The Lancet Countdown report on health and climate change is a formidable document but downplays three vital factors: inequality, consumption and growth, says **Ian Gough**

IT SEEMS churlish to criticise the Lancet Countdown report on health and climate change. It provides a comprehensive framework to chart the impacts of climate change on health across the world, brings together research on adaptation, mitigation, finance, policies and politics, and compiles a formidable but not too numerous array of indicators to plot all this. My concern is that it downplays three critical issues: inequality, consumption and growth.

Inequality: the major contributors to climate change have been the rich – mainly centred in the global North but with rapidly rising numbers in the South. The World Bank calculated that if the 40 million drivers of SUVs in the US converted to average European cars, the emissions saved would enable all 1.4 billion people in the world without electricity to be connected without raising the overall CO2 envelope.

Consumption: the widening disparity between countries' territorial and consumption-based emissions. The former are produced within a country's borders, and the latter refer to emissions bound up in all the goods and services consumed, including imports. With the global outsourcing of production in the past four decades this disparity has grown: UK consumers are responsible for some 80% more emissions than our waning territorial emissions would suggest.

Growth: the idea of massively decoupling economic production from harmful environmental impacts including global warming. Such decoupling is urgent but is unlikely to be sufficient if endless compound growth is not questioned.

What might all this imply for climate change and public health? First, we need to kick-start an attack on unearned wealth and income, deliver decent and safe retrofitting of housing, starting with social housing and fuel-poor households, and introduce 'social tariffs' for electricity, gas and water (lower tariffs for the first units consumed).

> **We need to challenge the idea of unending growth**

Second, we need to rethink the idea of necessities and luxuries for a carbon-constrained era. The Lancet Countdown report's advocacy of 'co-benefits' – policies on pollution, transport and food that serve both health and climate goals – is important here. We could go further: for example, increase VAT on luxury products harmful to health and the environment, and reduce VAT on necessities with co-benefits. We should consider too how essentials such as water, energy, transport and housing could be delivered within a citizenship framework, analogous to health and education, rather than left to increasingly unregulated markets.

Third, we need to challenge the idea of unending growth. One gradualist way of rethinking this could be via work-time policies. We know there is a close relationship between average hours of work and emissions, so reducing paid work-time becomes not just a social and economic policy but a climate policy. A four-day week and less stressful work would likely also facilitate improved physical and mental health – becoming another co-benefit.

This radical programme raises many issues: in particular, who is to decide what constitutes 'luxuries' and 'necessities'? How can this be squared with consumer autonomy and 'choice'? How far can inequality be restrained in the light of planetary boundaries? In my book I advocate the way that forums of citizens could address these big issues, informed by radical local initiatives such as Transition Towns.

But at some stage our reliance on worthwhile co-benefits must be complemented by confronting the contribution of inequality, consumption and growth to ill-health and climate change.

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Ian's latest book, 'Heat, Greed and Human Need', is published by Edward Elgar

Information

ISSN – 2043-6580

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Themes for 2018 include Brexit and public health funding.

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The magazine of the
UK Faculty of Public Health
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Winter 2017

In this issue
> **Alan Maryon-Davis puts down the blue pencil**
> **Martin McKee on making the invisible visible**
> **What the Lancet Countdown report is missing**

Public Health Today

Through a glass darkly
How alcohol harms continue to challenge us

Public Health Today
The magazine of the
UK Faculty of Public Health
www.fph.org.uk

Winter 2017

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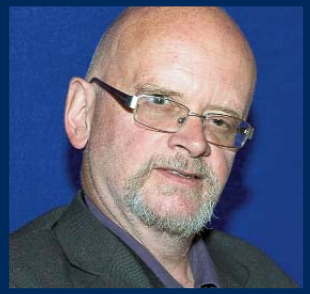
Welcome



ALCOHOL is still our favourite drug. In *Bad liver and a broken heart* Tom Waits sang: "I've drunk me a river since you tore me apart." We drink to forget, to drown our sorrows, to be sociable and to celebrate. Tom Waits also sings: "I don't have a drinking problem unless I can't get a drink." In Billy Wilder's film *The Lost Weekend* we get the image of alcoholism the industry would like us to hold – "One's too many and a hundred's not enough" – the alcoholic is diseased, deviant, alcoholism an addiction, a behaviour divorced from the regular experience of the rest of society.

The alcohol industry has learned greatly from the lies, the obfuscation and deception of the tobacco industry. They have hired their merchants of doubt to challenge the science, to resist new laws in the lobbies, to battle agreed laws in the courts, within nations and internationally. They have invented the ace denigration for the public health community – calling us 'nanny state.' They have learned to play down harm, delay and escape regulation. Bans on alcohol advertising and promotions, controls on availability, all resisted or introduced grudgingly. They have created token agencies, marginally funded, to show how responsible they are.

And the alcohol industry has been able to hide behind the notion, rarely contested, that a little alcohol is a good thing. Doctors, lawyers, journos and politicians have colluded with this. The J-shaped curve has been a cosy defence. But we also have the normal distribution of alcohol consumption. Severe alcohol dependence on one side, teetotal on the other, the majority in between. Societal harms – violence, accidents, poor mental health, poor relationships, absenteeism, poor productivity, as well as the burgeoning range of clinical conditions – can be moved, for better or worse, by shifting the level of consumption across society.

Modelling has shown a minimum unit price (MUP) for alcohol would discourage harmful consumption, with little impact on social or occasional drinkers. But MUP was opposed and deflected successfully by the industry for over 10 years. We congratulate the Scottish public health lobby on the recent momentous decision to implement MUP in Scotland. We predict confidently that Wales will follow. It's difficult to understand why it should still be such a problem for England.

Ironically though, our preoccupation with MUP has seen the tax escalator for alcohol removed, and the real price of alcohol continuing to drop. The alcohol-related harms are now particularly manifest in health losses. The number of potential years of working life lost through liver disease now approaches that caused by coronary disease and has overtaken breast and lung cancer. Hospital episodes for liver disease in the four nations of the UK are going through the roof. Nearly double in England since the Licensing Act. Over a million hospital admissions a year caused by alcohol – contributing to the 'winter pressure' all year round.

The UK has a big drink problem – we need to do something big about it.

And Tom Waits has come off the booze.

John Middleton

That's enough – Ed.

After eight years as Editor-in-Chief of *Public Health Today*, Alan Maryon-Davis has decided this will be his last edition at the helm. Here he shares his memories

What was the original concept for *Public Health Today*?
We wanted a livelier publication than hitherto – a bit more user-friendly, with contributions coming from outside and not just the 'official FPH message', type of thing. We wanted it to be broader than that.

Why did you want to be editor?
I was in my last year as President. I leapt at the idea because I'd done a fair amount of writing in the past; I was an NUJ member and vice-chair of the Medical Journalists' Association; I'd edited a magazine called *Health Education Journal*; I'd contributed lots of articles to all sorts of publications; and I'd also done a regular column for a thing called *Public Health News* published by the Chartered Institute of Environmental Health. I thought this was a way that I could be involved in FPh after my presidency rather than just fall off the cliff edge which is what happens to a lot of presidents when they get to the end of their three years.

What have you enjoyed about the role?
The themes are different for each issue, so I learn a whole load of stuff when we have our editorial meetings. They are always a bit of a mad dash – a one-hour teleconference. It's a very jammed agenda but lots of good ideas get thrown around. I love the fact that it's a vital process – it's energising.

I also like working closely with the Production Editor, the planning process, commissioning and checking the articles, the copy editing, the proof reading and then finally seeing the finished product. The whole process from beginning to end is really very satisfying.

I've also enjoyed writing the editorial bit. It's been a great opportunity to introduce

> **The whole process from beginning to end is really very satisfying**

the special feature topic and a chance to add my own spin on things. I think future editors would appreciate having that.

Any particular challenges or problems you've had with the role?
Obviously you can't pay people to contribute, so sometimes it's a bit of an issue to get them to deliver on time. One slight disappointment is that we haven't got more advertising in, because I think the magazine could pay its way if we could just get more advertisers – people running conferences and courses, masters courses in particular, book publishers, public health consultancies. I always wanted to expand it to 24 pages on a more permanent basis to make it a more substantial magazine. That of course means more time, more staff; we've always been strapped for internal resources in that sense. That's been something of a disappointment, but it could still happen. Moving it partly online could help because that would cut down on the postage bill which is a big expense. I think the magazine could have a healthy future if it's managed properly.

What has *Public Health Today* done for the world of public health?
I'd like to think it has helped bring people together into more of a public health community. Perhaps it has also helped some public health people who have gone through the training programme and are working in local public health departments or academia to be a little more aware of others outside the field who contribute to the public's health in all sorts of different ways. We always try to broaden it out and get contributions from a wide variety of sources, so that people realise there's a whole wider organism out there trying to improve the health and wellbeing of the people.

Interview by Richard Allen

INTERVIEW

Martin McKee CBE is Professor of European Public Health at the London School of Hygiene and Tropical Medicine. He is currently research director of the European Observatory on Health Systems and Policies and is Immediate Past President of the European Public Health Association. He has published more than 1,020 scientific papers and 44 books

CONNECTIONS: A remaining section of the Berlin Wall

'Making the invisible visible'

We bring the evidence to bear, says McKee

How did you first get into public health?
I qualified in medicine at the age of 22 and was moving rapidly towards an academic career in internal medicine. The work I was doing was very much focused on lab research. At the same time I was seeing patients in Belfast in the early 1980s with scurvy and beriberi, and the impact of poverty was very obvious. It was also very clear that the research I was doing on small peptides was not of much real value to them. I became quite disillusioned, and so I made a move.

I'd always been interested in issues beyond medicine. I'd seriously considered doing politics, philosophy and economics at university. But I came from three generations of medics in my family, and there was an expectation that I'd do medicine. I've been fortunate in being able to combine it with work on the political and economic determinants of health.

When I did the masters at the London School I did an attachment with Leila Lessof in Islington, and she set up a post which allowed me to come back from the training scheme in Northern Ireland and work half-time at the London School with Nick Black.

So how and when did you start getting involved in the Europe scene?
I had always been very interested in the history of Europe. I'd travelled extensively as a teenager on Interrail, including countries like Romania and Bulgaria – about 20 European countries by the time I was 21. Money was available at the time for new senior lecturers to develop links with Europe, and I was encouraged to apply. That was in 1989 and on 9 November the Berlin Wall fell and suddenly Europe got a lot larger. Because I knew the countries on the other side of the Iron Curtain reasonably well I was able to immediately build connections with colleagues, particularly in what was then Czechoslovakia and Hungary. By the mid-1990s I had started working in the former Soviet Union.

What have been the main issues you've worked on?
My work on the collapse of communism led me into researching the health effects of rapid social, political and economic transition. Following on from that, David Stuckler and I looked at the health effects of the global financial crisis in 2008, subsequently looking at economic, social and demographic change worldwide, in particular urbanisation and trade liberalisation. As a result of that, I now lead the health systems part of the Prospective Urban Renewal Epidemiology Study, working with Salim Yusuf at McMaster. We're following up 300,000 people in 25 countries worldwide to try to understand their changing experience of healthcare and what we can do to overcome the barriers and economic costs they face, with a focus on hypertension.

What do you think the impact of Brexit will be on public health in the UK and Europe?
It's a complete disaster. There's going to be much less money around – even the most optimistic predictions talk about a £15 billion-a-year hit for the economy. There's going to be far fewer workers, not just in the NHS but in a whole range of other areas like agriculture. Many government departments are already buckling under the strain, and there's a real danger of government failure.

In research terms the UK has always punched above its weight – in large part because scientists from other parts of Europe have come to the UK to work – and that will be missed. Informal collaboration is going to be even more important. Much can be managed on the basis of personal relationships, but clearly loss of access to things like Marie Curie scholarships and Erasmus funding is going to be a problem. Unfortunately, the British government's position is that we can have our cake and eat it, but they have absolutely no feasible proposals as to how this could come about.

> **There's such a lot to be done out there. I don't want to sound too pious, but I do believe strongly in speaking out in the face of injustice**

What would you regard as your proudest achievement so far?
The people I've been able to support at an early stage in their careers. There's quite a large number of people all over Europe that I've been able to support and mentor and many are now in quite senior positions. Also, being able to bring people together to achieve a lasting legacy. In terms of scientific achievement, I would point to our research on the concept of 'precariousness' – that a precarious existence, whether in relation to income or employment or food security or housing tenure, has a major impact on health.

And your next big challenge?
Corporate determinants of health – understanding the ways in which global corporations shape our lives. Not just the tobacco industry, although the fight against the tobacco industry has definitely not yet been won. The new Philip Morris Foundation is an example of how we need to be continually vigilant. But more than that, the way artificial intelligence and social media are shaping the way people think and behave. The evidence that foreign powers are deliberately trying to create divisions within societies, for instance supporting both white supremacists and black resistance movements in the US at the same time. We need much more understanding of things like these.

You're renowned for your prodigious energy and output. What drives you to keep up such an incredible pace?
Well there's such a lot to be done out there. I don't want to sound too pious, but I do believe strongly in speaking out in the face of injustice. I always think of Edmund Burke's saying that all that's required for evil to succeed is for good people to remain silent. I get very annoyed when people say that commenting on things like inequality and social determinants is "too political". I think we need to ask who is defining these things as political. We can bring the evidence to bear. Public health has a hugely important role in making the invisible visible.

What keeps you awake at night?
Jetlag. I travel an enormous amount. Nine flights in the next 10 days. It's a completely crazy life – but I work with some very interesting people and hopefully we do make a difference.

Finally, how do you relax?
Well, that is a problem – it's a pretty relentless schedule. I do go to the gym in hotels as far as possible. I enjoy classical music and read a lot. And there's always BBC iPlayer. Documentaries and histories mainly. Basically, anything with Alice Roberts or Lucy Worsley.

Interview by Alan Maryon-Davis

Take it to the min

This is a pivotal year in the struggle against alcohol harms as minimum unit pricing finally launches in Scotland. The results could be fascinating, says Alan Maryon-Davis

FOLLOWING the biggest and best Dry January to date, 2018 is shaping up to be a Big Year in the battle to reduce the harms caused by Big Alcohol.

The Big Red-letter Day is Tuesday 1 May, when minimum unit pricing (MUP) finally arrives in Scotland – five long years (and a bruising battle with the Scotch Whisky Association) after being enacted by the Scottish Parliament. The breakthrough came last November when the UK Supreme Court unanimously ruled that MUP does not contravene laws on competitive trading and is therefore legal.

As well as Scotland, Wales is also well on the way towards MUP with a clear statement of intent. And Northern Ireland is ready to press ahead just as soon as it can get back to properly devolved government.

So, yet again, as with the ban on smoking in enclosed spaces, England is the last part of the UK to embrace a potentially massive step forward for public health. Despite constant pressure from the Alcohol Health Alliance (which includes FPH) – but bolstered by covert and much stronger pressure from Big Alcohol – the Government is refusing to budge from its wait-and-see-what-happens-in-Scotland policy.

This leaves us with another five years' delay, hundreds of avoidable deaths and the interesting prospect of busloads of rollicking bootleggers pouring across the Cheviots, laden with bulging suitcases of White Star cider.

> **This leaves us with the prospect of busloads of rollicking bootleggers pouring across the Cheviots**

Meanwhile the Scottish Government and the National Institute of Health Research have put in place an impressive evaluation package covering pretty well every angle you can think of – consumption, health, crime, jobs, family budgets, social attitudes, the wider economy – with a special focus on dependent drinkers comparing Scotland with north-east England. It will be a fascinating quasi experiment – unless of course England were to have a sudden change of heart and join Scotland with the same MUP, in which case there'll be a sizeable bunch of very disgruntled researchers tearing up their spreadsheets in frustration.

In this edition of *Public Health Today* we've tried to capture a range of issues from alcohol policy to front-line practice. We consider the impact of alcohol on families, on older people and a pan-Europe study of harm to others. We investigate the crime dimension, and the complex interactions of alcohol with depression. We look at licensing and fiscal initiatives. We debate the Chief Medical Officer's guideline on drinking in pregnancy. And we cast a beady eye over the shady influence of Big Alcohol on labelling and marketing. Lots for you to sip and savour.

Finally, just to say that, after eight years of editing this magazine, I've decided to make this my last wielding of the blue pencil. If you think you'd like to give it a whirl, do get in touch. Goodbye and thanks for reading.

Alan Maryon-Davis
Editor-in-Chief

Harms to others being investigated and measured at last

AROUND 63% of Europeans report that they have experienced negative effects from other people's drinking. In the UK, the figure is higher at over 70%. These are the headlines from the recent Reducing Alcohol Related Harm (RARHA) study* which surveyed alcohol consumption and harm in 19 European countries.

Alcohol-related harms to the drinker are well documented. But it is only recently that attempts have been made to measure the negative effects of alcohol on someone other than the drinker. The RARHA survey asked about harms respondents had experienced over the previous 12 months and which they associated with someone else's drinking. The eight measures ranged from items such as 'woken at night' to 'involved in a traffic accident'. The inclusion of lesser harm with more serious harm explains the headline-grabbing figures. For policy purposes, it is more useful, perhaps, to tease out some of the detail of the findings.

Looking at the four items that measured 'more serious' harm, across all countries, 14% reported they had been 'in a serious argument', 3.3% had been 'harmed physically', 6.8% had been a 'passenger with a drunk driver' and 1.7% had been 'in a traffic accident'. For the UK, the figures were higher: 17%, 4.6%, 3.6% and 1.5% respectively. Along with Bulgaria, Estonia, Lithuania and Romania, the UK had the highest percentage of respondents reporting any of the eight harms measured and also reporting a relatively high prevalence of 'more serious' harm. As might be expected, women were more likely than men to report harm; but compared to most other countries where experience of harms decreased with age, in the UK, there was little difference across age categories.

It is also important to consider people's views on the extent of negative effect from others' drinking. The UK was in the top five countries for prevalence of being negatively affected 'a lot' by others' drinking, with 10.1% reporting 'being woken at night', 5.8% 'felt unsafe in a public place', 9.8% 'annoyed by vomit, urine or litter,' 5.8% 'verbally abused', 6.8% 'in a serious argument', 2.5% 'harmed physically', 0.4% a 'passenger with a drunk driver' and 0.7% 'in a traffic accident'. Nearly 9% of UK respondents reported having been affected 'a lot' by a known heavy drinker, largely family, relatives or household members.

It is difficult to gather good information in retrospect regarding negative experiences in childhood. With that reservation, RARHA results found that for all countries, 9.1% of men and 13.4% of women said they had been negatively affected a lot by living with a heavy drinker during childhood or adolescence. In the UK, the figures were 6.1% and 13.3%.

These findings – a small selection from the RARHA report – highlight the nature and extent of perceived harm from others' drinking. Much remains to be done to improve measurement of harm and to improve understanding of the experience of harm from the perspective of those affected. Even within the UK, we can expect considerable differences at regional, community and social group levels. But the importance of the findings for policy and practice emerge clearly from the report and the case for further examination of 'harm to others' is well made.

Betsy Thom
Professor of Health Policy
Drug and Alcohol Research Centre
Middlesex University

** Reducing Alcohol Related Harm. Comparative monitoring of alcohol epidemiology across the EU. Synthesis report (2016) https://tinyurl.com/ybft574w*

Lager louts grow up into ageing drinkers

IT WOULD have been inconceivable, 30 years ago, for older people to be suffering the consequences of alcohol misuse in their own homes. In the 1980s, it was younger people staggering home from the pub, often incurring the wrath of the law.

Perhaps what we are now seeing as a public health problem is those baby boomers who were the lager louts of the mid- to late-20th Century. This population of post-war hedonists now has higher lifetime and current rates of alcohol misuse than any other generation.

It is not the marital, occupational and legal consequences of alcohol-related harm that our society needs to tackle. The focus should now be on retirement, bereavement, social isolation, multiple chronic physical problems such as pain, interaction of alcohol with prescribed drugs and an increased likelihood of alcohol-related brain damage. These are very different problems from those usually seen by substance misuse and addiction services.

The challenge is to manage this complexity in a way that also looks at age-sensitive matters in service delivery, such as sensory and cognitive impairment, mobility problems, dignity and stigma. It often seems that older people with alcohol problems are at the bottom of the commissioning ladder.

In 2015/16, 55-74 year-olds formed 45% of alcohol-related admissions to hospitals in England. The number of alcohol-specific deaths in people aged 50 and over had risen by 45% over the previous 15 years. This contrasts with no increase in numbers for the 15-49 age group.

There is strong evidence for minimum unit pricing to reduce alcohol-related harm. We also know that age-specific interventions delivered to older people result in similar, if not better, outcomes in improving health and social function.

Sadly, there remain only pockets of good practice in integrated care for older people with alcohol misuse. One success story is in the London Borough of Southwark where there is a strong partnership between the local authority and mental health services.

We've dropped the ball in commissioning services for older people with alcohol problems. Let's pick it up and run with it.

Tony Rao
Consultant Old Age Psychiatrist
South London and Maudsley NHS Foundation Trust

DEBATE: Are the drinking-in-pregnancy guidelines too strict? Clare Murphy says women need information not judgement, while Colin Shevills says total abstinence is simpler

No evidence of harm from low-level drinking

THE shift to a policy of advising abstention from alcohol in pregnancy was not borne of changes in the evidence-base – there remains no evidence of harm at low levels.

The change was apparently spurred by the guideline group's concerns that previous guidance "may have been read as implying a recommendation to drink alcohol at low levels during pregnancy". The basis for this anxiety? An unpublished, unavailable presentation to the group based on a discussion with some new mothers. It doesn't feel like a good evidence base for an evidence-based policy.

The group was clear its advice was based on the need "for clarity and simplicity", a bit like how you might talk to a child. Because what ultimately underpins the chief medical officer guidelines is a lack of faith in women's ability to understand information and their capacity to make their own decisions, based on the available evidence.

For some, it is irrelevant whether small quantities of alcohol in pregnancy are harmless. Is it such a hardship to forgo alcohol for nine months for your baby's sake? Isn't such a policy entirely benign? To imply, however, that the evidence says something it doesn't is not benign.

For one, it adds to the growing climate of anxiety around pregnancy today, with

YES

women's behaviour increasingly scrutinised. It was extraordinary to see a recent survey in the *Journal of Public Health* asking the public if they supported the abstinence-only approach – as if pregnant women's choices are a legitimate target for judgement and sentiment a suitable basis for health policy.

In this climate, scientists too increasingly position themselves not as truth-bearers but public health messengers. Despite finding no evidence of harm from low-level drinking in pregnancy, studies frequently conclude with calls for greater scrutiny of women – whether pregnant or potentially pregnant (you just need a working womb to require monitoring), including the development of alcohol 'biomarkers' to assess whether women are lying. A Scottish hospital is working on just this.

Pregnant women today are held accountable for a whole manner of negative outcomes in their offspring on the basis of little or nothing. The discussion around alcohol – but above all obesity – in pregnancy is a case in point. This is not benign. It is dangerous.

And what's really tragic is that calls for old-fashioned, society-wide public health initiatives which genuinely could improve the health of babies – such as the fortification of flour with folic acid – have been completely drowned out.

Clare Murphy
Director of External Affairs
British Pregnancy Advisory Service
www.bpas.org

People need simple, clear messages

BACK in 2014 directors of public health in the north-east of England were concerned that, in a region with high alcohol consumption, they needed to send out a clear message about the dangers of drinking during pregnancy. The existing guidance left the public confused and in the interests of clarity they advocated delivering a message that it's safest not to drink at all during pregnancy.

In January 2016, the chief medical officers (CMOs) decided to adopt the same precautionary approach: that, in the absence of evidence that small amounts of drinking during pregnancy was safe, it were best to advise no drinking at all. They did, however, address concerns relating to women drinking before being aware of their pregnancy, stating that the risks were likely to be low if only small amounts had been consumed and advising that women consult their midwife or doctor if they had concerns.

I believe women have a right to know that alcohol passes through the placenta to their unborn child, and there is no guarantee it isn't doing any harm. Women are used to being advised to stop eating certain food products and to stop smoking when pregnant. The suggestion that we should compromise on alcohol probably says less about the risks and more

NO

about the wider role it plays in society.

My experience working as a communications professional in public health leads me to believe that we are generally excellent at getting the science right, but sometimes not so good at turning that science into simple, compelling messages. It is always a compromise, and the results can often be messy, but I strongly believe that while what you say is important, what people understand is what really matters.

In the north-east we have been promoting the '0 for 9' message for over three years, and its simplicity is clearly cutting through with the public. In a survey of over 2,000 adults in the UK carried out in late 2017, only 41 per cent of women were able to correctly identify the new CMO pregnancy guidelines. However, I believe that the simplicity of the new guidelines will see that figure increasing, because in the north-east awareness now stands at 52 per cent of women.

My big concern is that the Government and its agencies are singularly failing to effectively communicate the new alcohol guidelines; we're being kept in the dark throughout every stage of our lives. That is unforgiveable in a society where drinking, sometimes to excess, is the norm.

Colin Shevills
Director
Balance North East
balance.grtest.co.uk

Social drinking

The current system of advertising regulation was designed in a pre-digital era, so it struggles to deal with alcohol promotions on social media, says James Nicholls

THE alcohol industry has long been at the forefront of developments in marketing. In 1876, the Bass Triangle became the first registered trademark, and the iconic 'Guinness is good for you' campaign, launched in 1929, has a good claim to be one of the most influential advertising campaigns of the 20th century. There are plenty of people who still believe that, by roasting barley at a slightly higher temperature than usual, stout is imbued with additional health-giving properties. That is impact which marketing executives can usually only dream about.

The rise of social media in the late 2000s proved no exception to this trend. Having already invested heavily in digital marketing, major drinks producers were among the first to recognise the changing tide represented by the emergence of Facebook and, later, Twitter and Instagram. In 2011, Diageo (producers of Guinness, among other brands) agreed a multimillion-dollar deal with Facebook, building on what it claimed was a 20% increase in sales the previous year as a direct result of Facebook promotions. Since then almost all of the major brands have moved into the social media space, and increasingly place digital interaction at the heart of wider marketing strategies.

Social media presents an array of new opportunities to drinks producers, and a swathe of problems for regulators. In particular, social media exchanges the tradition of broadcast advertising, in which one message is viewed by a large number of people, for interactive engagement marketing. This blurs the line between brand-developed material and user-generated content, allowing consumers to act as brand ambassadors through actions ranging from uploading videos to simply liking or sharing a post. As a consequence,

> **"We need a review of existing systems to bring regulation into the modern age"**

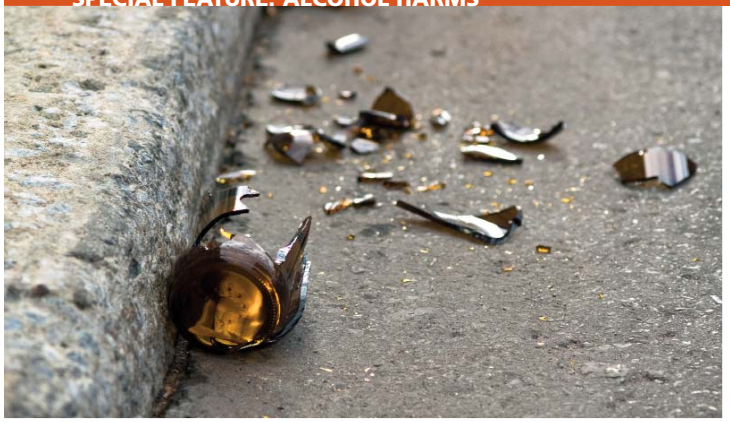
an enormous amount of material can pass below the regulatory radar.

The rhythm of social media marketing is also different. Posts are targeted and scheduled to reflect the patterns of work and leisure across different consumer groups. Again, this poses tangible problems for regulation. In April 2017, for instance, a complaint was raised with the Advertising Standards Agency (ASA) about a post for a Bristol nightclub which used pseudo-pornographic imagery to advertise a drinks promotion. In fairness, the ASA ruled the advert contravened its regulations; however, the ruling came in August – four months after the advert was placed on Facebook, which was for an event the following week.

In reality, our current system of advertising regulation was established in a pre-digital era. Although alcohol advertising is subject to some stringent rules, these are increasingly hard to enforce in an age of multi-platform social media marketing. We need a comprehensive review of existing systems to bring regulation into the modern age. This may conclude, as many public health campaigners would prefer, in a comprehensive ban on alcohol advertising. It may, by contrast, establish new limits on how social media can be used or who takes responsibility for material appearing on brand timelines. It may simply tackle the increasingly thorny problem of how to regulate online sales of alcohol.

Whatever the result, it is clear that what we have in place is not fit for purpose, and it is surely not a matter of if, but when, there is an overhaul.

James Nicholls
Director of Research and Policy Development
Alcohol Research UK and Alcohol Concern



Antisocial behaviour: a chance for treatment

THE Antisocial Behaviour, Crime and Policing Act 2014 introduced the civil injunction and criminal behaviour order (CBO). This replaced, and represented a step-change from, the antisocial behaviour order (ASBO). These powers may appear to lie some way outside the public health domain; but they can help public health teams support a challenging client group and enhance the commissioning of alcohol treatment services.

The orders allow courts to ban behaviours, such as visiting a location, and impose positive requirements to encourage change. They are appropriate for people whose antisocial behaviour is due to alcohol problems, and the requirements can include 'treatment' interventions, such as support and counselling or alcohol-awareness classes.

Public health teams now have responsibility for alcohol treatment. These new orders offer an opportunity to discuss and develop responses to treatment-resistant clients who may be having a significant impact on local communities.

Alcohol Research UK (ARUK) is currently funding a project to help community safety and alcohol treatment staff to develop alcohol-focused positive requirements. This project has been very well received. Over 100 staff from local authorities across England and Wales have contributed, and three regional workshops were over-subscribed.

Evidence of the positive impact of these orders has been identified. For example, Bedford Borough Council has published a case study of a woman who received a CBO as a result of her drunken behaviour. It highlighted the positive outcomes and cost savings that can be achieved by joint working – £45,000 in one year in that case (www.bedford.gov.uk/pdf/CaseStudy_ASB.pdf).

The key message from those consulted is that work is required to enable alcohol treatment services to support these orders. This offers an opportunity to engage a wide range of partners in discussion about the shape and focus of services.

Senior police officers, police and crime commissioners and community safety managers should work with public health commissioners to design service specifications and contracts that support involvement in positive requirements. Alcohol services should be designed to be part of the process that leads to a CBO from the earliest possible point. This would involve offering specific positive treatment requirements, but also:

- community outreach alongside police officers and neighbourhood wardens.
- offering a speedy, even proactive, response to individuals at high risk of receiving orders.
- attending multi-agency meetings with the client where the behaviour is discussed.

If public health teams wish to learn more about the ARUK research and potential training, please email mward@alcoholconcern.org.uk

Mike Ward
Senior Consultant
Alcohol Concern

You don't have to drink to be affected by it

WHEN you hear the phrase "alcohol harm" what is the first thing you think of? Damage to your liver? Drink-driving? Antisocial behaviour? What about the impact on the drinker's family? While problematic alcohol use can detrimentally affect individuals, it can also have a devastating impact on those closest to them. Families affected by alcohol often suffer in silence, feeling ashamed of their loved one's drinking and stigmatised as a result, or they see heavy alcohol consumption as a 'normal' part of both society and family life, so don't realise there's a problem or that support is out there.

Support for families has been proven to be effective and can take a variety of forms, from one-to-one work with professionals to peer support groups, from structured interventions to information leaflets. As is often the case, however, support varies a lot locally; it is excellent in some areas, but minimal in others, if it exists at all.

At Adfam, we passionately believe that families deserve support in their own right. No-one should have to suffer in silence because of the actions of those closest to them. Support for families should be well resourced, available in every area, and well promoted so that families know it is there and how to access it.

We should be motivated, not only by the clear moral argument for supporting fellow citizens at times of need, but also by the beneficial consequences and savings for society as a whole. Properly supported families can themselves support their loved ones through the challenges of life and hopefully into treatment and recovery. Every £1 invested in support for families affected by substance use gives £4.70 in value back to society (https://tinyurl.com/ycca6o52). This includes through improving the health and wellbeing of both family members and drinkers.

For more on how we improve life for families affected by substance use, to find a local support group or for resources for both families and practitioners, visit www.adfam.org.uk

We also lead the Alcohol and Families Alliance (www.alcoholandfamiliesalliance.org). Why not join us?

Oliver Standing
Director of Policy & Communications
Adfam

Cheap at the price

Alcohol is more affordable than it was 30 years ago, but the recent push for minimum unit pricing should help to redress the balance, says Aveek Bhattacharya

A SPECTRE is haunting the alcohol industry – the spectre of price regulation. In November, the Supreme Court confirmed the legality of the Scottish Government's legislation for minimum unit pricing (MUP), bringing to an end a five-year dispute. The Irish Government is in the process of passing MUP into law. In October, the Welsh Government announced its plans to implement the policy. For the Westminster Government, officially at least, MUP is "under review".

So why is price regulation needed for alcohol? Accounting for income growth, alcohol is 60% more affordable in the UK today than in 1980. Drink is particularly cheap in supermarkets and off-licences, where the average price of beer is lower today than in 2001, even though the overall prices have increased by 52%. Strong white ciders, overwhelmingly drunk by underage and harmful drinkers, contain the equivalent of 22 shots of vodka for as little as £3.49.

This is deeply worrying, because affordability is one of the key drivers of consumption and harm: cheaper alcohol invariably leads to higher rates of death and disease. Alcohol is responsible for 21,000 deaths and 1.1 million hospital admissions in England each year, and liver disease is now one of the leading causes of premature death in the UK.

The World Health Organization and the Organisation for Economic Co-operation and Development recommend raising taxes on alcohol to reduce its harmful impact on health and society. A meta-analysis of 50 academic studies found that doubling the rate of alcohol tax is associated with a 35% fall in alcohol-related mortality, and reductions in the number of traffic collisions, sexually transmitted diseases, crime and violence.

> **Strong white ciders contain the equivalent of 22 shots of vodka for as little as £3.49**

In the wake of the financial crisis, the UK government introduced the alcohol duty escalator, raising tax on alcohol by 2% above inflation each year between 2008 and 2013. This encouraged falls in the rates of consumption and alcohol-related deaths. Yet this progress has stalled, with tax on beer cut by 16% and tax on cider and spirits cut by 8% in real terms since 2012.

In any case, much of the most harmful alcohol is sold so cheaply that taxes would have to be raised dramatically in order to fully address it. Moreover, alcohol taxes are levied on businesses, not consumers, and so retailers sometimes choose to absorb the cost of higher taxes rather than raising prices on the shelves.

A more direct and targeted way of dealing with cheap alcohol is minimum unit pricing, which sets a 'floor' price per unit, below which it is illegal to sell alcohol. For example, an MUP of 50p would require a typical pint of beer to be at least £1 and a bottle of wine to be no less than £4.50.

Evidence from Canada, which operates a similar policy to MUP, shows that higher minimum prices are associated with lower consumption, hospital admissions and deaths. Modelling by the Sheffield Alcohol Research Group suggests that a 50p MUP in England would reduce hospital admissions by 22,000 each year and save 525 lives.

The recent momentum behind MUP should therefore be a cause of excitement for the public health community, and it comes as no surprise that alcohol companies are fearful. By raising the price of alcohol we can reduce its toll.

Aveek Bhattacharya
Policy Analyst
Institute of Alcohol Studies

Responsible parties?

Why is the alcohol industry still invited to the policy-making table while tobacco companies have long been excluded from discussions, asks Emma Kain

THE alcohol industry is dominated by a handful of multinational corporations wielding enormous economic and political power. With great power should come responsibility, and alcohol producers seek to demonstrate this through Corporate Social Responsibility (CSR) programmes which purport to mitigate their economic, social and environmental impacts.

The alcohol industry has a number of CSR strategies, including public awareness campaigns and educational programmes, funding industry-led organisations such as Drinkaware, self-regulation policies, collaboration with charities and sponsorship of research. Whilst some organisations and their employees undoubtedly see these initiatives as a force for good, there is a growing evidence base to suggest that in most cases, these activities are more likely to be designed to raise brand awareness, ward off regulation and portray a socially responsible image to the public and policymakers.

While it is now unthinkable that the tobacco industry would have a seat at the policy-making table, the alcohol industry has been able to retain this important influence over policies which could significantly affect their profits. When it is enshrined in law that businesses' first responsibility is to the shareholder, the conflict of interests is clear. Profits come first; as one industry report stated: "It's good business for the industry to promote responsible drinking."

It has been widely reported that, given the opportunity, industry representatives seek to develop industry-friendly policy by framing the issues to shift responsibility to the individual and casting doubt on the established evidence base of measures designed to reduce alcohol-related harm at a population level, including regulation of the price, availability and marketing of alcohol. Instead, the industry has promoted interventions known to be ineffective, such as education programmes with limited value for behaviour change, and self-regulation pledges.

> **These activities are more likely to be designed to raise brand awareness and ward off regulation**

Many health and charitable organisations walked out on the 2011 UK Public Health Responsibility Deal due to concerns that industry arguments were carrying more weight than those of public health experts. These concerns have been vindicated, with evaluations of the deal showing that many of the pledges made have not been adhered to or have had limited effect.

Outside the UK, global industry actors have also provided 'assistance' to policymakers in developing countries, including the writing of large sections of government alcohol policies in several sub-Saharan African countries. The offer of financial support in the wake of international disasters has been suggested to be more about gaining political influence and increasing brand recognition in emerging markets than true philanthropy.

The activities of the alcohol industry to improve their reputation, promote their brands and increase profits in the name of CSR are now being recognised. Leading public health figures are calling for action, including the exclusion of the alcohol industry from the policy-making arena, the creation of an independent body to regulate alcohol promotion, and for the prohibition of all alcohol advertising and sponsorship. Social norms have finally shifted in response to a strong and consistent approach to tackling the tobacco industry, and the effects on population health are clear to see.

Isn't it time for the same approach with the alcohol industry?

Emma Kain
Specialty Registrar in Public Health
Devon County Council

Why drugs make a poor mixer with drink

SO HOW much is too much? Read the patient safety leaflet and you'll find that, if taking prescribed drugs for depression, anxiety or psychosis, the message is clear: don't mix alcohol with these medications.

Sounds straightforward, except that people who are depressed often rely on alcohol to keep the black dog down. Substance-use disorders often co-occur with mental illness such as depression, anxiety and psychosis. In a number of high-profile celebrity deaths – Whitney Houston, Amy Winehouse and Heath Ledger, for example – there was much speculation that a cocktail of alcohol and prescription drugs played a role.

Mental health professionals have long faced the difficulty of trying to work out which came first – the alcohol dependency or the depression. Alcohol may help to relieve the numbness caused by psychiatric medications. Conversely people who drink alcohol may develop depression because it is itself a depressant.

Many medications can interact with alcohol, leading to increased risk of illness, injury or death. Mixing drugs and alcohol can result in a life-threatening overdose or the development of alcohol dependence. For example, alcohol increases the sedative effect of tricyclic antidepressants such as amitriptyline, impairing mental skills required for driving. Consuming alcohol with antipsychotics – used to reduce delusions and hallucinations – can also result in increased sedation, impaired coordination and potentially fatal breathing difficulties. The combination of chronic alcohol consumption and antipsychotic drugs may result in liver damage.

Low-level reliance on alcohol may potentiate the impact of prescribed medications by competing with the same set of metabolizing enzymes. This increases the risk of harmful side effects.

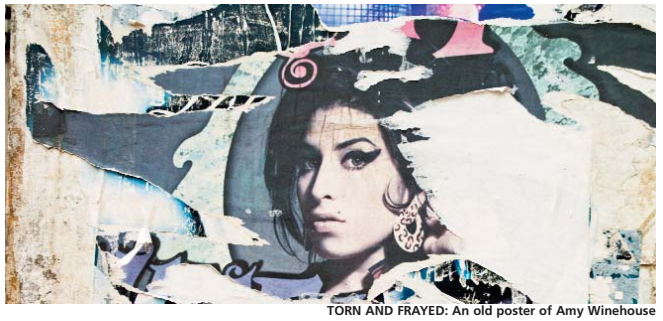
In contrast, long-term or chronic alcohol consumption may activate drug-metabolizing enzymes which reduce the effects of medication. So a patient may require higher doses to achieve a therapeutic level. Elderly people may be at increased risk of these harmful interactions partly because older bodies take longer to metabolise toxins and partly because elderly people may be on a cocktail of drugs to treat a number of co-existing conditions.

Prozac is one of a group of medications popular for depression, anxiety and panic disorders. These drugs increase the levels of the neurotransmitter serotonin in the brain. Alcohol too can increase the level of serotonin, a combination which can lead to 'serotonin syndrome' – manic and dangerous behaviour. Mixing alcohol with Prozac can also heighten feelings of depression and anxiety – the very symptoms that Prozac is designed to treat – and may increase suicidal ideation.

People often overlook warning labels but they are there to reduce harm to patients. Drug and alcohol interactions are not completely predictable, and everyone's biochemical make-up is different, so people have different sensitivities to alcohol-medication interactions.

Alcohol and psychiatric medications don't mix, but just saying 'no' rarely works. With prescribing of antidepressants more than doubling in the past decade, this is a problem that is not going to go away.

Frances MacGuire
Freelance consultant in environmental and health risk management



TORN AND FRAYED: An old poster of Amy Winehouse

Helping young people make better choices

THE National Institute for Health and Care Excellence (NICE) is drafting new guidance to help educate children and young people about their alcohol choices and consumption.

The new guideline is aimed at giving teachers, local authorities and education providers advice about which alcohol education programmes can help young people make better decisions about their drinking habits. It aligns with the recommendations set by the UK chief medical officers which advise that an alcohol-free childhood is the healthiest and best option.

The guidance will be looking at school-based interventions which will help children and young people aged 11 to 18 in full-time education, as well as those young people aged 18 to 25 with special educational needs or disabilities who are in full-time education. It comes at a time when the education system has changed, in particular with the introduction of academy-status and free schools which do not have to follow the national curriculum.

Work on the guideline has begun and will continue throughout the next year. NICE published other guidance on alcohol consumption back in 2010, which looked at a mix of population- and individual-level interventions including the pricing and marketing of alcohol-based products.

For more information about this guideline, or to be kept updated and/or involved in its development, you can sign up to become a stakeholder. And to find out about the work of NICE more generally, follow it on Twitter @NICEcomms.

Amraze Khan
External Communications Manager
National Institute for Health and Care Excellence

Reducing harm by having a say in licensing

A MAJOR study is aiming to find out if public health teams can make a difference to unhealthy drinking by getting involved in alcohol licensing.

Since 2011 in England and 2009 in Scotland local public health teams are notified of premises applications for a licence to sell alcohol and have the right to formally comment. Many work intensively to try to influence the alcohol premises licensing system. Although there have been some encouraging studies, it is not known if, or how, these activities have an influence on licensing processes, health outcomes or crime rates. Better evidence is needed to guide practice.

There were 339,000 alcohol-related hospital admissions in 2015/16 and 6,813 alcohol-related deaths in 2015 in England alone; both figures have risen since 2005 by 10% and 22% respectively. Systematic reviews have identified control of the availability of alcohol as a key approach to reducing alcohol-related harms. However, the relationships between public health activities, specific local licensing controls, indicators and types of availability, and alcohol-related harms, are not clear or consistently examined in the literature.

In the UK, local licensing authorities may influence the types of premises licensed, hours of operation or density of outlets. Public health teams may collate local data to assist with policy formulation, make formal representations against licence applications, develop licensing conditions for individual premises and trial innovative activities.

> **Reviews have identified control of the availability of alcohol as a key approach to reducing alcohol-related harms**

The ExILEnS (Exploring the Impact of alcohol Licensing in England and Scotland) study aims to find out what public health teams have been doing in this area, and whether their actions have had any impact on health and crime outcomes over the period 2012 to 2018. The study consists of four work packages:

- examining current public health team engagement in licensing
- analysing changes in health and crime outcomes over time in areas of high public health activity compared with areas of low activity
- examining whether this activity might impact on health inequalities or longer-term outcomes
- developing a theory of how such activity may work and making recommendations about future practice, policy and research in this area.

The project is led by Dr Niamh Fitzgerald at the University of Stirling and funded by the National Institute for Health Research Public Health Research Programme (project 15/129/11). The study involves co-investigators from the universities of Bristol, Edinburgh and Sheffield, the London School of Hygiene and Tropical Medicine and Alcohol Research UK and

is overseen by an advisory group that includes public health professionals, academics, charities and members of the public.

The project began in April 2017 and will run until March 2020; recruitment of local public health teams is underway. The intention is that the study findings will enable public health teams and local authorities to make best use of their resources and powers to influence the local alcohol retail environment and reduce alcohol-related harms.

More information is available from www.ukctas.net/exilens or by emailing exilens@stir.ac.uk.

Colin Sumpter
Specialty Registrar in Public Health
NHS Forth Valley
Currently working on the ExILEnS study while on academic placement at the University of Stirling
Niamh Fitzgerald
ExILEnS Principal Investigator
Senior Lecturer in Alcohol Studies
Institute of Social Marketing
University of Stirling

Alcohol labels fail to inform consumers

WHEN it comes to alcohol, we're not doing enough to help people make informed choices. There are no high-profile mass media campaigns to offset the glamorous advertising of the big alcohol brands. And there's a real lack of information about alcohol on packaging and at point-of-sale.

There's far more consumer information printed on a pint of milk than on a bottle of vodka; the first is an everyday essential, the second an addictive and carcinogenic substance. The need for better information is clear: only one in 10 of us is aware of the link between alcohol and cancer.

Manufacturers have got away with providing minimal information – usually the number of units in the container and a no-alcohol-in-pregnancy symbol. They should be compelled to display prominent health warnings, along with information about units, ingredients, nutrition and calories.

We took part in research, as part of the Alcohol Health Alliance, which showed that letting alcohol producers decide what to put on labels meant that consumers were being left in the dark. A review of 315 product labels found only one which showed the low-risk drinking guideline of 14 units a week. There was no mention of any health risks nor advice on spreading drinking throughout the week and alcohol-free days.

Consumers have the right to be informed about products that may pose a risk to health, and they expect this information to come from an independent, trustworthy source. Unfortunately, the Department of Health recommends that alcohol labels direct people towards the alcohol-industry-funded Drinkaware website, despite the World Health Organization stating that the alcohol industry should not be involved in health promotion. NHS Choices (or NHS Inform in Scotland) would be a far better source of information on alcohol.

More information and health warnings on labels alone won't lead to people drinking less. For that we need policies to reduce the affordability, availability and marketing of alcohol. But better labelling would be a positive step forward in repositioning alcohol and letting people know the significant risks associated with its consumption.

Alison Douglas
Chief Executive
Alcohol Focus Scotland
www.alcohol-focus-scotland.org.uk
@AlcoholFocus

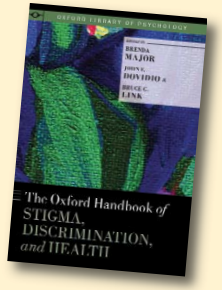
Why stigma is a major health determinant

IN 1930s CENTRAL Europe, an elected government began requiring Jews to wear yellow badges to distinguish 'them' from 'us'. They were drawing on a long tradition of stigmatisation. A caliph in the 8th century, a pope in the 13th, and many other rulers in France, Spain and England had all forced visible stigma on Jews, Muslims and Christians variously. It was an important way of normalising their ill-treatment, deportation and premature deaths.

In 2017, a UK council passed legislation to criminalise rough sleepers who beg – potentially increasing their suicide risk. Recently, a powerful president has manipulated public opinion, putting the mark of stigma on Muslims, the poor, African countries, migrants and transsexuals, legitimising them as acceptable targets for discrimination. Another offered Africans payments to emigrate.

This books shows how our profession must confront, quantify and tackle stigmatisation and discrimination as major health determinants affecting huge populations. Discrimination actively legitimises war, rape, murder and torture. It must be tackled directly and at source if we are to prevent and mitigate its impact. Witness the astonishing life expectancy gaps between the 'us and them' in the US and the UK. The authors show how just six stigmatised characteristics (mental illness, sexual orientation, obesity, HIV/AIDS, disability and ethnicity) affected more than half the US population. These stigmas directly impacted on critically important life domains such as housing, employment, social relationships, education and health. There are now clear causal pathways, and the numerous chapters are crammed with models for effective action. Here are blueprints for tackling enduring pervasive determinants of misery, illness, premature mortality and inequalities.

The contributors' distillations of research-based material detail the many ways through which discrimination about skin colour, body size, deformity, deafness and many other characteristics damages health. At the same time it shows how we can take effective action against it. It covers social and psychological mechanisms and pathways, but also examinations of how stigma and discrimination influence, not just economic disparities, but also the healthcare quality and provision given to



different groups. We must incorporate this book's recommendations and guidance into our profession's vision for better health, and into our curriculum, training and work.

Andy Beckingham

Oxford Handbook of Stigma, Discrimination, and Health
Edited by Brenda Major, John F Dovidio and Bruce G Link

Published by Oxford University Press
ISBN 9780190243470
RRP: £115

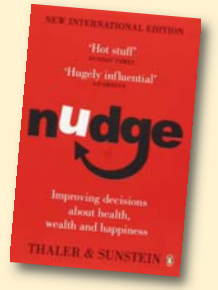
Less judgement and more nudgement

'CHOICE architecture' is sure to be the phrase on everyone's lips following Richard Thaler's Nobel prize in economics for his work on behavioural economics and nudge theory. This has prompted a new edition of his 2008 book *Nudge*, written in collaboration with Cass Sunstein. Not being well versed in either economics or finance, I was initially sceptical that I would find a book that includes chapter titles such as 'Privatizing Social Security: Smorgasbord Style' or 'Credit Markets' interesting, but I was wrong. It is a treasure trove of amusing, outrageous and amazing observations about human behaviour and how to change it.

The book makes the case for policy-makers or employers to deploy nudges. According to Thaler and Sunstein, a nudge is "any aspect of the choice architecture that alters people's behaviour in a predictable way without forbidding any options or significantly changing their economic incentives… Nudges are not mandates. Putting the fruit at eye level counts as a nudge. Banning junk food does not." This is an interesting dichotomy – nudging versus banning – for policy-makers to consider when assessing levers for change.

Nudge is very wide-ranging and includes interesting anecdote such as how to encourage men to have better aim at a urinal (paint a black housefly on the centre of the urinal) to how to increase your own self-control around temptations. I found the chapter on organ donation the most interesting having worked on the issue in a policy role. It's also especially relevant given the Prime Minister's October announcement that England will consult on following Wales in switching to a system of presumed consent for organ donation. Thaler and Sunstein describe the model of presumed consent (as opposed to routine removal or explicit consent) as passing the 'nudge' test. Essentially, a system of presumed consent assumes that all citizens consent to donation and provides them with the chance to 'opt out' if they don't agree. This is a very successful and simple way to nudge people towards donation. Studies in the US have shown that when people have to opt in, only around 40% become donors, but when they have to opt out, the figure more than doubles.

Other chapters discuss marriage, how to save money and lose weight (sometimes at the same time), and how to save the planet.



I don't know if I'm a complete convert to the Church of Choice Architecture, especially considering the magnitude of the public health challenges we face, but I've definitely been nudged in that direction.

Lisa Plotkin

Nudge: Improving decisions about health, wealth and happiness
Richard Thaler and Cass Sunstein

Published by Penguin
ISBN 9780141040011
RRP: £7.99

From the CEO

FPH President John Middleton and I attended the European Public Health Association (EUPHA) 10th conference in Stockholm in November, along with 2,000 other delegates.

We took this opportunity to raise our profile and influence debates through a mixture of oral presentations, posters, chairing and contributing to sessions, but also of course through networking and side-meetings.

As well as representing FPH at the meeting of the Governing Board of EUPHA, we also discussed opportunities with many other key partner organisations, including the Association of Schools of Public Health in the European Region and the Agency for Public Health Education Accreditation. The FPH Europe Special Interest Group began to structure a forward plan, including engagement with the World Health Organization 'Coalition of Partners' capacity-building work, and developing collaborations between schools of public health.

FPH was strongly represented at the roundtable session on 'The Moral Mandate of Public Health', with John chairing and Farhang Tahzib, Chair of the FPH Ethics Committee, presenting on active engagement in the science of social justice. Martin McKee presented on the abuses of power in old and new media to influence social perceptions and inequalities.

The opening ceremony gave us an entertaining presentation from Ola Rosling, in memory of the late, great, Hans Rosling. Ola challenged his audience to be more positive about the progress we have made on health in the last 200 years and pointed out the rather dismal basic understanding of significant health facts among groups who should know better! I subsequently took the 'gapminder test' (www.gapminder.org/), partly to see if I could score better than a chimpanzee, but also to take advantage of an excellent set of resources. I encourage you to try it.

My third take-away came from a plenary looking at how public health systems adapt to a world moving from public to private ownership. Aaron Reeves of the London School of Economics gave a summary of the evidence, highlighting the trend away from a collective organising society. He flagged the adverse impacts of economic policy on pension values and how changes in collective bargaining and minimum wage policies are adversely affecting health. Aaron gave a similar call to arms: it's not enough for public health to monitor and research these changes – we need to challenge them!

David Allen

How to get involved and help a SIG grow

I WAS involved in the first meeting of the Sexual and Reproductive Health Special Interest Group (SH SIG) and from that was instantly involved in its work. The first meeting had support from FPH for the administrative work, but this changed shortly afterwards as FPH was unable to continue to provide support as the number of SIGs grew. It became apparent that without some help, the SH SIG would flounder, as all the members were extremely busy and under pressure in their day jobs. So I stepped in and began to work under the exciting title of 'coordinator'.

Although I had done some work on sexual health topics both before and during my work as a speciality registrar, I had no clinical background or any expertise in sexual health. However, I have learnt a great deal in a short period. As well as issues relating to sexual health, it has included navigating the structures and policies of FPH and trying to build the SH SIG membership and increase its presence among members and professionals working in the field. I have also been able to work with SIG members to develop articles for the newsletters and briefings, and listen in to discussions on a range of topics from PrEP to commissioning services.

We have achieved a lot in a short space of time. In around 18 months we have doubled our membership, had a poster at the FPH annual conference in Telford, put out two newsletters and one professional briefing on sex and relationship education. The work we have undertaken is all available on FPHs website at: http://bit.ly/2FM9XOz

As well as enjoying the work and interactions with members and the professional development in sexual and reproductive health issues, I have also been able to add a great deal to my ePortfolio and competency development. This work balances leadership, writing for publications, policy development and professional development. We have also received a great deal of positive feedback from the members of the SIG and the wider FPH members on the publications we have undertaken.

The SH SIG continues to grow and two new professional briefings are planned this year on Modern Slavery and Sexual Health, and Adolescent Sexual Health. We at the SH SIG continue to discuss new ideas to improve our outreach to the wider membership to support your work.

If you want to get involved with the SIG, or have any ideas for possible topics for our professional briefing, or just want to be added to our email list for newsletter, please do not hesitate to contact me.

Megan Harris
Speciality Registrar in Public Health
meganharris@nhs.net

For further information on FPH SIGs, go to www.fph.org.uk/special_interest_groups

In memoriam

Gary Black HonMFPH
1949 – 2017

Gary Black lived in Clover, North Carolina, USA and was a Public Information Officer for Mecklenburg County, retiring in early 2016. Gary and I, representing the American Public Health Association (APHA), worked many hours and formed a productive partnership with the then FPH President, John Ashton, and FPH member Uy Hoang as we forged on to establish the popular film festival component at the FPH annual conference. Gary attended FPH conferences, led sessions and lent advice related to capturing compelling stories on film for the purpose of promoting public health. He was the co-founder of the APHA Global Public Health Film Festival which served as a model for three film festivals established in the UK: FPH's, the Public Health Film Society's in Oxford and the Royal Society of Medicine's Global Health Film Festival.

FPH President John Middleton says: "Gary was a great public health advocate, an enthusiast for film, a great colleague and a friend to the United Kingdom."

FPH CEO David Allen adds: "Every now and again we are lucky enough to meet someone special – someone who has the capacity for wonderful things, to cheer us, support us and who asks for nothing in return. Gary was one such person."

While Professor Ashton recalls: "Gary was a very special man. Evocative of all that was best about the 1960's: 'Peace and Love'."

I knew Gary to be a grassroots, roll-up your sleeves advocate, who propped-up the reluctant and cheered the needy. He encouraged them to tell their stories in hopes of creating change and improving their lives and others. This is a continuing story for all of us in this profession. The story continues; the show must go on.

Pamela Luna

Basil Hetzel FFPH
1922 – 2017

Basil Hetzel was born in London to Australian parents. After an education in Australia and then abroad, he became a medical pioneer, with impacts so influential that he was awarded Companion of the Order of Australia.

He studied medicine in Adelaide, going on to become a Fulbright Research Scholar in the 1950s, which included an appointment at New York Hospital and a Research Fellowship at St Thomas' Hospital in London. His first job was as a house officer in a mental health hospital (later becoming a founding member of the South Australian Mental Health Association).

He was the University of Adelaide's Professor of Medicine and then Foundation Professor of Social and Preventive Medicine at Monash University in Melbourne, before joining the Commonwealth Scientific & Industrial Research Organisation as the first Chief of Human Nutrition. At times stationed in remote areas of Papua New Guinea, he and his team established the effect of iodine deficiency as a common cause of brain damage, stillbirths and foetal growth retardation. As Director of the International Council for Control of Iodine Deficiency Disorders he worked to translate the scientific and clinical findings into effective preventive public health policy on dietary iodine supplementation.

Basil's work led to the research facility at the Queen Elizabeth Hospital, Adelaide, being named the Basil Hetzel Institute for Translational Health Research. In May 1992, he was appointed Lieutenant Governor of South Australia and elected Chancellor of the University of South Australia. He was given the Prince Mahidol Public Health Award and awarded FPH's Alwyn Smith Public Health Medicine Prize in 1993.

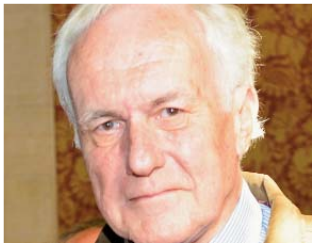
Timothy Stamps FFPHM
1936 – 2017

TIMOTHY Stamps' remarkable career took him from his early life in Wales to become Minister of Health for Zimbabwe from 1986 to 2002. Despite being the only white minister in Robert Mugabe's cabinet for much of that time, he was able to achieve a great deal to improve healthcare for the people of Zimbabwe. However, his refusal to distance himself from the regime's worst excesses brought him much opprobrium internationally and he was barred from visiting the EU.

Timothy qualified from Cardiff medical school, having been active in left-wing student politics, and emigrated to what was then Southern Rhodesia in 1962, working in the public health service. In 1970 was appointed chief medical officer for Salisbury, today's Harare, only to be sacked four years later for trying too hard to improve healthcare provision for blacks.

He worked on a number of community projects, becoming a fervent advocate for citizen's rights. This soon led him into politics as a city councillor and in 1980 he stood as an independent parliamentary candidate for the Kopje seat in central Harare against Ian Smith's Rhodesian Front party. He lost but gained important friends in Mugabe's ZANU party.

In 1982 he won a $2 million grant to set up a cooperative dairy farm giving work and homes to 2,000 blacks, an initiative that won him international recognition. Three years later Mugabe made him an MP and minister of health and child welfare. Among



his many achievements was the establishment of health centres in every district in Zimbabwe and the setting up of a national agency for AIDS which had infected a quarter of the sexually active population.

Timothy's international reputation was tarnished when he actively defended Mugabe's seizure of white-owned farms in 2000. He stepped down as minister in 2002 after a stroke.

In 2016 he wrote to this magazine to complain that a piece by Baroness Kinnock about water and sanitation in Harare had got the facts wrong. Interestingly, for someone who had built his career on political activism, he also criticised FPH for allowing itself to be used as a vehicle for political comment.

Deceased members

The following members have also passed away:

Allison Thorpe MFPH
Charles Camm FFPH
Douglas Paton FFPH
John Charlton HonMFPH
Michael Ashley-Miller CBE FFPH

© Alan Maryon-Davis

FPH Annual General Meeting

The 46th Annual General Meeting (AGM) of the Faculty of Public Health will be held on the morning of **7 June 2018** at City University, Tait Building, Northampton Square, London, EC1V 0HB.

The AGM will note the admittance of new members and fellows to distinction and honorary grades of membership, prize and award winners, election results and the composition of the Board for 2018-2019. It will also receive the FPH annual report and accounts for 2017 and reports from the officers on the first half of 2018.

Elections

- Dr Stephen Watkins has been elected as Vice President for Policy for a term of three years from the AGM on 7 June 2018.
- Professor Neil Squires has been re-elected as International Registrar for a second term of two years, again from the AGM.

A number of vacancies will arise from the AGM for faculty advisers, deputy faculty advisers and CPD advisers across the English regions. Details of the vacancies, including post descriptions, are available on the FPH Online Members' Area or from Caroline Wren (carolinewren@fph.org.uk, 020 3696 1464). Nominations close on **3 April 2018**.

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between September 2017 and January 2018

Fellows
Cristina Renzi
Joanna Leung
Roberto DeBono

Members
Ankush Mittal
Caroline Tait
David Smith
Harriet Edmondson
Hendramoorthy Maheswaran
John Mair-Jenkins
Laurence Gibson
Liann Brookes-Smith

Diplomate Member
Shuk Mui Lai

Specialty Registrar Members
Ahimza Thirunavukarasu
Alice Kadri
Beverley Griggs
Bronagh Clarke
Danielle Solomon
Emily Robinson
Fiona Maxwell
Grace Grove
Hannah Barnsley
Hannah Jary
Jennifer Clynes
Jessica Jarvis
Julia Darko
Kathryn Clare
Kirsty Bell
Laura Stoll
Louis Hall
Louise Sweeney
Malcolm Moffat
Megan Emma Gingell
Michael Allum
Natalie Daley
Robert Green
Rooah Omer
Sally O'Brien
Samuel Hayward
Sarah Hanae Reeves
Smita Nagmoti

Practitioners
Briege Lagan
Edwin Larry Panford-Quainoo
Jonathan Herbert
Peter Hudson
Rachel McIlvenna
Russell Sinclair

International Practitioners
Arif Azad
Geoffrey Clark
George Duke Mukoro
Jabulani Nyenwa
Mohamed Abdalla
Terna Nomhwange
WingTung Ho
Yvonne Powell Campbell

Student Members
Adam Jones
Ali Blatcher
Armida Gunzon
Bernadette Gallagher
Calum Barnetson
Charlotte Northin
Dorothy Jane Maria Terhune
Eimer McGuckian
Elsie Ososese Ugege
Jun Tian Wu
Mey Alfadil
Olujimi Olusola Aina
Rachel Louise Hepburn
Ramia Jameel
Rebecca Cudworth
Rhea Danielle Snounou
Victoria Rice

Associates
Angela Turner-Wilson
Anna Goulding
Catherine Huntley
Catherine Pratt
Chidi Chima
Chris Ramsden
Christopher Exeter
Deborah Harrington
Imo-Obong Emah
Jessica Ormerod
Karen Nicolson
Karen Thomas
Lorna Isabela Hall
Lynne Walker
Michelle Graham-Steele
Molly Agarwal
Oliver Jackson-Ager
Philippa Parrett
Rajeev Raja
Roger Nascimento
Simone Reilly
Sindisile Dube
Sultan Cetiner
Vickie Braithwaite

Letter

THE article on vaccination (Debate: Should childhood vaccinations be mandatory? *Public Health Today* Autumn 2017) mentioned that Wakefield's article had been discredited and its findings refuted but omitted to mention that they were actually fraudulent, not just wrong[1] and that he profited personally from the allegations about MMR[2]. The many issues have been summarised[3].

1. Deer B. *How the case against the MMR vaccine was fixed.* BMJ. 2011; 342:c5347 https://doi.org/10.1136/bmj.c5347
2. Deer B. *How the vaccine crisis was meant to make money.* BMJ. 2011; 342:c5258 https://doi.org/10.1136/bmj.c5258
3. Rao TSS, Andrade C. *The MMR vaccine and autism: Sensation, refutation, retraction, and fraud.* Indian J Psychiatry. 2011; 53(2):95-96. Doi: 10.4103/0019-5545.82529

Jenny Mindell FFPH

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Emily Parry-Harries
Gerald Tompkins
Ian Diley
Judith Stonebridge
Kathryn Cobain
Kathryn Ingold
Katy Scammell
Keith Allan
Martin Seymour
Martine Usdin
Sarah Tunnicliff
Shannon Katiyo
Stuart Keeble
Conall Watson
John Mair-Jenkins

Defined specialist portfolio route
Paula Hawley-Evans
Laurence Gibson
Muhammed Khan
Philippa Pearmain
Liz Petch
Tom Frost
Dianne Draper
Denice Burton

GENERAL MEDICAL COUNCIL REGISTER

Katharine Warren
Daniel Todkill
Rachel Mearkle
Kate Mandeville
Catherine Mbema
Tazeem Bhatia
Lilianganee Telisinghe
Robert Aldridge
Shamil Haroon
James Elston
Esther Curnock

Have you started thinking about your annual CPD return yet?

THE end of the continuing professional development (CPD) year approaches and so now is the time to submit your annual CPD return for 2017/18. This is the return that states how many CPD credits you will be claiming for the period 1 April 2017 to 31 March 2018. Your return is due to reach FPH no later than 30 April 2018.