifying aims of the global health movement today. 'Ensure healthy lives and promote well-being for all at all ages', otherwise known as Sustainable Development Goal 3, was an objective committed to by world leaders in 2015. In order to achieve this goal, stronger and more effective health systems are required, and 'health system strengthening' is a focus of the strategies of leading global health financing institutions and donors from the World Bank to the Global Fund.

The Tamil Nadu Health Systems Project [TNHSP], supported by World Bank, saw an investment of US$ 211 million over a decade with the aim of significantly improving the effectiveness of the health system (both state-funded and private) in the Indian state. The aims of the project were broadly to:

- increase access to health services, particularly for poor, disadvantaged and tribal groups;
- develop effective interventions to address key health challenges;
- improve health outcomes, as well as the quality of service delivery; and
- increase the effectiveness and efficiency of public sector hospital services.

In order to help measure progress of the project against aims, Ipsos was commissioned to carry out a range of research, including patient experience research, research with frontline staff, an evaluation of the quality of care provided, and testing of marketing materials.

Our research highlighted some key findings which resonate with much of the health research we do across the world. For example, as Daniel Evans highlights in this journal, patients' perceptions of care are influenced by broader aspects of their experience than just health outcomes. We found that factors such as the cleanliness of wards and wards, how easy it is to register at a health facility and whether or not you are treated by a doctor who can communicate with you in a language you understand all influence patient satisfaction levels.

Interestingly there was very little improvement in patient satisfaction in the 8 years between the baseline and endline research. We think this can be best explained by a rise in patient expectations over this time. As the quality of healthcare facilities have improved, so have patient expectations. Jonathan describes how more affluent communities demand ever more advanced health solutions and we may be seeing this in microcosm in India.

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Ageing, globalisation and climate change

The changing landscape of global health

Bobby Duffy,
UK

Bobby Duffy interviews Dr Flavia Bustreo, the World Health Organization's (WHO) Assistant Director-General for Family, Women's and Children's Health.

BD: As Assistant Director-General for Family, Women's and Children's Health, could you give us an overview of your role at WHO?

I oversee a broad area of the WHO agenda. This covers all the issues of health throughout the life course – conception, reproductive, maternal and child health, maternal and infant mortality and healthy ageing. I also lead on all aspects of immunisation, vaccine and biological issues as Vice President of the Global Vaccine Alliance for three years.

In addition to that, I've been looking at the environmental and social determinants of health – recently, we published a report on the impact of indoor and outdoor air pollution, the quality of water and sanitation and, as part of the discussion on the Climate Change Agreement, the right to healthcare. And finally, more generally, it is my responsibility to advance the work that WHO does on equality, gender and human rights, across the entire organisation and provide tools that countries can use in improving these issues when it comes to improving health and provision of health services.

BD: This is quite a large portfolio! What would you say has been an important goal that WHO has achieved?

In recent years, a key focus of WHO has been to address maternal and child mortality, which was particularly crucial during the last phase of the Millennium Development Goals (MDGs) – a UN-led agreement of eight goals, signed in September 2000, to combat disease, illiteracy, environmental degradation, and discrimination against all women by 2015 . Our most traditional counterparts are policymakers in government, but to advance the health MDGs, we wanted, and needed, to engage all the key actors in the development agenda.

To accomplish this, we created an alliance called Partnerships for Maternal, Newborn & Child Health, to involve people beyond the governments and our own Secretariat. This was an alliance where everyone was working in one way or another on issues of women's and children's health. We had people from the health sector—academics, civil society actors, healthcare professionals, including paediatricians, obstetricians, midwives, and nurses—and people from other sectors. It was important to include the private sector in this partnership in the appropriate manner, and very recently, we also included young people in the alliance. With our non-governmental partners, we found the resources to make change happen where it mattered most.

Working on the MDGs was challenging but it is also one of the accomplishments of which I am proudest. Before 2005, there was very little progress on MDGs 4 & 5 that are aimed at reducing maternal and child mortality. From the early 1990s to 2000 more than 30 million children under five died usually due to preventable

causes. In addition, there were half a million deaths from causes related to pregnancy and childbirth. We changed this situation. By 2015 the Partnership had contributed significantly to achieving an approximately 50% reduction in child and maternal mortality from 1990.

BD: What approaches would you attribute this success to?

In addition to continuing to emphasize the importance of delivering evidence-based interventions for child and maternal health, we also prioritised the importance of tracking progress and being held to account for the progress or lack of progress achieved. This aspect of accountability was essential. We know from experience that people, groups, and governments can make promises and commitments that don't always come to fruition. We created a commission to explore how to ensure there was accountability, and how to track progress on the commitments. We also tracked the results. An independent group of experts was put into place to oversee this accountability process. We used some innovative means such as citizens' hearings where ordinary women and young people discussed issues with policy makers, sometimes exposing the shortcomings of services and policies. This created good political pressure and promoted transparency and accountability. This strategy provided something we need in the development arena and led to real progress. It has been the basis of the global strategy for women and health which we renewed in 2015 working with the United Nations Secretary General's Office. Under the new Strategy an independent panel will monitor the progress we make over the next 15 years, between now and 2030 when the SDGs are to be achieved.

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It is important to create conditions in society where older people can have flexibility in how they remain able to work.

BD: Thinking about the changing landscape of global health, what do you think are the new opportunities and threats facing the world, and linked to that, the next areas of focus for WHO?

The world we live in today has seen several transformations – globalisation, contraction, a significant increase in migration, as well as concern about preserving local identities. This has created new health challenges for us. People move around the world faster than they did 20 years ago. Unfortunately, this means that pathogens also circulate faster.

We have already seen the dreadful effects of the Ebola epidemic. When we were looking at it with the London School of Hygiene and Tropical Medicine, we found that the infectious disease would normally run its course and be self-contained in the most rural and remote parts of Africa. Yet, what we saw was rapid spreading of the disease, an unprecedented epidemic. It not only highlighted how weak the health systems were of the countries affected, but also the weakness and unpreparedness of the global response. Our big challenge is how we prevent the transmission of infectious diseases in a world where people are constantly on the move.

In addition to communicable diseases like Ebola, non-communicable diseases are a new threat and already highly prevalent across the globe. Cancer, strokes, and diabetes have become more common as people live longer and populations age. In 2015, WHO published a report documenting the changing demographics across the globe. Japan, for example, has the highest proportion of people aged 65 or over. Many countries see their ageing society as a costly burden, but our goal is to ensure that we shift this perception. Older people must be seen as a resource to society. To make this shift we need to focus on keeping people healthy, active, and productive so that, even in our later years, we have the opportunity to contribute.

BD: Those are interesting examples of the challenges that lie ahead. Climate change is an area of study for Ipsos, and our measures of perception show that while people in Britain are supportive of taking action against climate change, they are still divided on whether it should be prioritised at the expense of other priorities such as health and education. We know that the WHO has done a lot of work on the impact of climate change on health. What are some of the effects on human health?

Climate change is a huge challenge for us and for the international community as a whole. It is a challenge that requires cooperation to address. As you note WHO has done some significant work on climate change and health.

Climate change is something that is impacting human health in several ways. We have seen the burden of diseases grow where climate change contributes to increased transmission rates. For example, we have seen more mosquitos transmitting malaria in sub-Saharan Africa because of warmer temperatures. We are also examining the modification of the climate for its impact on the spread of the Zika virus. We have already noted mosquitos that are carrying neurotropic viruses further than in the past. We have seen that climate change is also affecting the quality of our water, air, and food. Food insecurity is one of the impacts that particularly effects human health. In fact, we are seeing that climate change has a significant impact on human health everywhere in the world.

WHO is working on the wider determinants of health like climate change to reduce global mortality. So, participating in government activity, like the Paris Agreement, and ensuring joint work between the environmental and health sector, is very, very important to us. At COP21 in Paris, and in the meetings leading up to the Paris Agreement, we stressed that climate change has a significant adverse impact on human health. This is recognized in the first article of the United Nations Framework Convention on Climate Change. In the Paris Agreement, we further recognized that all people have a right to health, no matter where they are found. This was a significant step in realizing our responsibility to protect people's health from the impacts of climate change.

None of our work on climate change has been done alone. We have cooperated with our Member States, other intergovernmental organizations, and a wide variety of non-State actors.

BD: Looking more closely at global preparedness, the Ebola and Zika virus outbreaks highlighted the potential for unanticipated health emergencies — and WHO bulletins highlight how commonly pandemics are "lived forwards but understood backwards." How do you think we can use research to better predict such crises and improve our responses?

There are several things we can do to improve our reaction to outbreaks; research is key to all of them.

First and foremost, we need to improve our surveillance capacity to be able to identify the spread of both new and old pathogens, especially those that are resistant to drugs. The International Health Regulations have established procedures whereby countries must report outbreaks and other public health events to WHO, but this system must be made to work better so that we can detect infections quickly in all parts of the world. The ability to detect infections and share knowledge is very important. It is an ability that I am committed to strengthening.

Second, we must use our convening power to bring top members of the research community together to deal with health emergencies. In WHO, it was my cluster that was tasked with finding a vaccination to stop the spread of Ebola and we did so in record time because we used our ability to convene partners and encourage cooperation.

Thirdly, we need a shift in the way we share data. In the past, it has been difficult to monitor progress or adjust responses because the needed data, which we had, was unavailable for distribution to the people who need to use it. In cooperation with the governments of Member States we need to make needed data available immediately.

BD: Following on from that, the UN has been calling for a "data revolution" to underpin the Sustainable Development goals you've described. What more do you think we can do with data? What's missing or what could we do more smartly with the data that we do have?

Using data is fundamental to achieving our Sustainable Development Goals. As I have already noted the WHO needs to be a leading actor in ensuring that reliable data is collected in all Member States and made available to the right actors in a timely manner.

Today there are data gaps in many countries — sometimes these concern very basic data such as the registration of births and deaths or the causes of death. This means that often a child might die without there ever being a record of it, and, if there is, there may be no record of what caused the child's death. Transformations need to be made — unless all countries have good basic statistics and pathogen surveillance that can detect cause of death and feed back into the system in real time, the promises to end preventable deaths will not be feasible.

With that in mind, we are seeing different types of data collection emerging in low income countries, which means that we have more data now than we had in the past. The data revolution is happening now — the availability of cell phones, for example, means that we can have information from the remotest villages in India. The next challenge is to have information in real time which can be shared, stored, exchanged, and used appropriately. Real time information is valuable — that's why it's so important to have a collaborative approach.

Data is also important for the democratic process, which is linked to health. If you don't have a civil registration process, you can't account accurately for an electorate, you can't identify cohorts entering education and the migration of the population. So it's a fundamental measure of progress.

BD: Absolutely. You mentioned ageing societies as another key challenge in your work. Populations are ageing

across the globe, which is a great success story for our improving healthcare systems and a reflection of economic growth – but one that also brings its own challenges. What is your approach to shifting the idea of it being a burden to an opportunity?

Yes. I would start off by saying that rapid ageing is happening over the last century. We are witnessing it in places like Thailand and Singapore where societies that are developing economically have seen their life expectancy rise and their fertility decline. So on one side of the coin, it's great that people are living longer.

But fundamentally, we need to tackle the misperceptions between biological age and functionality or productivity. It is important to create conditions in society where older people can have flexibility in how they remain associated to work and social opportunities. Last year, we launched a big global campaign to take a stand against ageism and end discrimination against people on the basis of their age.

Also, longevity needs to be capitalised on in the senior economy. A key example of this is Japan, and to some extent my own country, Italy. People over 65 are the healthiest that they have ever been in the history of their respective countries. These are the people who became productive in their country in the economic boom of the 60s and 70s. It's quite stunning to see what level of economic growth they can achieve. So the most successful policies for a productive population are not just health-based, they are social and economic policies that maintain people's ability to function and be productive. The senior economy is a great opportunity.

Secondly, there is the healthcare aspect. Healthcare systems need to adjust to the needs of older people and we have seen many successful strategies. For example, Thailand, a country affected by an ageing population, has seen a successful expansion of universal coverage of healthcare services for people in different socio-economic levels. In developed countries like the UK, we have witnessed strong healthcare systems where you have specialists that treat different organs.

The trouble is, it is common for older people to suffer from multi-pathologies. So a person can have cancer, as well as a developing loss of functional capacity, but only be treated by a cancer specialist – we need systems which can provide a more integrated service around the older person specific needs.

BD: That's really interesting. Ipsos regularly conducts work focussed on how to improve the quality of life for older populations. How much of that do you think relies on long-term care?

Long-term care is a big challenge. Even in developed countries like the France, the UK or Italy, we are not yet fully equipped to deal with the long-term care of people who have lost their functional or cognitive ability. And again, this is not just something that only the healthcare system has to address – like I said before, we need a more integrated approach to the services which have that older person in mind, and which can provide support for the daily living.

Holland is a very interesting example. They have constructed small residential villages for older people to facilitate mobility and wellbeing. Buildings are on the ground floor, all facilities are close by and people can live independently. It also deals with the isolation and mental health problems that the older people experience when in conventional care homes. There are local primary schools where children play nearby. So anything that keeps people connected to society is important in long term healthcare. But we still require a lot of resources and common sense to make that final part of life for everyone as decent and dignified as possible.

BD: And finally, have you seen any effective examples of communication and engagement that improve health outcomes? What would be the key message you would like to give to the health sector on how to deliver messages that stick?

I am pleased to say that, in the last 20 years, I have seen an incredible

transformation of how public communication is done. And now, with social media and the use of cell phones, we have incredible opportunities to continue this transformation. Part of our work looks at ways of using the new technologies to deliver health messages – in areas such as tobacco use, obesity or maternal health, and we study the effectiveness of these interventions.

Sometimes we need to be effective in the communication to counter false information claims. In many parts of the world there are still people spreading misconceptions and theories that are not based on science, regarding the risks associated with vaccines. The World Health Organization has a huge responsibility and role in sharing truthful information and scientific knowledge to the ordinary public, but it's not easy to do this. There are lots of campaign groups that are seeking out information on the web, on social media and are criticising the value of immunisation. So combating this is an important aspect of our work, going forward.

Behavioural science is also transforming communication. Educated men and women have a lot of knowledge about health accessible to them, in a way that wasn't possible 20 years ago. Understanding what drives the behaviours, how people think, what stops them from exercising and having an active lifestyle is very important to us. I must say, the public health community have really grasped this opportunity.

It is important for us to inform people but also change perceptions about how we look at health. It should be viewed as an asset, an investment and key driver for socioeconomic development. If we succeed, this shift has the potential to transform many of the challenges we face today.

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Getting older, but can we get wiser?

Lessons from Britain on using survey feedback to improve care quality

Elizabeth Copp
and Lewis Hill, UK

The global population is ageing on an unprecedented scale. By 2050, for the first time in history the proportion of people aged 60 and over will match that of the those aged under 15.[17] Population ageing is a phenomenon of which the public are well aware. So much so, in fact, that we seriously overestimate the proportion of our population aged over 65. For example, in Britain, we guess that on average, 37% of people are aged 65 or over compared with the actual figure of 17%[18]. And in other countries the disparity is even greater – in Italy the average guess is 48% when the real figure is only 21%.

So it seems that ageing is very much in the public's consciousness. But when it comes to thinking about our own life in older age, our focus tends to be on retirement, pension pots and our physical health rather than what our future care needs might be. Only one in ten adults aged 50 or above in Britain consider requiring care services as a defining aspect of older age[19].

In some ways this makes sense – people don't typically need care services until much later in old age, and much of the care provided to Britain's older population is given informally by family members rather than by the social care sector. Data from the Office for National Statistics[20] suggest nearly 1.4 million people aged 65 or over in England and Wales provide unpaid care for a partner, family, or others, and, according to Age UK[21], just 16% of people in the UK aged 85 and above live in a care home.

And, while most of us will have come into contact with the National Health Service or similar health services in our lifetime, familiarity with, and experience of, residential care for the elderly is relatively low. One in four people say they don't know if people are treated with dignity and respect when they use social care services (27%) compared with

14.

only one in twenty who say the same about NHS hospitals (5%).[22] Ratings of services among users themselves are also lower for social services for older people in general, when compared with ratings of NHS hospitals, and indeed other types of public service.[23] Negative news stories highlighting sporadic failings in the care sector have filled the gap, doing little to inform customers about the range of (good quality) residential care services available.
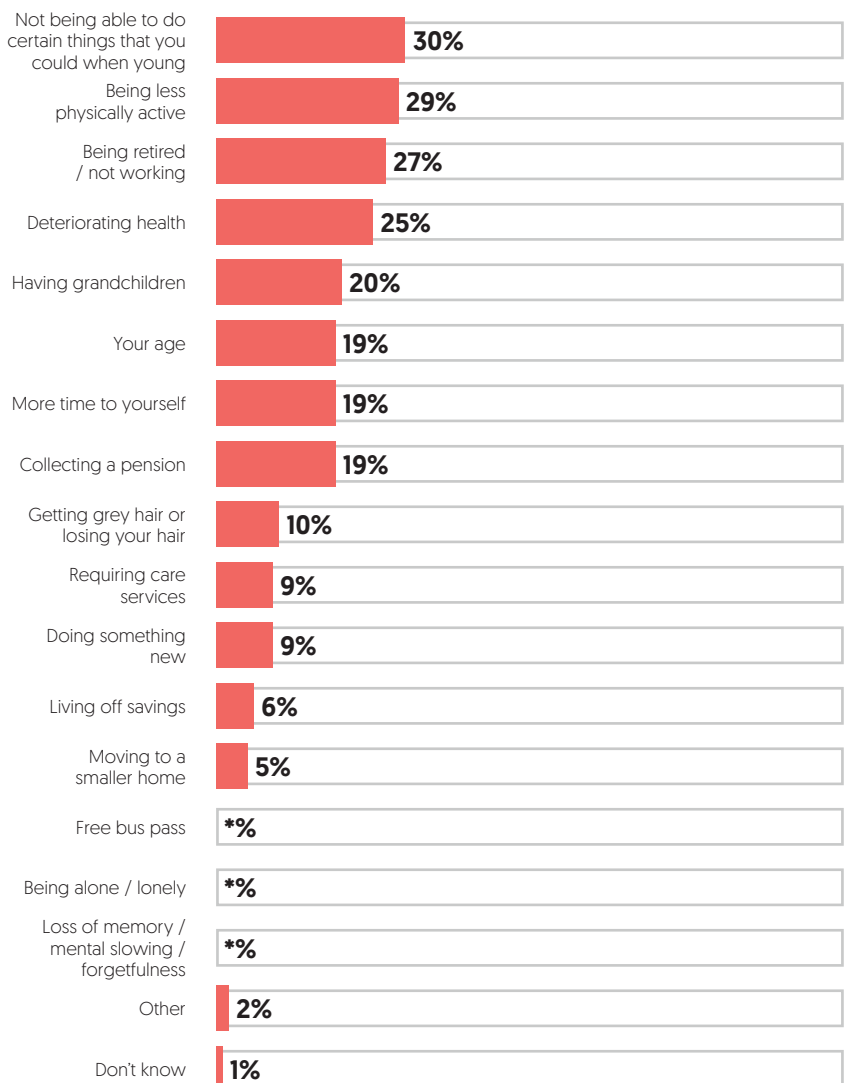
The Your Care Rating survey was developed as a sector-led response to these issues. It is endorsed by Care England, the representative body for independent care services in England, the National Care Forum, which represents UK not-for-profit health and social care providers, and supported by a Board of representatives from across the sector.

For the past five years, providers of residential and nursing care have taken part in an annual survey covering more than one thousand care homes across Britain. By collecting residents' views through an anonymous, paper-based survey and by publishing the results[24], providers make a commitment to transparency and to hearing and acting on residents' opinions of their care. In 2015/16 over 20,000 residents took part in the survey. At the same time the survey was expanded to capture views of residents' family and friends and this year, an employee engagement pilot survey is in its design stage, providing a vital benchmark for employees in the care sector and helping to complete the picture of life in the care sector.

Results from the survey tell a very different story about life in residential care from some of the newspaper headlines. An average of 96% of residents taking part in the survey were satisfied with the overall standard of their

Figure FIVE.

Which two or three of the following phrases define "older age" to you?

Phrase	Percentage
Not being able to do certain things that you could when young	30%
Being less physically active	29%
Being retired / not working	27%
Deteriorating health	25%
Having grandchildren	20%
Your age	19%
More time to yourself	19%
Collecting a pension	19%
Getting grey hair or losing your hair	10%
Requiring care services	9%
Doing something new	9%
Living off savings	6%
Moving to a smaller home	5%
Free bus pass	*%
Being alone / lonely	*%
Loss of memory / mental slowing / forgetfulness	*%
Other	2%
Don't know	1%

* indicates a percentage of less than 0.5% but greater than zero.

Results from the survey tell a very different story about life in residential care from some of the newspaper headlines. An average of 96% of residents taking part in the survey were satisfied with the overall standard of their care home in 2015.

Figure SIX.

	Residents' survey	Family & friends' survey
Overall satisfaction	96%	93%
Residents are treated with kidness, dignity and respect	98%	96%
Residents can have enough of their own things around them	98%	98%
Residents' privacy is respected	95%	93%
Staff have time to talk to residents	85%	73%
Involvement in decisions about / have a real say in how care is provided	84%	93%
Enough staff to meet the needs of residents*		58%

■ Residents' survey – % strongly/tend to agree
■ Family & friends' survey – % strongly/tend to agree
*Asked in the Family & friends' survey only

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care home in 2015. Nearly all residents agreed they were treated with kindness, dignity and respect (98%). Relatives and friends of those in care homes were similarly positive, particularly about their involvement in decision-making processes and aspects of care relating to quality of life in the home.

Results are not uniformly positive, however: relatives and friends were less sure about whether there are enough staff to meet residents' needs – over a quarter disagree that this is the case (27%), giving providers an opportunity to identify aspects of their service which need improving.

Your Care Rating provides a model for other countries to emulate. While ageing populations will undoubtedly affect different countries in different ways, it is vital that care home residents' voices are heard across the world. Your Care Rating shows that it is possible for care providers and the care sector more widely to listen to residents and relatives, and use their feedback to meet some of the issues outlined above. The survey provides a credible, and much-needed challenge to the adverse publicity which has damaged public perceptions of life in care homes. At the same time, it provides vital information on exactly what aspects of the service do need improving.

Choosing a care home is arguably one of the most difficult choices an individual or family requiring care is likely to have to take in later life, so ensuring that customers are as informed as possible is absolutely crucial. Yes, we are getting older, but Your Care Rating shows the benefits of being a bit wiser about residents' needs and improving the quality of later life.

Figure SEVEN.

Participating Your Care Rating Care Homes 2015/16

Exporting healthcare

A new phase for the 'lucky country'   Daniel Evans, Australia

Australia's economy is in transition. The nation is actively trying to set course for an economy where the relative GDP footprint earned from being the world's quarry is smaller, replaced by all manner of services, knowledge and experiences; mostly exported into emerging Asian countries. We are plotting a plan to be less brawn, more brains. Less soil, more skills.

Australia prides itself on delivering high quality public services. Our citizens have come to demand it, and for the most part we deliver. Exporting high quality services – in the areas of tourism, education and health-care – can assist the nation in working towards achieving its new economic goals.

The lucky country

In 1964, journalist and academic Donald Horne labeled Australia the lucky country. Horne's phrase – intended to jibe the nation that random good fortune, not governance, innovation, nor effort, had informed our prosperity – was, perhaps ironically, accepted by Australians as something to be proud of; a phrase to be printed on badges, recited at citizenship ceremonies and spoken aloud during adverse times.

Blessed with a favourable climate, abundant minerals, export markets for those minerals, and comfortably isolated from some of the world's more defining worries – such as disease and war – Australia has historically been lucky. Australia has made the most of this good fortune, for most of its people. Australia ranks second only to Norway on the United Nations Human Development Index[25], our cities appear on the world's most livable lists[26] and our citizens are more likely to be satisfied with their lives as a whole than the average human[27].

While Australia may well be the lucky country – and this luck has been fashioned into a higher quality of life – those base elements that informed our prosperity to this point have shifted. In recent years, export demand for our minerals has contracted. Drought, fire and flood are more common, severe and impactful. Those benefits of isolation are ever less relevant in a global, unpredictable, connected and yet atomised world.

Australia is facing other challenges too. Our growing population is concentrated on the urban fringes of our major cities – where houses spread like a well-humidified moss – placing pressure on infrastructure, services and hurting productivity, wellbeing. Conversely, as the population grows, the relative (and absolute) share of Australians living and working in rural areas is in decline. People – mainly young people – leave regional and rural Australia because they cannot find work, education, meaning. Relatedly,

our adolescent suicide rates are some of the worst in the world.

Like a lot of developed countries and as discussed in other articles in this journal, we have an obesity problem. One out-of-every four adult Australians is obese. We also have an ageing population. Just 30 years ago, you could almost fit every Australian aged over 100 into the same bus. By mid-century, we will have around 40,000 centurions[28] – enough to fill a football stadium.

These few examples of the macro geo-demographic challenges facing Australia, coupled with the contraction in our traditional export markets, mean that we have to start finding our luck from elsewhere if we are going to even maintain our living standard, let alone improve upon it.

Making our own luck

Government and business have recognised this need for a step-change, and have identified a range of new opportunities that exist beyond our shores. We are well positioned to capitalise on the delivery of high quality services to the likes of China, Korea and Japan. To this end, smartly, an acknowledgement of such was central to the design of our free trade agreements with those nations.

Looking now at China in a bit more detail. China's economy will (like Australia's has done) transition away from a manufacturing base to one that is more focused on consumption, and services. Already we are observing that the relative share of Australian services exported to China has and will continue to increase.

The rapid, and unprecedented ascent of China's middle-class initially created opportunities for Australia in the primary resources sector. This next wave opportunity was (and is) demand for education and tourism services. Beyond education and tourism, a new wave exists in the provision of high quality health services and health related education.

In the 2016 Ipsos Life in Australia report[29], Australians selected the provision of high quality health services as the third most important attribute that makes somewhere a good place to live. Given its importance, and long-term reign as a top issue facing our nation as reported through the Ipsos Issues Monitor[30], the availability and performance of health services is always in the societal and political lens.

Perhaps because of this, Australia excels in the delivery of these services. Despite our relatively complex government structures and vast geography we offer one of the most efficient and equitable health systems in the world; ranking eighth of 55 nations on the 2015 Bloomberg global health efficiency ranking[31]. Beyond efficiency, the 2015 edition of our biennial Ipsos Healthcare and Insurance Australia report showed that Australians have never had more confidence in their local public hospitals. In addition, the Ipsos administered New South Wales Patient Survey[32] found that two out-of-every three patients from Australia's most populous state reported that the overall care they received from public hospitals was 'very good'.

Australia not only provides high quality health services, it places a value on – and is a leader in – effectively measuring the experiences of patients who engage with services.

We have an ageing population. Just 30 years ago, you could almost fit every Australian aged over 100 into the same bus. By mid-century, we will have around 40,000 centurions — enough to fill a football stadium.

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Patient experience rather than patient satisfaction

Patient experience research is a growing global movement that acknowledges that a person's health outcomes and perceptions are not only influenced by the nature and quality of the clinical care provided, but how that care is delivered[33]. This type of research recognises that while consumers themselves may not have the medical nous to assess the quality of the clinical treatment provided, they are certainly best placed to comment on the care that they receive. Ipsos in Australia is at the forefront in the provision of this type of research.

Patient experience surveys utilise an 'experience' survey model, rather than a traditional 'satisfaction' model. In short, this means the majority of questions focus on whether or not best practice aspects of care occurred, as perceived by the patient. In a satisfaction model patients are asked how they felt about – or would rate – their experience. Evidence suggests that experience healthcare surveys are more robust, objective and actionable than satisfaction surveys[34].

Beyond measuring experiences, there is a growing acceptance of the utility of the information derived from patient experience research, and the role it can play in identifying and remedying cultural and/or clinical deficiencies. Further, there is an emerging movement towards making the results of such research fully available for public consumption.

While Australians' are feeling more positive about the public hospital system than ever before, the ageing, obesity, other lifestyle and population distribution issues will continue to drive demand for services delivered through this system. In addition, that positive sentiment and high quality experiences will also push Australians who have private hospital insurance to make an economic decision as to whether they should receive care through a public hospital as opposed to a private facility.

One out-of-every two Australians has private hospital insurance, and the government imposes financial disincentives for dropping the cover. Despite paying this insurance, Australians still have to co-pay for most procedures delivered in the private setting. Given the high quality of clinical care in the public system – and increasingly high standard of public hospitals themselves – the service-quality gap between public and private hospitals is narrowing.

While this view of the future is certainly no dystopia, it raises two clear questions. How can Australia continue to deliver such high quality services in an environment where demand is increasing and national revenues are projected to be relatively stable, and what can private hospitals do to adjust to a market where the perceived quality of care is similar in the public setting?

In practice, the China-Australia free trade agreement [FTA] has provision for Australian private hospital providers to

Figure EIGHT.

Proportion rating service in hospitals as 'high quality'

Public hospitals   Private hospitals
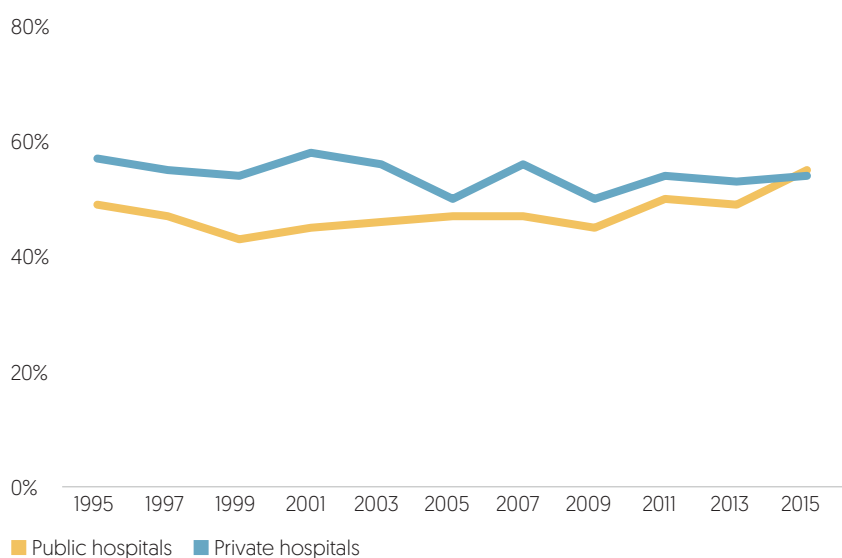
establish and operate profit generating hospitals in China. While this will certainly create opportunities for Australian providers on-the-ground in China – and some large operators have already exercised this opportunity – it also opens the door for those same providers to explore delivering services to Chinese citizens in existing Australian private facilities, coupling the experience with other unique export opportunities that are in high demand – such as tourism.

Further to this, a recent report by the China Studies Centre at the University of Sydney cited several areas[35] where Australia could leverage its expertise

to meet the ever-growing demand for high quality health services. Like Australia, China has an ageing population. However, unlike Australia, China does not have the infrastructure, experience or necessarily the skills to deliver against their massive demand. China will need assistance, and, given the provision of aged-care services is also included in the FTA, we are well positioned to provide it.

With regard to health education, China consumes one-third of the world's cigarettes. Australia has one of the lowest tobacco consumption rates in the world. Working with the Chinese government to assist in reducing smoking rates –

through education and treatment – is another area where we can leverage our skills to meet their need.

Australia is, has and will hopefully continue to be lucky. But luck is fickle, a head-start and potentially useless without intervention. If Horne were around to coin his famous phrase today, one would hope it would be because we have made the most of our random good fortune, through strong governance, innovation, and effort. And that is something to be proud of, to print on a badge, to recite at citizenship ceremonies and speak aloud during adverse times.

Australia has been lucky, but luck is fickle and potentially useless without intervention; strong governance, innovation and effort.

Choose life

Looking at health beyond healthcare

Ben Page, UK

Ben Page interviews Duncan Selbie, Chief Executive of Public Health England (PHE). PHE is an executive agency of the UK government's Department of Health, and an independent delivery organisation with the operational autonomy to advise and support the UK government and the NHS.

BP: It's now been almost four years since Public Health England (PHE) was established, bringing together public health specialists from more than 100 organisations into a single public health agency for England. Looking back over this period, what do you think have been your organisation's greatest achievements during this time?

One of our early achievements has been to put an apostrophe and 's' after public. It's about the public's health. We have established the beginnings of a narrative that explains health is more than about healthcare. It is also about the wider determinants like having a job, having companionship and friendships and belonging to some kind of social support network. These are vitally important to your health and wellbeing and more so than only the treatment of disease.

An important area of our work that is perhaps less well known is on infectious diseases and other hazards such as radiation and chemicals. We have 3000 scientists stationed all over the country, working on deadly pathogens and quietly keeping the country safe. Also, we have dealt with significant and better known challenges like Ebola and quite controversial topics like E-Cigarettes and sugar.

In the Five Year Forward View,[36] we addressed the balance of running an efficient healthcare system and improving the health of the people. We are also changing the language we use in healthcare. When clinicians talk about 'isolation of the elderly', they're not only talking about conditions and diseases. Most people – young and old – want to meet their friends once a week, and have enough money to live on and a reason to get up in the morning.

The two global measures of health are life expectancy (which is improving in England), and how long you live in good health. The NHS comes top for efficiency but we are second to bottom only to the US when it comes to healthy life, and that is because we conflate good health with the healthcare system. In the UK, we believe that further and greater investment in the NHS will improve the health of the people and the truth is that it won't, certainly not on its own. Improving health in life is about the wider questions – is our economy creating jobs that people can get, is our education system up to scratch to prepare young people for work, is there enough training?

BP: The national unemployment rate has fallen to 4.8%[37]. Are things getting better? To what extent do we need to widen the narrative about public health to workplace health?

If you take the example of the North East, which has a very good health system, there is a stubborn health gap that is not improving. There is a difference of 20 years in life expectancy between the north and the south of the country. 4.8% is the national unemployment rate but in the North-East, it's at 7.5%.[38] The combination of tobacco use and unemployment means that people are dying before their time. So you can look at the nation and conclude that it's not so bad, but when you look at the pockets and the variations, it's a different story.

Work is a very important part of public health and I think we are gradually changing the mindset. So when the government said in its recent Green Paper that work is a health outcome, we were delighted. Having a job is good for your health, not having a job is not good for your health.

And the way support is offered is changing. If you don't have a job, we want to help you get into work. If you do have a job and become unwell, we want to see support re-framed to ensure you keep your job – rather than just getting signed off.

BP: In terms of preventative spending and investment in public health over the next three years, what are your goals?

We have given advice to the NHS across six priority areas. Tobacco accounts for half of the health gap and, in spite of 50 years of tobacco control, accounts for half a million hospital admissions a year. I want to start by making hospitals tobacco free – we don't want staff smoking in hospital doorways. There are also a million alcohol admissions a year and having alcohol expertise at the front of house of every hospital makes a big difference.

Another topic of focus is sugary drinks

sold in hospitals, which Simon Stevens, Chief Executive of NHS England, is pursuing. Levying a fee on these drinks is a huge step in the right direction. We are also looking at hypertension and falls in the elderly – all of which will help manage demand in the NHS.

BP: We know from our 'Public perceptions of the NHS' survey[39] that cancer and, to a lesser extent, dementia, mental health and heart disease are among the public health issues the public are most concerned about. Are we worrying about the right things, or are there others we should be thinking of?

We have found that dementia is the biggest concern for those over the age of 55. I think that's because with things like cardiovascular disease and cancer, people have a clearer sense of what the treatment looks like. With dementia, this is still unclear.

But again, this is about people and it's not just a simple case of presenting people as conditions and diseases. We're still focusing too much through a healthcare lens. The message we are putting out there is that things like cutting down on smoking and doing exercise will impact on your health, and the earlier you do it, the better. If you take action on these things now, you can expect to double your chances of good health when in your 70s. How do we keep you out of hospital and well for longer? That is what we should be worrying about.

Across government, we are focusing on three priorities: air quality with the Department for Environment, Food and Rural Affairs and the Department of Transport, child obesity, which is a cross-government issue, and worklessness, which we have already touched upon.

BP: You describe obesity as being an 'all of government' issue. Following the publication of the Childhood Obesity Plan in August 2016[40], who specifically should take responsibility for this, and what would you say is the role of the private sector on this issue?

So firstly, the Childhood Obesity Plan is a government plan backed by the Prime Minister. As we implement the plan we can expect to see a reduction in child obesity. For example, there is something called Nutrient Profiling, which PHE is responsible for. It outlines what 'good' looks like in food and sets the advertising standards on what you can and can't say. So when a manufacturer says their product is 'healthy', it must be in line with the Nutrient Profiling.

There are two major initiatives that we've worked on in this plan. One is the sugar levy – which hasn't yet been implemented but we are already seeing its impact. Tesco has announced that it is changing its product lines. Ribena – who are a big player in this – are reducing the sugar content of their products in line with the levy, but I would add that this is not entirely due to the levy. A big part of it is that the industry wants to be on the right side of the health message and be where consumers are.

And the other big priority, which remains unparalleled across the world, is to take 20% of sugar out of the food that children consume, which is really all foods. We're focusing on nine food groups, including ice cream, yoghurt and cereal, and we are kicking off the discussion with the food industry to achieve this over four years. The industry did it with salt and has led the world. Half of the salt that used to be in bread is gone, and it was done without regulation, in a collaborative and collegiate way.

Work is a very important part of public health and I think we are gradually changing the mindset. Having a job is good for your health, not having a job is a health hazard.

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BP: It's interesting you say that. We're looking at the marketing of these foods in focus groups, and when you tell people that the ice cream that they have just consumed is 'indulgent', they report enjoying it more in blind tastings. This brings me to communication — so much of our work is around how best to make messages stick. The rational public health clinicians would believe that you give people the evidence and they will absorb it. You and I both know that's not how it works. What have you found are the most effective examples of communication to improve health outcomes?

The thing I am constantly striving for is to have these health conversations in a relevant and meaningful way. Behavioural insight is also a key part of it. What is the point of telling someone, who has twenty other problems to worry about, that smoking is bad for their health? They obviously know that! It's a bit like the 'indulgent' ice cream...

We're engaging in new ways. We've got a talented group of marketers who have worked on a wide range of industry-leading campaigns including Change4life, Stoptober and Stay Well This Winter, as well as some exciting new developments like the Be Sugar Smart app that has just won the industry's Oscars.[41] Around two and half million people have downloaded it and manufacturers are responding because consumers are using it. We have just released a new app, Be Food Smart, which includes information on sugar, saturated fat and salt.[42]

BP: That's interesting. Given the amount of data being collected about our lives via devices, like our smartphones and Fitbits, how effective do you think they are to communication and improving health outcomes?

Very effective. So, the Heart Age tool is a great example. This app tells you the age of your heart compared to your real age. When we launched it, half a million people completed it in one day. With the Stoptober campaign, we used digital marketing exclusively, primarily on Facebook — at only 20% of the cost compared to the television ads in 2015. We already know that 73% of smokers are on Facebook. Research tells us we have got just three seconds to get the user's attention and 11 seconds to get across our message. We haven't got all the evaluations back yet, but early results of quitting rates have been very positive.

So we have millions of data points about people, and we're also using this data to show the food industry what and how people are buying. Companies want to make a product that customers are willing to pay for. And connecting it back to us, what possible advantage would PHE have in not helping these people to succeed?

BP: For our readers — health practitioners, researchers and politicians — what's the single message you would like to deliver about what we should be doing in public health in Britain and around the world?

To the public, I would say the following. Poor health is not inevitable. And not everybody has the same choices, but everybody has a choice. Nobody is suggesting, least of all PHE, that you shouldn't drink or eat the foods you enjoy. No one is suggesting that the indulgent ice cream is bad. We're saying that there are options, and it's about being more aware of long term health

Half of the salt that used to be in bread is gone, and it was done without regulation, in a collaborative and collegiate way.

factors and things you can do to make a difference — to make sure you're around for your family and friends.

For a healthcare audience and politicians, we must tackle the mindset that conflates good health with the NHS. We have a lot of opportunities and assets that make a difference to good health - we need to choose how best to use them, focusing on people living in places rather than the treatment of avoidable illnesses. And there is always a choice.

Wake up and smell the fat

Communicating the personal risk of obesity   Louise Park, UK

There is a lot of noise about obesity in the world today. The attention it attracts is not surprising given the WHO says it is, "a significant and urgent threat to health that is relevant in all countries"[43]. Taking the UK as an example, one in four UK adults is classified as being obese whilst almost two in three are considered overweight or obese. The scale of the challenge faced by the UK is matched elsewhere, with similar or higher levels seen in the USA, Australia, Saudi Arabia and Mexico among others[44]. Globally, we have transitioned to a world where more people are obese than underweight, reflecting the increasingly globalised nature of this issue[45].

Obesity represents not only a health crisis in the UK, but a significant contributor to the funding crisis, with Simon Stevens, the Chief Executive of NHS England, recently revealing that, "we now spend more on obesity than on the police and fire service combined."[46] Given the multitude of challenges presented by obesity, there are calls in the UK for it to be treated as a "national risk", giving it a significance on par with that afforded to terrorism[47]. This echoes Michelle Obama's words at the launch of Let's Move [the US initiative to tackle childhood obesity] when she said, "the physical and emotional health of an entire generation and the economic health and security of our nation is at stake."[48]

Obesity is an issue which is not only widely recognised by policy makers, the NHS and the media but also by the British general public who, over the past decade, have consistently named obesity as one of the greatest health threats facing the general population[49]. There are however, two problems with the public's awareness about obesity. The first is that, whilst they recognise obesity as an issue, the public still don't grasp the full scale of the issue. They believe 44% of the population is overweight or obese when the reality is far greater at 62%[50] The second is that they don't believe the issue applies to them. Over two in five say obesity is one of the biggest threats to the overall health of the British population (42%) yet only 17% say it is a threat to their own health.

The British public are not alone in this regard. Most countries underestimate the proportion of their population who are overweight or obese (most notably in Saudi Arabia). And many countries show higher levels of satisfaction with their weight than perhaps they should[51].

One could argue that the first issue doesn't matter: in fact, raising awareness of the scale of the issue could be counterproductive by setting a norm for being overweight/obese. As American psychologist Robert Cialdini[52] has long warned, there are dangers to suggesting undesirable behaviour (or in this instance, excess weight) is widespread as it risks normalising that behaviour.

But the second issue does matter and so far, it seems communicators could do more to bring home the personal realities of obesity given so few see it as a risk to themselves.

So how can we more successfully communicate these personal risks? Our research points to a number of factors. The first concerns clarity of message. Through our work we know the public complain of receiving a high volume of, at times confusing, messages concerning their diet and weight. Confounding advice risks disengagement with

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Most countries underestimate the proportion of their population who are overweight or obese. And many countries show higher levels of satisfaction with their weight than perhaps they should.

Figure NINE.

Out of every 100 people aged 20 years or over, how many do you think are either overweight or obese?

% point difference	too low | too high	Avg. guess	Actual
India	+21	41	20
Japan	+9	32	23
China	+6	34	28
South Korea	0	32	32
South Africa	-8	47	55
Netherlands	-9	40	49
Brazil	-9	47	56
Serbia	-11	42	53
Australia	-11	51	62
Hungary	-11	49	60
Argentina	-12	40	52
Canada	-13	43	56
Chile	-13	53	66
Italy	-14	36	50
Ireland	-14	44	58
Peru	-15	41	56
Mexico	-16	53	69
United States	-16	50	66
Belgium	-17	36	53
France	-17	32	49
Germany	-17	40	57
Poland	-17	40	57
Great Britain	-18	44	62
Sweden	-19	33	52
Colombia	-20	35	55
Spain	-20	38	58
Norway	-20	33	53
New Zealand	-21	47	66
Montenegro	-24	35	59
Russia	-26	31	57
Israel	-33	24	57
Turkey	-33	32	65
Saudi Arabia	-43	28	71

the issue. Public Health England (the national body tasked with improving the nation's health and wellbeing) is acutely aware of the need for clear, consistent messaging concerning diet and weight, as evidenced by its response to the National Obesity Forum and Public Health Collaboration's recent opinion paper,[53] though communicating unambiguous advice is a challenge when even the experts don't agree on issues such as dietary guidelines.

Salience is also important. Often the issue of obesity is discussed in terms of statistics; used as a means to convey the scale of the problem. However, we've shown above this has limitations given the scale of the problem remains unrecognised by the public, and across our work we've observed that the use of vivid anecdotes and more emotional messaging concerning the health of friends and family resonates better with the public than the presentation of numerical facts about health risks.

We need to make sure the messaging around obesity reflects how the public think about the issue if we
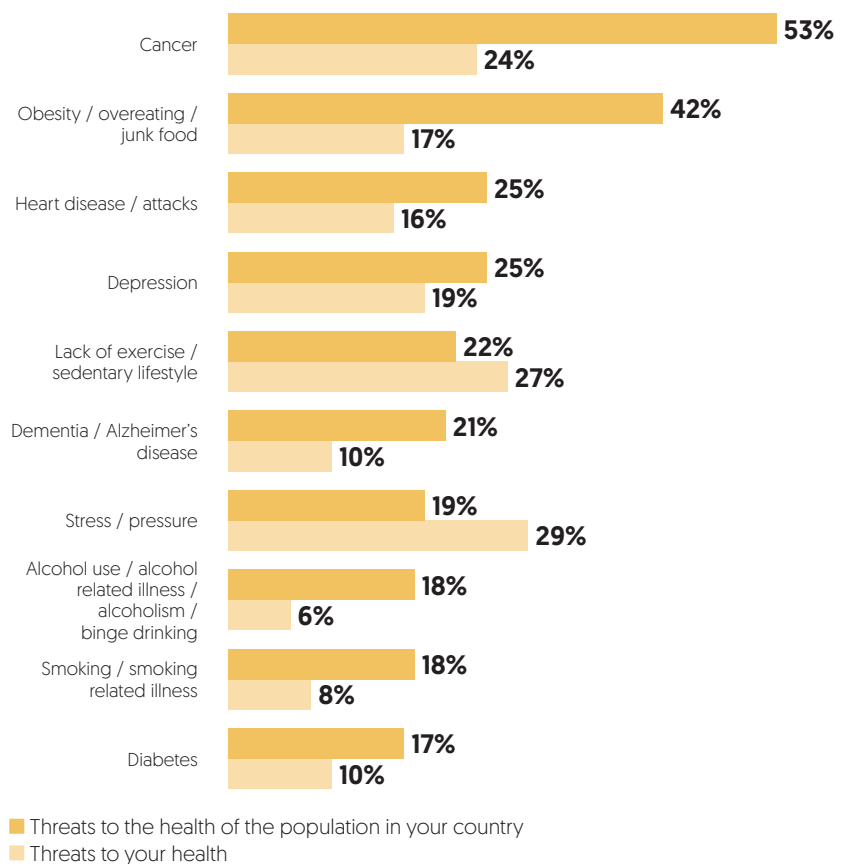
26.

want to maximise the impact of any communication. The approach taken in Public Health England's Change4Life campaign in England and Wales is to convey positive, motivational messages that do not mention the word 'obesity' but instead focus on making healthy behavioural changes – and doing this it has seen traction with its target audience of young families[54].

But perhaps this could be complemented by communications targeted at individuals which make more explicit reference to body image. We know from our research that people often register their concerns about weight problems in the context of body image and confidence (rather than worries about distant health problems). Could governments better leverage these body image concerns rather than ignoring them? But of course the question then becomes whether this could ever be done sensitively enough to avoid the risk of 'fat-shaming'[55]?

How to communicate sensitively on what is an emotive subject just adds to the plethora of other risks facing communicators, such as how to avoid being seen as a nanny state (as stated by the UK Faculty of Public Health, a "canny, not nanny, state is needed to tackle obesity"[56]) and how to avoid individuals being entirely blamed for this epidemic, recognising we live in an increasingly obesogenic environment[57]. Clearly raising understanding of the risks posed by obesity is just one lever to be pulled in trying to tackle this incredibly complex and entangled health issue. However, it seems that better connecting the global issue of obesity with the personal realities of individuals' lives needs to be a considered part of the UK, and other nations', response to (and prevention of) obesity.

Figure TEN.

Which of the following, if any, are the 3-4 biggest threats to the health of the population in your country / your health? (Prompted) Top 10 mentions shown

Category	Threats to population	Threats to your health
Cancer	53%	24%
Obesity / overeating / junk food	42%	17%
Heart disease / attacks	25%	16%
Depression	25%	19%
Lack of exercise / sedentary lifestyle	22%	27%
Dementia / Alzheimer's disease	21%	10%
Stress / pressure	19%	29%
Alcohol use / alcohol related illness / alcoholism / binge drinking	18%	6%
Smoking / smoking related illness	18%	8%
Diabetes	17%	10%

■ Threats to the health of the population in your country
■ Threats to your health

A new medicine?

Can health literacy drive system transformation, improve public health and foster patient engagement?

Chris Martyn, Jennifer McLeod Macey and Lauren Korosec, Canada

1. Is health literacy even a challenge among the public?

The answer is yes. Using the nine metrics we developed to feed into an index (bucketed into three themes – "Skills," "System Navigation," "Proactivity"), we found that health literacy is a challenge for a sizeable proportion of the public, with those at the top matched by the numbers of those with low levels of literacy.

Furthermore, while the three buckets that comprise the overall index all appear to be a challenge for the public, the weakest link is "Proactivity" (e.g., "I pro-actively seek out information on how to preserve my overall health and well-being," "When accessing health care services, I'd rather be told what to do instead of having to figure out things for myself").

2. Can we assume that health literacy reflects actual (proven) knowledge?

Absolutely. We developed a test as part of the survey where we scored respondents on their actual knowledge across nine "test" questions around labels, recipes, recommended screening, exercise, diet, and more. This test included asking respondents to interpret an example recipe and an example nutritional label that we presented to them. The results indicated that only 47% of those with the lowest health literacy could be classified as having some degree of accurate actual knowledge compared with 77% among those with the highest health literacy. Importantly, those with the lowest health literacy appeared to have particular difficulty in interpreting things they might be faced with in real life situations, such as nutrition labels.

The concept of health literacy is nothing new. There are reams of studies and definitions, and it comes and goes as a topic in discourse in the healthcare community. However, it is universally accepted as important and relevant. Improving people's levels of health literacy, their access to health information and their capacity to use it effectively, is critical to empowerment and ultimately improving people's health (while also reducing pressures on healthcare systems).

With this in mind, as part of its Patients First: Action Plan for Health Care, the Ontario Ministry of Health and Long-Term Care (which oversees one the largest publicly funded healthcare systems in the world) wanted to determine whether health literacy could be a valuable enabler in healthcare quality and delivery in the province. The Ministry also wanted to assess whether they could develop an accurate, replicable and quick way to measure health literacy in the various studies they conduct. Below we answer nine key questions about health literacy among the public.

Canadian Public Health Association: "Health literacy is the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course."

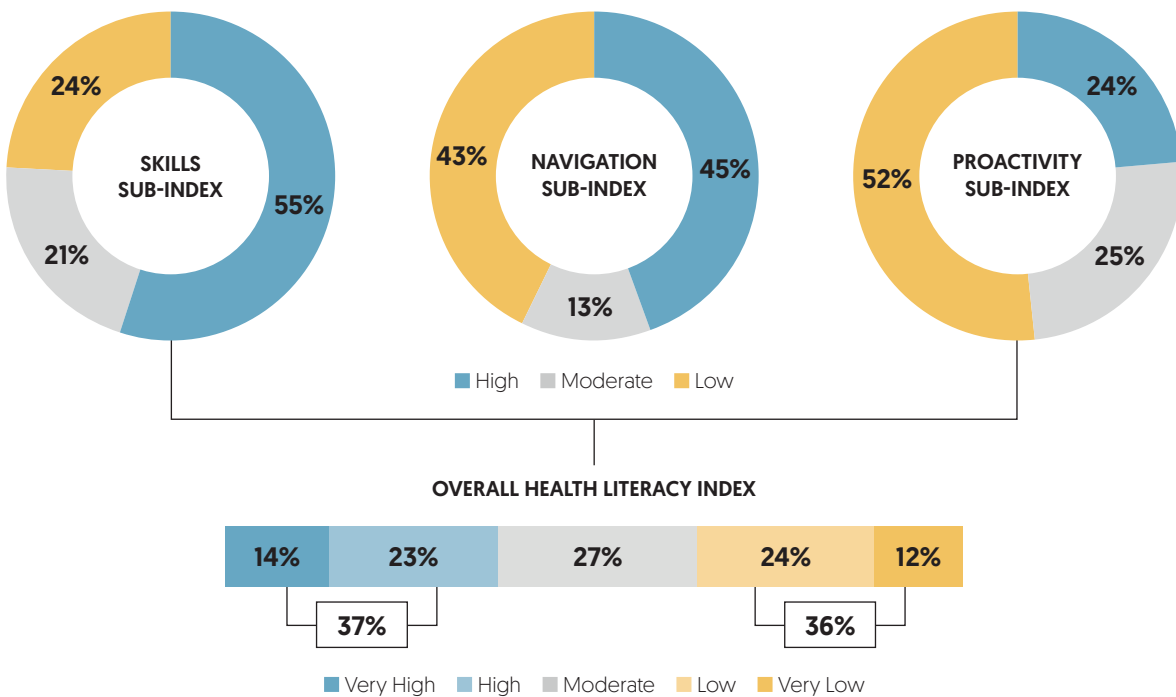**World Health Organization - 7th Global Conference on Health Promotion:** "Health Literacy is the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health."

Figure ELEVEN.

Overall health literacy index

The index is unweighted – each sub-index is a simple combination of responses across relevant items calibrated to a 1-10 scale; overall index simple combination of the three sub-indices; 9,10 = Very high, 8 = High, 7 = Moderate, 6 = Low, 1-5 = Very low

3. Is health literacy related to living a healthy life overall?

Unequivocally. There is a very clear relationship between health literacy and personal behaviours such as healthy eating, increased physical activity, and good mental health. This was best reflected in the results from a Healthy Ontarian index we created by combining responses to eight questions addressing healthy diet, physical activity, proper sleep, stress management, not smoking, limited alcohol consumption, and a healthy weight. While it is clear that living a healthy life overall is a significant challenge among the general public (only 51% can be classified as living at least a moderately healthy life overall), twice as many high health literate Ontarians as low health literate Ontarians (61% vs 32%) fit this profile.
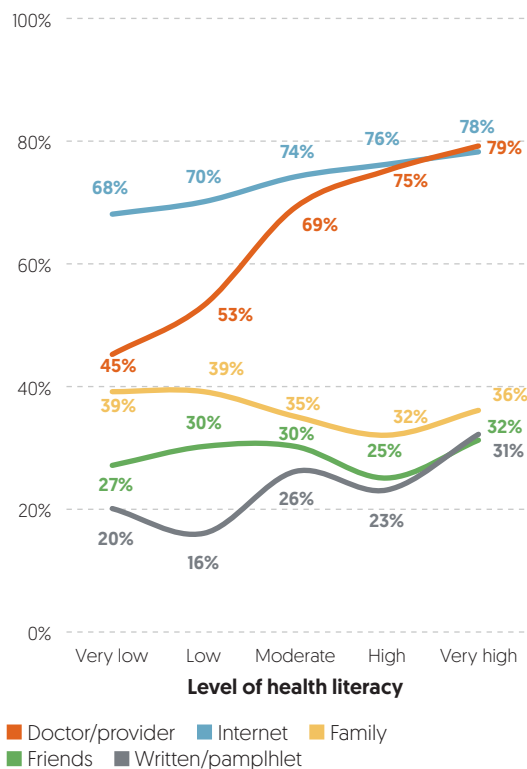
4. Is health literacy related to how well someone manages their healthcare challenges?

Yes. For example, among chronic illness sufferers, more than twice as many high health literate Ontarians as low health literate Ontarians (58% vs 26%) rate high on an index of chronic illness management (combined responses to six questions including ability to manage, if they have ever experienced a crisis, etc.)

Furthermore, high health literate

29.

Figure TWELVE.

Sources used for health information in last year

Level of health literacy

- ■ Doctor/provider ■ Internet ■ Family
- ■ Friends ■ Written/pamplhlet

Figure THIRTEEN.

Activities carried out online relating to health in last month

Level of health literacy

- ■ Asked questions ■ Shared links

Ontarians who have used select healthcare services in the past two years (hospital stay, surgery, ER) are much more likely than their low health literate counterparts, to say that they fully followed discharge plans.

5. Is health literacy related to system perceptions?

Yes. High health literate Ontarians are much more positive than low health literate Ontarians in assessing the healthcare system. For example, they have higher confidence in the system (87% vs 65%) and are much more likely to believe that they are getting good value for their tax dollars (64% vs 34%).
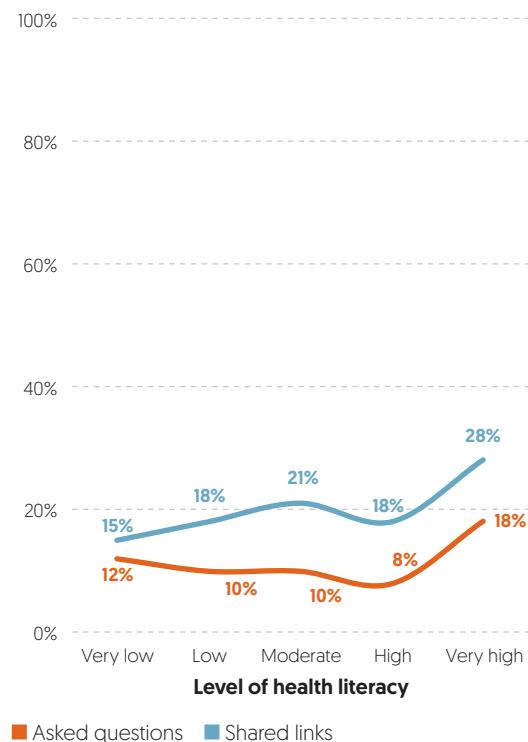
6. Is health literacy related to propensity to "engage" with the system?

Absolutely. High health literate Ontarians are much more likely than low health literate Ontarians to believe they have a personal responsibility to take care of their own health (personal responsibility measured as a combination of responses to five questions including important to take personal responsibility,

people have obligation take control, etc.).

Furthermore, high health literate Ontarians are much more likely than low health literate Ontarians to feel that they are equipped to "engage" across several areas including having the tools, skills, knowledge and opportunity.

A key barrier, however, is that low health literate Ontarians are significantly more likely than high health literate Ontarians to believe that efforts to enhance patient engagement is really only about public relations (PR).

30.

Figure FOURTEEN.

Belief in personal responsibility to care for own health (combined responses to 5 questions)
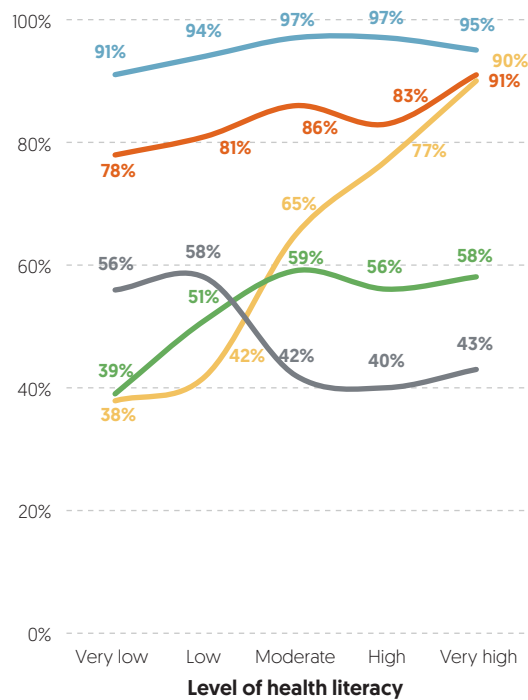
- Interested provide personal experiences
- Important able provide feedback
- Personal responsibility
- Currently feel engaged
- Engagement really just public relations (PR)

Figure FIFTEEN.

Feel "very well" equipped to engage

- Have skills
- Have tools
- Have knowledge
- Have opportunity

7. Is the Internet the answer to increasing health literacy?

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Possibly, but not necessarily. If current behaviour is any measure, while the Internet is a widely used source for health information currently among high health literate Ontarians, it is much less frequently used among low health literate Ontarians. Whether this is driven by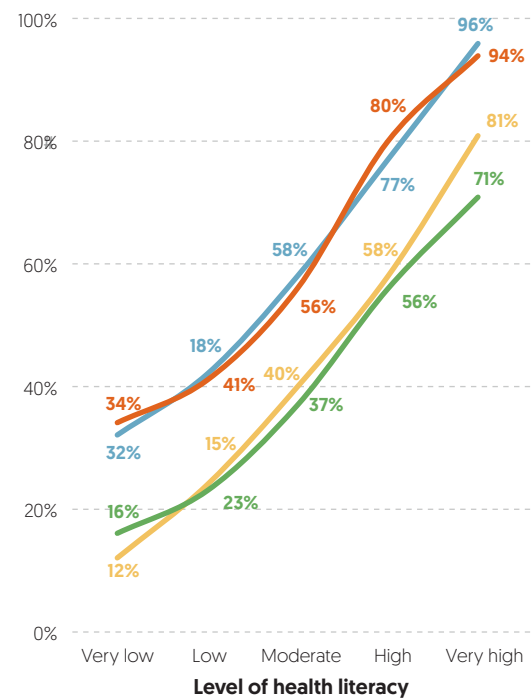 access, perceived comfort, or awareness is a key question still needing to be explored. But the implications are simple: at this point, the Internet has an important role, but does not appear to be the silver bullet.

8. Are there any negative impacts of health literacy?

||||||||||||||||||||||||||||||||||||||||||||

Not many. But there are some. For example, compliance (by which we mean the extent to which a patient correctly follows medical advice) has always been an issue that healthcare providers struggle with. On an index of compliance (combining responses across three questions about how often they follow-through on doctor recommendations regarding vaccinations, prescriptions and screening), Ontarians with low health literacy tend to rate higher on compliance compared with those

31.

with high health literacy (76% vs 66%). The implication may be that one of the downsides of increasing health literacy is that it might give license to some people to self-diagnose, question the recommendations of healthcare providers, and so on.

9. So, what is the bottom line?

The Ministry's studies show that health literacy is a very important enabler for the delivery and improvement of healthcare services, patient engagement, and ultimately the public's health. Therefore, it should most certainly be considered as a key element in the government's system transformation and service delivery strategies.

The challenge for the Ministry is now, of course, to highlight the importance of health literacy across other government ministries and departments who might be able to help drive other literacy programs (e.g., education), and mobilize the healthcare community and stakeholders around a common definition and strategy.

Thinking more broadly, the findings from this research are generally consistent with the conclusions drawn from the work done in this area by the World Health Organization[58], the UK National Health Service, the Centers for Disease Control and Prevention and other groups in the US and health authorities in many other countries. The challenge moving forward is not only to ensure sustained attention to health literacy as a key element in worldwide health, but also to identify the very specific levers that health authorities can use to enhance health literacy in their jurisdictions. One promising area in this regard could be to apply the principles expounded in behavioural science. For example, if we can determine the extent to which the main barriers to increasing health literacy are grounded in System 1 versus System 2 thinking (i.e. in fast, instinctive and emotional reactions versus slower, more deliberative, and more logical thought)[59], then work to identify workable interventions can become more targeted.

Improving people's levels of health literacy, their access to health information and their capacity to use it effectively, is critical to empowerment and ultimately improving people's health, while also reducing pressures on healthcare.

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