



Generating Cultural Change in Public Health: Evidence and Effectiveness

**Report of the Social Market Foundation
Conference 20 June 2006
Edited by Barney Gough**



The Social Market Foundation

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Foreword

Public health in the UK is no longer a matter purely for the NHS or the Department of Health. Government should not and cannot address healthcare issues single-handedly. In order to avoid nanny-statism emphasis must be placed on shared responsibility between employers, communities, individuals and the state. As part of the public health agenda, policymakers have begun to address underlying factors affecting public health, such as those specific to this conference: binge drinking, unhealthy eating habits and risky sexual behaviour.

Preventing illness, not just curing it, is now recognised as an essential part of healthcare in the UK and is an absolute necessity to maintain affordability. As part of that shift, more effort has been placed on encouraging people to live healthier lives; we are seeing the beginnings of cultural change in this respect. This publication is part of the concerted effort to address behavioural change in public health and advance this agenda.

We know that excess alcohol consumption is detrimental to health. However political responses to this have often focused more on reducing crime than improving health – an important distinction. Although figures from the Office of National Statistics only suggest a marginal increase in average weekly alcohol consumption for both men and women,¹ other data shows a startling rise in levels of under-age drinking.² The associated health and social problems mean that alcohol policy should form a central part of an overall approach to improving public health.

Growing obesity and unhealthy eating habits, emphasised by Jamie Oliver's broadly publicised campaign to improve school lunches, continue to be a national concern. The levels

1 Office for National Statistics, *Drinking: adult behaviour and knowledge in 2006*, Omnibus Survey (ONS, November 2006).

2 "Drinking among girls continues to rise" (ONS, 21 February 2006).

3 "Diet & Nutrition: Proportion of overweight children up" (ONS, 24 March 2004).

4 National Audit Office, *Tackling Obesity in England* (NAO, 2001).

5 Office for National Statistics, *The health of children and young people: Chapter 6, Adolescent sexual health* (ONS, March 2004).

of childhood obesity have continued to increase, with no sign of abatement.³ However, the focus on our children's diet must broaden to encompass all Britons' eating habits – the National Audit Office reported that more than 31,000 people are dying prematurely each year as a result of unhealthy diets and lifestyles.⁴

The current sexual behavioural of teenagers and young adults also provokes heated debate. British culture has become increasingly bombarded with depictions of sexual behaviour, nearly all of it glamorising sex. Along with this increased publicity and exposure comes decreased celibacy – teen infection of chlamydia nearly doubled during the 1990s and new sexually transmitted disease (STI) episodes in Genito-Urinary Medicine (GUM) clinics have been on the rise for the last decade.⁵ Both of these phenomena demonstrate the increasing need to address our nation's risky sexual behaviour. It is a complex challenge, which must be urgently addressed.

Cultural change is a difficult task as 'old habits die hard'. It requires a coordinated campaign to influence healthy lifestyle changes. One important tool is disseminating information and providing large, broad-reaching messages to the public, but this must be coupled with other policies. Recent research suggests that combined policies of positive incentives and disincentives often provide the greatest results. A good example of such a policy mixture is the anti-smoking campaign, which coupled high cigarette tax and negative, hard-hitting advertisements with subsidised counselling and alternative treatment, such as the nicotine patch.

Similar to the anti-smoking campaign, policymakers are calling for clear and far-reaching public messages regarding binge drinking, unhealthy eating and risky sexual behaviour. Successful advertisement campaigns and public messages could provide an effective means toward improving Britain's health. Throughout this publication, many contributors call for accessible information and substantial public messages to help spur cultural change.

Health education is also empowering. It enables people to make informed decisions about their lifestyle and take control of their lives. A healthy cultural shift would impact positively on health inequalities – smoking rates are higher among manual

workers than professionals, for example. Improved public health would disproportionately benefit the least well off, and help to reduce demand for NHS services. How to improve our public health is one of the key challenges we face as a society and we hope that the debates reproduced here will make a positive contribution.

Andrew Murdock
Pharmacy Director
Lloyds Pharmacy

Overview from the SMF

As in many other Western countries, UK health policy has tended to focus on sickness rather than on public health. The NHS has traditionally been a service structured to treat illness, rather than to foster its prevention. However, there are encouraging signs that this is beginning to change, not least with debate now focusing on the role of government, advertising, producer industries and other parties in shaping people's attitudes to their own health and, ultimately, their behaviour. This is a highly relevant debate from the point of view of the social market since it involves an exploration of the role of the market, the effectiveness of government action, and the place of civil society in delivering healthcare.

As a result, we have undertaken work looking at government's role in shaping the cultural background against which people take decisions about their health. Debates about public health all too often take place in isolation from these important factors, which have very significant effects on our behaviour. Whether it is advertising, public health messages, peer pressure, or press coverage, these elements need to be understood in the context of the nation's health culture. We have argued strongly that all of those involved in the debate have a responsibility to help promote public health messages, and that includes industry and government.

The SMF's conference, 'Generating Cultural Change in Public Health', covered the specific issues of binge drinking, healthy eating, and risky sexual behaviour. The conference provided an opportunity to discuss how public health messages are formed, disseminated, received and acted upon across society. The conference examined the ways in which people are helped to change their individual behaviour and how, more

widely, cultural change is achieved.

Public health is a very complex and difficult issue for government. Politicians have to tread the fine line between being too interventionist and being too laissez-faire.

Intervention tends to produce accusations of nanny state-ism, but even when this is the case, government is held accountable for the faults of the health service and broad public health outcomes. For government, we believe a focus on how the health environment, most broadly conceived, can be transformed is a fruitful way of approaching the issue of public health. Such a shift would allow government to intervene less directly in people's lives, while also being able to spend more on unavoidable health problems: recent National Consumer Council research has suggested that £187 billion is spent every year as a result of preventable health conditions.⁶

6 Ed Mayo, *It's Our Health! Realising the Potential of Effective Marketing* (National Consumer Council, 2006).

Ann Rossiter
Director
Social Market Foundation

Attendance

Generating Cultural Change in Public Health: Evidence and Effectiveness

A Social Market Foundation half-day conference, Tuesday 20 June 2006

Name	Position	Organisation
Dr Catherine Armitage	Staff Grade Doctor, Sexual Health	Mortimer Market Centre, London
Ms Uzma Aslam	Assistant Manager	REACH Community Health Project
Ms Jenna Avent	Health Programme Manager	CanIGoThere.com
Mr Komel Bajwe	Project Associate	APCO UK
Mr Shabir Bandy	Policy and Research Officer	REACH Community Health Project
Ms Rachel Barber	Public Affairs Officer	Rainer
Mr Matt Bell	Director Policy and Communications	CABE
Ms Charlotte Blencowe	Acting Public Health Development Manager	The Healthcare Commission
Mr Mark Brangwyn	Head of Health and Social Care	Association of London Government
Mr Adam Brimelow	Health Reporter	BBC
Mr Neil Carmichael	Chief Executive	Strategic Impact
Ms Emma Carr	Public Affairs Executive	BUPA
Ms Sarah Carver	Business Development Manager	St George's, University of London
Ms Deborah Cohen	Assistant Editor	British Medical Journal
Ms Sarah Cook		Fishburn-Hedges
Ms Helen Cooke	Principal Analyst, Public Health Intelligence Service	South West Public Health Observatory
Ms Lucy Cork		Associate Parliamentary Health Group
Mr Richard Cottrell	Director	The Sugar Bureau
Ms Rachel Cunningham	Healthcare Consultant	Fleishman-Hillard Public Affairs
Ms Vida Cunningham	Public Health Project Manager	Surrey and Sussex SHA
Mr Dan Dedman	Public Health Information Specialist/Analyst	North West Public Health Observatory Centre for Public Health
Dr Tom Dickens	Principal Lecturer	School of Psychology, University of East London
Dr Peter Draper	Health Policy Analyst	University of East London
Professor Walid El Ansari	Professor of Family Health	National Centre for Social Research
Mr Bob Erens	Group Head, Health Research	Morgan Allen Moore
Ms Hilary Evans	Government Affairs Adviser	Terrence Higgins Trust
Ms Victoria Field	Policy Officer	Fishburn-Hedges
Mr Ron Finlay		Eastern Region Public Health Observatory
Dr Julian Flowers	Director	AccountAbility
Ms Maya Forstater	Senior Associate	Cancer Research UK
Ms Genevieve Frisby	SunSmart Campaign Manager	Standard Life Healthcare
Mr David Furness	Public Affairs Executive	Public Finance Magazine
Ms Sally Gainsbury	News Reporter	

Mr Ivo Gormley	R&D Director	thinkpublic
Mr Chris Gribben	Associate Director	Ashridge Centre for Business and Society
Dr Charmaine Griffiths	Press and PR Manager	British Heart Foundation
Ms Kate Groucutt	Senior Policy Adviser, Employment and Health	CBI
Mr Jamie Hardie	President	Society of Sexual Health Advisers
Ms Kim Haskins	Journalist	YouthNet UK
Ms Vivien Hepworth		Grayling
Ms Sabina Hussain	SpR in Public Health and Research Associate	Bristol University
Mr Tim Kellow	Managing Director	CanIGoThere.com
Ms Ruth Kipping	Public Health Specialist Trainee	South Gloucestershire Primary Care Trust
Ms Christine Kirkpatrick	Committee Specialist	Health Select Committee
Mr Dafni Kokkidi	Healthcare Practice	Ogilvy Public Relations Worldwide
Ms Tamora Langley	Account Director	Weber Shandwick
Kate Lawson	Acting Head of Health Promotion	Brighton and Hove City Primary Care Trust
Ms Pamela Learmonth		AS Biss
Ms Lucy Lee	Policy Group Secretary, Public Services Improvement Policy Group	Conservative Party
Dr Wai Ching Loke		St Thomas' Hospital
Ms Jenni MacDougall	Health Information Manager	Cancer Research UK
Mr Neil Mainprize		Associate Parliamentary Health Group
Mr Nicky Martin	Student Nutritionist	Scolarest
Mr Conor McGinn	Health Policy Officer	Federation of Irish Societies
Mr George McGregor		Politics International
Ms Emma McKinney	Senior Consultant	Media Strategy
Ms Louise Meincke	Policy and Communications Assistant	Foyer Federation
Ms Jenny Morris	Policy Officer	Chartered Institute of Environmental Health
Ms Rebecca Morris	Research Director	Opinion Leader Research
Mr Suresh Munuswamy	Researcher	Oxford Brookes University
Ms Aileen Murphie	Director	National Audit Office
Ms Hazel Nunn	Science Information Officer	Cancer Research UK
Dr Jo Nurse	Consultant in Public Health	Public Health Group South East
Mr Chris Oulds		The ALCO Group Ltd
Mr Will Palmer	Researcher Health VFM	National Audit Office
Ms Julia Pearlman	Journalist	YouthNet UK
Ms Liz Plastow	Professional Adviser for Specialist Community Public Health Nursing	NMC
Mr Nigel Pollard	Communications Manager	Scottish & Newcastle UK
Ms Jennifer Rankin	Research Fellow, Health and Social Care	IPPR
Ms Cathy Ratcliffe	Communications and Operations Manager	HEART UK
Mr Simon Redfern	Director	Connect Public Affairs
Ms Laura Riley	Press and Public Policy Manager	BPAS
Dr Franco Sassi	Lecturer in Health Policy	LSE
Mr Adam Savitz	Analyst	Innovest Strategic Value Advisors
Ms Sarah Schofield	Associate Director	Fishburn-Hedges
Mr David Sheehan	Development Manager	Public Health Group South East
Ms Saranjit Sihota	Associate Fellow	Social Market Foundation
Ms Margaret Simons	Independent Public Health Specialist	
Ms Deborah Smith	Head of Alcohol and Drug Misuse Team	Scottish Executive
Ms Emma Steel	Team Leader, Performance Ratings Team	Healthcare Commission
Ms Lucy Stowe	Regulatory Reform Advisor, Food and Health Team	Better Regulation Executive
Ms Deborah Szebeko	Director	thinkpublic
Ms Melanie Taylor	Corporate Communications Manager	BII
Mr Midori Ura	Researcher	Oxford Brookes University
Ms Helen Vaughan-Jones	Corporate Communications	BUPA
Mr Adrian Ward	Communications Executive	National Institute for Health and Clinical Excellence
Ms Melinda Weir	Health Policy Consultant	
Mr Marcus Weisen	Health and Disability Adviser	Museums, Libraries and Archives Council
Mr Samuel Whaley	Team Leader, Performance Ratings Team	Healthcare Commission
Mr Dennis Wilkes	Director of Public Health	Solihull PCT
Ms Sarah Woolnough	Public Health Policy Researcher	Cancer Research UK

Session 1: The Role of Government, Society and the Individual in Changing Cultures

Speakers:

- Andrew Lansley CBE MP, Shadow Secretary of State for Health
- Dr Jeff French, Programme Director, National Social Marketing Centre
- Paul Kelly, Corporate Affairs Director, Compass Group plc
- Andy Murdock, Pharmacy Director, Lloyds Pharmacy
- Chris Arrowsmith, Producer, *The Challenge*, BBC
- Chair: Ann Rossiter, Director, Social Market Foundation

Andrew Lansley MP is the Shadow Secretary of State for Health, a post he has held since 2003. Since he became a Member of Parliament in 1997 he has been extensively involved in health issues; he has served on the Health Select Committee and has been Chair of the All Party Parliamentary Group on Stroke.

There is no doubt that institutional and structural changes are needed to ensure the development of a stronger public health service. The dis-aggregation of public health activity into 303 primary care trusts (PCTs) has substantially undermined its ability to operate effectively. As a result, the public health service needs to be aggregated back together. It needs to be a public health service with ring-fenced budgets and with directors of public health who are appointed both by the NHS

and by local authorities.

That ring-fenced budget must meet the needs of UK healthcare, but more particularly it must be focused on health inequalities and poor health outcomes. At the moment we have a system in which NHS funding is distorted or allocated in relation to proxies for need. Yet it is very rare that resources are allocated specifically to levels of disease in particular areas or to inequalities of health outcomes. Much greater precision as to why resources are allocated is needed.

This leads to another point: we need a better evidence base. A lot of the research material relating to public health is an analysis of problems, while only a tiny proportion is an analysis of the relative effectiveness of interventions. Relatively few analyses are absolutely definite about the outcomes that result from particular interventions. For example, from looking at the valuation report on health action zones it is quite clear that a great deal of effort, time, energy and money has been invested. However, the conclusion of the report does not actually reveal the outcome of the health action zones; so we do need a much better evidence base.

Furthermore, we have had far too few national health education campaigns in recent years. The only one that has had an impact has been that of the British Heart Foundation, supported by the Department of Health, in relation to smoking. The abolition of the Health Education Authority led to something of a desert for some years in national health education campaigning. It is therefore important to start working with 'at risk' groups and to carry out targeted campaigns across the population. Much of the success of the 'tombstone campaign' in the 1980s was due to the fact that it was both directed to those who were specifically at risk and it created a population-wide environment in which to work.

For these campaigns to be most effective they must start with a focus on young people. The way in which young people's attitudes to diet, exercise, drink, drugs and sex are changed is terribly important. Children with poor self-esteem are vulnerable to peer pressure. Consequently, it is important that schools and parents are helped to raise the self-esteem of young people.

Therefore, it is very disappointing that life education centres reach only a fraction of schools and do so primarily on

the basis of the subscriptions of parents themselves, and so are disproportionately concentrated in middle class areas. With some departmental support, centres are reaching poor areas, but there is a great deal more that can be done, as they are only just beginning the task of talking to parents at the same time as they are talking to children. It is important that centres are geared not only to telling people about the nature of drink, drug or sex problems, but also actually giving them the self-esteem to be able to make their own decisions.

The debate about 'junk food' is another aspect of this current public health discussion. It will not make much difference whether junk food advertising is banned before 9pm; Ofcom is right on this particular issue. It is right to say that banning junk food advertising before the watershed might achieve only a 1% or 2% shift in behaviour. We have to work with both young people and parents.

Clearly parents – as well as young people - have got to learn about diet. We are at risk in the debate about junk food of ignoring the necessity of understanding that many of the changes in recent years have been due to a deterioration in the quality of diet and a reduction in the level of exercise. We need to work on both sides of that equation. Parents and young people need to be encouraged to have a good diet and a positive attitude towards exercise.

Finally, we need to give people a much better sense of risk. Cultural change is difficult enough but trying to get people to understand risk is even harder. Let us give people the opportunity to understand their health status, through screening programmes that identify risk factors. For example, cardiovascular disease has a generic set of risk factors. This means that we can, at a relatively early stage, identify what those factors are and give people an understanding of the nature of risk for them and a means by which they can respond to that. It is not clear if health trainers are going to be effective in that context or not. But what is certain is that we need to greatly improve the way we identify particular sections of the population who suffer from certain diseases. It would then be possible to open a route by which individuals can do something about their illness, and understand the nature of the problem as it affects them.

Jeff French is Programme Director for the Social Marketing Centre. He is also a Fellow of King's College London and is currently developing a national social marketing strategy for the Department of Health.

There is an urgent need for a cultural change in attitude towards public health. Without a step change in approach the NHS will become bankrupt. This fact is illustrated by the problem of obesity in the UK. The Social Marketing Centre has just completed an economic review of the cost of preventable health and we have come to the figure of 19% of GDP. That is a fantastic economic drag on the UK.

To tackle this problem we need to move away from the 'lone ranger' mentality that the Department of Health and government have got trapped into, and view society and the wider public as our biggest asset. The small amount of money that the Department of Health has does not compare with the mass of funding, resource and talent, expertise and interest that is in the private sector. The self-esteem industry is worth £30 billion in this country. And the reason that it is worth so much is down to marketing and the public's desire to take care of themselves. That is something we have to tap into.

Figures taken from a variety of market research surveys show that people are aware that they must take some responsibility for their health and the health of their family: 63% of people have changed their family's eating habits or activity levels in attempts to lead a healthier lifestyle; 93% agree that parents are more responsible than anybody else for the health of their children. Therefore, this is not a demand-side problem, it is a supply-side problem. While 33% of people believe that the government has an important role, only 4% think it has the *most* important role. People are starting to see themselves as accountable; it is essential that this is harnessed and all assets in the population are embraced.

But there is a point when government has a role to intervene: when there is a severe risk; when there is a mass risk that affects many people; or when it has a plausible intervention strategy. When there is a mandate for action; when there is an acceptable trade-off between risks and freedoms; when the cost effectiveness of the intervention can be demonstrated; when the

negative side effects are acceptable; and when the intervention is not going to increase inequality - these are occasions when government interference is justifiable.

Social marketing is part of the answer, as it draws on a rich tradition in the commercial and the public sectors. Furthermore, it brings an insight and understanding about why people do things, which is currently lacking in the public health sector. The sector uses epidemiology, disease and mortality data as a proxy for the living. There is a focus on demographics: where people are and what they do. But as a result, there is not a clear understanding of the reasons behind why people behave in certain ways. We need to have a clearer grasp of what motivates behaviour and a more developed understanding of the exchange concept: nobody ever changes what they do unless they make the calculation that it's worth the pain and the effort.

Social marketing is a mindset that you can apply to policy at a series of levels of intervention; it is also a systematic process. Social marketing is about co-delivery, moving away from a lone ranger, 'government can do it', syndrome to view government as a facilitator. Lots of communities are doing work in this area already, working with the private sector more proactively and more positively, and this must be supported and expanded.

Furthermore, there is a need to work with NGOs and charitable foundations in a much more co-ordinated way. Partnerships need to be built to make that happen - business-to-business marketing shows that. In the United States one of the main public health bodies, the Center for Disease Control (CDC), has a separate foundation that sits on the campus and works to build partnerships between the NGO sector and the private sector. It also runs a very successful social marketing programme called Verb. It invested \$128 million from CDC in the first year of that programme and a further \$75 million was raised from partnership donations.

There is a need to move away from campaigns that attempt to raise awareness and to shift social norms gradually. Instead we must focus on the bottom line: behaviour change. That must become the gold standard in terms of whether we are making progress or not. Behaviour change is what we must gear up our campaigns and interventions around.

The National Social Marketing Centre is launching a

review that will be available on our website. This sets out a series of five key recommendations to government about tackling preventable health, focusing on behaviour change and 39 specific changes it needs to make.

In brief, the recommendations state:

- I. A consumer-focused approach based on social marketing principles must be developed. This will shift the emphasis away from the belief that experts know best, in an attempt instead to try and understand why people do what they do and what can be done to help them change, in the way that they want to.
- II. There is a need to mobilise assets and develop a diverse resource base across all sectors.
- III. Prioritisation and expert commissioning must be introduced. The Department of Health needs to move away from being a body that commissions, runs, develops, delivers and evaluates programmes to become one that commissions that work from the market.
- IV. Social marketing capacity and capability in the workforce must be built. All the key workers across the public health system need to understand and apply social marketing principles.
- V. Research and evaluation must be reconfigured and there needs to be a move away from the very stilted and confined view of what the available evidence represents.

Paul Kelly is Corporate Affairs Director at Compass, the largest food service company in the UK. He is also a member of the School Food Trust and the Food Chain Steering Group.

Compass serves about twenty million meals a day in more than 90 countries. One in five of those meals are served in the UK, and one in three of those to people in public institutions like schools and hospitals and to public sector employees. That gives us a unique insight into the role that good food and good nutrition can play in changing behaviours.

Nutrition is key to changing behaviours. Thus it is quite legitimate for the government to invest in good nutrition to achieve positive public health outcomes and wider economic

benefit. There is an ever-increasing body of evidence that shows not only a link between good nutrition and, for example, academic attainment in schools, productivity in the workplace or patient recovery rates, but actually quantifies those benefits in hard cash terms.

The government has now, thanks to Jamie Oliver, started to introduce minimum nutritional standards for food served in schools. But banning these products from schools does not go far enough. Minimum nutrition standards should not just be applicable for schools, but also for food served to hospital patients, to prisoners, to the armed forces and - perhaps controversially - to public sector employees. With regards to the latter, such a move would give a very strong lead to the private sector about its obligations in terms of the wellbeing of its employees, with the dividend being increased levels of productivity.

It should not just stop at minimum standards. If nutritional quality is to be achieved there is a need for a fundamental change in the way in which food is prepared and served. Quality ingredients are essential, as are well-trained cooks and cooking methods that retain nutritional content and value. All too often, particularly in hospitals, the nutritional content of the food disappeared a long time ago because of the cooking methods.

Providing meals made from quality ingredients prepared by well-trained cooks is inevitably going to cost more. The public sector, at present, is not investing enough in feeding the vulnerable sectors of society in public institutions or its own employees. School caterers do not have enough money to deliver the government's aspirations in terms of minimum nutritional standards. With the abandonment of the Better Hospital Food Initiative and with NHS deficits, hospital food caterers are concerned about budget squeeze. Unsurprisingly, there has been a fall in the quality of the food served to patients, and this is only going to get worse.

Procurement culture is partly to blame for this. The emphasis on so-called 'best value' has created a culture where lowest price is deemed more important than nutritional quality. That is undoubtedly a contributing factor to some of the problems that we see. Sir Ian Donaldson has described it as a health time bomb.

There is a very clear message for government. It does have

a legitimate role in defining minimum standards but government must then ensure that the money is available to allow the public or the private sector to deliver on those standards.

This is not a call for a blank cheque signed by Gordon Brown. It is clear that the next public spending round is going to be particularly tight, and that in real terms new money for investment is probably not going to be available. What is required is a redirecting of existing monies to achieve efficiency savings. There are still a lot of efficiency gains to be had if we can change the culture and the way public institutions look at money. The cost of malnutrition among hospital patients is estimated at over £7 billion a year. Not surprisingly, some 40% of food in hospitals is wasted, that is, an additional £45 million in cost. Yet every £1 invested in better diet for patients saves £4.83 and can reduce the stay in hospital, on average, from fourteen to twelve days.

Obesity costs the UK economy in the workplace around £2 billion a year and accounts for around eighteen million sickness absence days a year. Yet there is evidence that health promotion, including the provision of nutritious food, can improve productivity by about 8½ per cent.

These are real benefits, but we are not going to be able to realise them unless we see government intervention at the highest level. The government has recognised that small changes can make a big difference, and that initiatives driven at a local level through collaboration and social marketing can be extremely effective. But that is only going to happen if the government gives a lead, states its determination to see the benefits realised, and then creates the framework that allows organisations to go out and grasp those benefits and achieve those efficiency savings.

Andy Murdock is a Pharmacy Director at Lloyds Pharmacy. He is also Director of the Company Chemists Association and Director of the National Pharmacy Association.

Lloyds Pharmacy has 1527 pharmacies across the UK. We see approximately two million people a week, so we interact with a large part of the population and see a lot of their problems and issues.

I can do nothing for housing. I can do nothing for the environment. I can do nothing for transport. So my view is a wholly medicalised view, rather than a social examination, of public health.

From a government perspective, public health and pharmacy have finally come together. This has been recognised in the new pharmacy contract in which promotion of healthy lifestyles is incorporated into what we do and what we get paid for. The only problem at the moment is that no national campaigns have been developed for pharmacies. There seems to be a lag between intent and implementation.

Pharmacies do signposting now, which means that a pharmacist can send a customer across to social services or other healthcare professionals so that they get the best multi-agency benefit for any problem they have. All pharmacies will start having consultation areas where we can engage with the general public.

Due to devolution, Scotland does things differently to England and Wales. In Scotland the public health service is now one of the four pillars for pharmacy, but we are still waiting to see how that is going to materialise in the type of campaigns that we undertake.

Pharmacy is accessible; it gives excellent message provision in a relaxed environment. This is very important in deprived communities where pharmacies act as an essential health source for the local community.

The messages that we have traditionally put across have been centred around product and advice, with the subjects usually being smoking cessation and emergency contraception. But there are more innovative ways of getting messages across. For example, we have our own live radio station on which we broadcast public health messages to the people coming into our units – 52,000 people every hour will listen to messages covering a variety of health issues, such as prostate disease or contraception.

Pharmacy is now involved in testing for infections. We are currently taking part in the Department of Health programme looking at chlamydia. We also use television to alert people to the signs of diabetes and high blood pressure. We have carried out 860,000 diabetes tests, 5% referrals, and over a million

blood pressure tests, 12% referrals. This will have a significant effect on the health of the nation.

It is important to give people answers to their ailments. We work hard to identify problems, but we must also concentrate on steering people to suitable solutions. Hopefully, the work that we are undertaking in this area will result in a greater number of positive outcomes.

We have been criticised about the lack of cost effectiveness of mass screening. Instead, a targeted approach to changing behaviour is needed. For example, a programme in Slough targets and identifies diabetes hotspots in the community. A second-hand London double-decker bus is driven round the community and is used as a mobile health lab. More schemes such as this need to be developed.

Pharmacy can make a difference; it can help achieve the Wanless aspiration.⁷ The NHS is faced with financial constraints, but the challenge should be to ensure we are meeting the need of the disease rather than the demand of the disease. The need is to improve public health, while the demand is for cardiac and accident and emergency units. Primary care trusts are left with the difficult question of how best to prioritise. It is a testing challenge as it is asking the PCTs to become health insurers, and currently they lack the skill set to do this successfully.

Chris Arrowsmith was the producer of *The Big Challenge*, a two-year public health campaign and programme run by the BBC. *The Big Challenge* aimed to give people easy steps through which to change their lifestyle.

The BBC's remit to educate, inform and entertain includes a responsibility to cover major cultural issues, like the health of its audience. There are many BBC examples to draw upon, such as our portals on BBC health and BBC parenting. There are numerous Radio 4 health features, and Jeremy Vine's health discussions on Radio 2. Radio 1's weekly *Sunday Surgery* and the safe sex campaign successfully convey important health messages in a credible tone and style for its younger audience. Plus we have television series such as *How To Live Longer* on BBC 1 and *Honey We're Killing the Kids* on BBC 3. Key health seasons

⁷ Derek Wanless, *Securing our Future Health: Taking a Long-Term View* (HM Treasury, London, 2002).

are being planned around issues such as fertility, IVF and mental health.

The BBC *Big Challenge* was a major campaign that engaged the audience by setting out a range of small steps for long-term change. It was a two-year sustained campaign with the aim of encouraging people to take simple steps to a healthier life by making healthy eating and exercise both accessible and entertaining.

In the first phase, the BBC1 series *Fat Nation* reached over twenty million people. Every BBC local radio station covered the campaign and, working with a range of health partners, the BBC hosted a series of health events across the UK. Over a quarter of a million people ordered a special *Big Challenge* health pack and pedometer, and one and a half million users have visited our website, which offers personalised information and health advice.

A second phase of the campaign concentrated on people at work by initiating the BBC Healthworks Awards, which awarded healthy employers. We received applications from over 2000 companies representing two and a quarter million employees. Again, working with partners in the field we ran *Big Challenge* health care clinics and featured the awards on BBC2's *Working Lunch* and on local BBC radio and TV, celebrating the successes of the local champions of employers. The campaign generated significant awareness and interest, and continues to run via the interactive website.

One of the key success criteria for the *Big Challenge* and our other health seasons is to communicate and work effectively with partners in the field. Much credit for this particular project is due to organisations such as Investors in People, Business in the Community, the Well at Work Initiative (funded by Sport England, the Big Lottery Fund and the Department of Health), the British Dietetic Association, the Awareness Trust and the British Heart Foundation.

The BBC's remit as a public service broadcaster includes a responsibility to cover major issues like health. A degree of responsibility also extends to the general media, to raise awareness and present public health issues to their audiences.

General discussion

The discussion session opened with the suggestion that the BBC had an advantage over government and industry because of the public's trust in it as an institution. It was pointed out that Channel 4 could run campaigns such as 'Jamie's school dinners' whereas the BBC was sometimes more constrained by its obligation to maintain neutrality.

There was general agreement that, unless there were major behaviour changes in society, the NHS would face serious financial consequences, perhaps even bankruptcy. It was felt that a collective sense of responsibility, as well as an individual sense of responsibility, was required to bring about a new cultural awareness of health issues. This would involve initiatives and co-ordinated action from many sectors, including government, the private sector and NGOs.

Delegates discussed the use of targets in the NHS. One speaker suggested that centrally determined targets distorted the way in which the NHS responds to patients' needs, but that public health targets were also necessary performance measures for holding government to account. The use of statistics in public health messages was said to confuse the public over particular issues. At the same time, it was pointed out that the opposition party needed to offer constructive criticisms and to present alternative policies if they felt they were required.

Finally, discussion moved on to the role of business in improving public health. It was proposed that, with the right incentives, the resources of business could be harnessed and used to drive up standards of public health. Delegates agreed that certain sections of the private sector, such as the catering industry, had a fundamental part in achieving this goal. Encouraging business to engage with the government's ambitions was seen as essential for bringing about progress in long-term public health improvements.

Session 2: The Binge Drinking Culture

Speakers:

- Srabani Sen, Chief Executive, Alcohol Concern
- Jean Coussins, Chief Executive, The Portman Group
- Barbara O'Donnell, National Alcohol Liaison Officer, Alcohol Focus Scotland
- Chair: Sue Saville, Health Correspondent, ITV

Srabani Sen is the Chief Executive of Alcohol Concern. Previously she was Acting Director of Nations, Regions and Campaigning for Diabetes UK. Srabani is a trustee of the Long Term Medical Conditions Alliance.

It is important to see binge drinking in context. As a phenomenon, it is part of the way we as a society view alcohol.

The large number of definitions of the term 'binge drinking' adds unneeded complexity to the debate. One definition states that binge drinking is the consumption of more than twice the daily safe limits of alcohol – by that definition it is probable that most adults have binge drunk at some point in their lives, if not frequently. Another definition declares that binge drinking is drinking to get drunk. Using that definition, according to Home Office figures published last year, very nearly half of all young men (18-24 year olds) regularly binge drink. Very nearly 40% of all young women in that age group also regularly binge drink.

More frightening, though, is the fact that of those people who confessed to regular binge drinking, nearly two-thirds admitted to some form of criminal or disorderly behaviour

resulting from that. The link between binge drinking and crime and disorder is startling. However, it is important that we step back from that for a moment and understand the context for that drinking.

Alcohol is far more affordable and far more easily available now than it was twenty years ago. We start drinking young in this country: we have one of the biggest under-age drinking rates in Europe. Those sixteen year olds today who admit to drinking now consume twice as much as their counterparts ten years ago.

The consequences for public health are astounding, but quite underestimated. Most people associate drinking too much with liver cirrhosis, but very few realise that it also causes cancer, heart disease, mental health problems, sleep deprivation and many other health problems. It can also adversely affect a person's relationships – with their children, their ability to parent, etc. The scale of the consequences of regularly drinking too much is something that we are not aware of.

It is possible to drink alcohol in a safe way. But very few of us know how to do that, and this is hardly surprising when you consider how little government spends on tackling problem drinking. In 2004 the government spent less than £40,000 communicating the sensible drinking message. Raising awareness is not enough on its own, but it has to be the starting point from which we change our behaviour.

Compare that figure of less than £40,000 with the £600 to £800 million a year spent by the alcohol industry promoting their products. It is hardly surprising, therefore, that the vast majority of people do not know how to drink safely and sensibly. It is all too easy to blame individuals and to say that they are not acting responsibly. Of course binge drinkers need to change their behaviour but they need to be supported to do so.

There has been a large amount of press coverage and government concern focused on binge drinking. However, it appears that we do not actually care about binge drinking. What we care about is the behaviour that results from, or is perceived to result from, the volume of alcohol that young people consume. It is not the binge drinking that people see as the problem, but the behaviour that they associate with it.

One of the reasons that we as a nation have a problem with

binge drinking is that people think drinking lots of alcohol will result in them behaving in a certain way. This is not true. The way you behave when you are drunk is determined by your personal expectations of how you think you will behave when you have consumed a certain amount of alcohol. Countries that are quoted as having a better drinking culture than the UK may not actually be drinking any less than we are, but their expectations of how they will behave when they have consumed that alcohol is different from the expectations of young people in this country today.

To its credit, the government has tried hard to tackle binge drinking. There has been various legislation and a lot of effort targeted at preventing the sale of alcohol to those who are under age. What the government has failed to do – or, at least, what any initiative has failed to do – is to tackle one of the real problems with the way that alcohol is sold as part of our night-time economy. The authorities are not discussing the widespread problem of the sale of alcohol to people who are drunk, even though this is an illegal activity. You just have to walk into a bar on a Friday night to know that the law is regularly flouted.

An MP, on behalf of Alcohol Concern, put down a question in the House of Commons to find out how many prosecutions there had been for selling alcohol to people who are drunk. In 2004, the last year for the figures, there were only 13 prosecutions in England and Wales for such an offence. Therefore, the fear of being caught and prosecuted for breaking this law among retailers of alcohol is small. That is something that must be tackled.

None of the government's measures are aimed at changing society's attitude towards alcohol. Drinking to excess is culturally acceptable - in fact, it is expected as the norm. That is at the root of our problems. Unless we tackle our attitudes to drinking alcohol we will never fully tackle binge drinking as a specific issue.

Jean Coussins was, at the time of the seminar, Chief Executive of The Portman Group, a not-for-profit organisation championing social responsibility for drinking. Jean left The Portman Group in September 2006, but continues to serve as a Commissioner on the Better Regulation Commission and as a member of the Advertising Standards Authority.

Binge drinking is all too prominent in the UK's drinking culture today. It is damaging both to those who do it and to others around them, and it is clear that something must be done to resolve this problem. Any progress towards tackling binge drinking will require much more concentrated effort than has already been given to the issue, by the government, the industry or the NGOs.

It is worth asking whether more sustainable culture change can be achieved by targeting the bad or by reinforcing the good, or perhaps by a bit of both. Looking at facts derived from official data, as opposed to tabloid headlines, provides a clearer understanding of our contemporary drinking culture. The National Centre for Social Research's most recent report on drug use, smoking and drinking among young people found that there are now more teenage abstainers than ever before, that nearly nine out of ten young teenagers are not regular drinkers, and that the average amount consumed by teenagers who do drink has, in fact, been stable since 2000.

The Office for National Statistics (ONS) General Household Survey suggests that binge drinking among 16-24-year-old men has actually been in decline since 1988. Even among 16-24-year-old women – the group with the most worrying drinking habits – binge drinking, as defined by the ONS methodology, has been in decline since 2002. Indeed, heavy drinking among all groups is either stable or in decline.

The newspapers may imply that another feature of the modern drinking culture is that people go to the pub less and instead go to the supermarket, stock up with huge quantities of drink, and consume it at home. However, the Department for Environment, Food and Rural Affairs (DEFRA) family food expenditure survey revealed that even drinking at home is down by 3.7%.

People, young people in particular, like to conform. They

seek the security of conformity, despite the stereotypes to the contrary. Social marketing must convince people that indulging in binge drinking is not the norm and is not acceptable.

The alcohol industry has a number of vital roles to play. First, it must comply with the extensive raft of rules and regulations that state what it must not do, to ensure that it does not encourage irresponsible drinking. Some of those rules are statutory, such as the laws on not serving under-18s or customers who are already drunk, or the regulating of television advertising.

Other rules that must be complied with are voluntary or self-regulatory, such as those on non-broadcast advertising or The Portman Group's code of practice on naming on packaging. In the last nine years this particular code has led to over 80 products being removed from the market following an adjudication that they appealed to children or were otherwise socially irresponsible. There are also in-house codes and standards observed by many companies.

The industry must also do more to promote responsible drinking. One of the ways to do that is by unit labelling. The government's sensible drinking message comes in units. That is the currency of the message and consumers need to become familiar with what a unit is and how that relates to what they are drinking. Hopefully this will help shape a drinking culture underpinned by responsible decision-making by consumers.

All The Portman Group member companies and many others voluntarily put unit information on bottles and cans of all major UK brands. Some go much further still and will put sensible drinking messages, as well as the raw numbers of the units, on bottles. A lot of companies in the industry are doing a little bit more still and are putting the address of the Drinkaware website on their bottles and cans. This is a consumer website that is a gateway to the detailed complexity of the sensible drinking message. It is not just appearing on three billion containers a year, but on £150 million-worth of advertising in print, in cinemas, on radio and on television. It is being promoted at thousands of points of sale. Because the Drinkaware website is being promoted by the industry it has an average daily hit rate of 50,000.

And yet the industry can do even more. Companies can

supplement their promotion of the Drinkaware website with dedicated brand-based campaigns on the television or the cinema, which many of them have done. They can, and our member companies do, give access to The Portman Group campaigns and the Drinkaware campaign materials through their distribution networks to the trade. That is one way of producers taking action that can influence good practice down the supply chain. They use drink awareness advertisements that The Portman Group provides within their programmes for sponsored events, like football or tennis or summer music festivals. The importance of producers and retailers working together cannot be underestimated. The Portman Group's charitable arm, The Drinkaware Trust, is currently looking at ways it can develop in the future in order to achieve, among other things, much bigger and better campaigns that will have more impact on behaviour in the long-term and on the drinking culture in the UK.

Although industry can and must play its part, there are a number of other important influences on culture change, which should not be forgotten. Television soaps and dramas, for example, often neglect to show the consequences of alcohol misuse. Alcohol education in schools can add great value in creating a new drinking culture among young people. There is also evidence that parents' drinking patterns seem to be one of the strongest influences on what will finally emerge as their children's drinking patterns. The media undoubtedly helps to shape our drinking culture, and the power of the new media must be harnessed to shape that culture into something more positive. The drinking culture of the 21st century will not be formed with leaflets and brochures, or even with conventional TV advertising. We have got to get to grips with all sorts of other new media, such as texting, podcasting and individualised television choice. There is an infinite capacity for individualising messaging on drinking, and we must come to terms with that.

Finally, we must look long-term if we are going to achieve sustainable culture change. Our focus must be the next generation, not the next general election. We need enough time consistently to put out important, strong messages and to have those messages backed up with enough resources, both from industry and from government. The approximate equivalent of the Drinkaware Trust in Australia, which has a very comparable

drinking culture to the UK, is funded by the voluntary sector and the drinks industry. The Australian government has just put \$5 million of funding into that. It would be very nice to see a similar effort being made here. This new culture will have to be created in partnership, for it is no one single agency's responsibility, but in the long-term there is no reason why we cannot succeed.

Barbara O'Donnell is the National Alcohol Liaison Officer (Scotland). She previously spent four years running the Scottish Executive and Health Scotland's responsible drinking campaign, Drinkwise.

The Prime Minister has described binge drinking as the 'new British disease, and as such is an issue of public health and requires a response'. One response is to challenge the cultural attitudes to binge drinking and alcohol dependency through counselling and working with service user groups.

If we wish to encourage a change of attitude it is perhaps prudent to consider the definition of culture in terms of alcohol. One definition of culture is 'something that is done without thinking'. Sadly, for many people binge drinking and the reliance on alcohol has become just that, which in turn has led to problems with employment, health and relationships.

Another definition is 'the way we do things around here'. Traditionally Scotland has an international reputation for being full of hardened drinkers and, in recent years, a country of binge drinkers: 85% of the Scottish population drink alcohol. Changing the culture of a nation cannot be done overnight and requires an approach that takes into account prevention and education, not just in schools, but with the general public. The national plan for action on alcohol problems means that Scotland now has a national communication strategy, prevention and education policies, along with provision of service for people with acute alcohol problems and for those who drink hazardously. The new Licensing Scotland Act 2005 has reviewed how alcohol is sold, served and consumed. Prevention education, provision of services, and protection and controls are the three main planks for the Scottish national plan on alcohol problems.

The Institute of Alcohol Studies has declared that counselling should form part of the treatment for those who suffer from problems of alcohol abuse. Counselling on its own cannot change the culture of drinking to excess, but it can be one of the levers for changing an individual's behaviour, which in turn could lead to a change in a family and in the community and, as such, has an effect on public health.

Alcohol Focus Scotland provides services for people with alcohol problems through its membership, which includes local councils on alcohol. It works in over 30 different locations throughout Scotland. Each council is autonomous and develops interventions and services in response to local need, providing services by using over 500 paid and volunteer counsellors. By providing counselling, a personal one-to-one relationship between a client and a counsellor can be created in which thoughts, feelings and the issues that can contribute to their problem are explored, the aim being to help clients find their own way of dealing with their problems. Counselling not only helps the drinker understand their problem, but it also gives the drinker, and consequently others in their social network, information on the effects of hazardous drinking. In particular, it provides an opportunity to challenge the social acceptance of drunkenness.

There are many different approaches that can be used in counselling in both the statutory and the voluntary sector, for example, counselling along with complementary therapies or counselling coupled with back-to-work initiatives. For dependent clients there may also be the need for a programme of detoxification alongside counselling that requires a response from medical staff. But no matter what intervention is used, there is the challenge for the client of learning to use alcohol in a sensible and responsible way. This is an engineered shift from intoxicating drinking to the use of alcohol in a social and responsible way.

Counselling also offers the opportunity for spouses or other family members to seek help in living with a problem drinker. It provides them with knowledge about alcohol and how dependence can affect the drinker. The hidden impact or harm created by parental alcohol misuse on children is a major issue of concern at present. Counselling services have an impor-

tant role in addressing these issues.

Alcohol counselling in Scotland is on the increase. Initially it was seen as support for those with chronic problems: the homeless, unemployed or groups of manual workers who had a history of heavy drinking. Today the client group spreads right across the social spectrum; religious and political leaders, senior and middle management professionals alongside the unemployed and the homeless are all receiving alcohol counselling. More and more young people are now entering counselling with an openness that is far removed from the early furtive approaches.

Figures show that those who have received alcohol counselling are generally much more successful than they previously were at sustaining patterns of controlled alcohol consumption. But measuring the effectiveness of counselling is not easy since post-service data is, for a variety of reasons, hard to collect. Furthermore, relapse is not uncommon and this in turn has created a debate about how to define effectiveness. Nonetheless, the evidence indicates that the counselling process, where effective, does have at least a harm-minimisation impact and at best creates a significant change in the drinker's behaviour.

Service user groups are also recognised as an important source of information. Alcohol Focus Scotland works with one such group through its alcohol client advisory group. User groups are made up of people who have suffered from alcohol abuse but who have been abstinent or drinking within safe limits for four to six months. They must be reasonably stable in their home life, relationships and offending behaviour, and be prepared to engage with and offer advice to development services

Members of the groups have undergone elements of culture change, leaving behind either hazardous or dependent drinking. While the key function of the group is to inform the development of services, several members have themselves progressed to be employed in care or addiction services and some are currently training to be alcohol counsellors.

While not wishing to give the impression that they have an evangelistic purpose, these individuals have a valuable insight into the issues of our drinking culture. Other dangerous drinkers can relate to the advice that service user groups give, and this

can be a significant contributor to generating change.

Counselling and service user groups are only two examples of cogs in the machinery of change. What is required is a planned approach by government, industry, health services and communities that ensures they all work together efficiently and effectively, acknowledging the strengths and weaknesses of differing opinions but all responding to the challenge of binge drinking and alcohol dependency.

A co-ordinated approach over time should result in a reduction of harm and a change in culture. This is a challenge to all, and perhaps especially to the alcohol industry. But if the industry took up the challenge, this would go a long way in reducing some of the current scepticism about its commitment to tackling the problem.

General discussion

The discussion opened with one delegate expressing discomfort with the current focus on binge drinking. It was suggested that binge drinking did not have a specific definition and so was not an especially useful term for understanding the nation's troubles with alcohol abuse. Although it was assumed that binge drinking was a problem for young people, there was a substantial and under-reported problem with 25 to 55 year olds indulging in hazardous levels of drinking on a regular basis.

This led to an examination of the role of the media and its influence over drinking culture. It was argued that there was little point in the BBC running positive media campaigns or documentaries on health improvement when, at the same time, tabloid newspapers encouraged the normalisation of excessive drinking. Elements of the press were criticised for the hypocrisy of condemning 'job culture' and binge drinking while simultaneously promoting extreme drunkenness as a cultural norm. Delegates agreed that it was vital for the media to engage constructively with the challenge of creating a more responsible drinking culture.

The discussion then focused on the alcohol industry. Unit labelling of alcoholic products was praised as a step in the right direction, and delegates considered whether such an approach could be expanded further. One speaker explained that there were a number of difficulties with unit labelling, especially in sectors where most production was designed for export and every county

had different regulations. As an example, it was pointed out that the UK had a unit definition that differed from everywhere else in the European Union (EU). A single EU definition would make unit labelling much easier for industry. Concerns were then raised over whether unit labelling could have a detrimental effect on those with alcohol problems. It was suggested that, unless today's drinking culture was changed, unit labelling could simply make excessive consumption of alcohol easier.

The culpability of retailers who held irresponsible drinks promotions was emphasised. Pubs that encouraged quick drinking, with special offers and designated times when the price of drinks was reduced, were said to be especially reckless for endorsing binge drinking. While millions of people drank sensibly, drinks promotions could contribute to peer pressure that coerced others into excessive consumption of alcohol. One of the speakers said that irresponsible drinks promotions could be reported to the licensing authorities and licensees who run such campaigns should have their licence revoked. There was agreement that licensees who breached the voluntary guidelines of the licence trade should be punished.

The chair closed the session by declaring that a change in society's cultural attitude to alcohol consumption was needed if we were to address the problem of binge drinking successfully, and that the collective nature of the problem meant that a solution would require a greater sense of shared responsibility.

Session 3:

The Undernourished Culture

Speakers:

- Julia Unwin, Deputy Chair, Food Standards Agency
- Dr Mike Rayner, Director, BHF Health Promotion Research Group
- Alison Nelson, Food and Health Policy Officer, British Dietetic Association
- Chair: Jessica Asato, Consultant, Social Market Foundation

Julia Unwin is the Deputy Chair of the Food Standards Agency. She is a member of many boards on the National Consumer Council, the Department for Trade and Industry, and the Audit Committee.

The state of British food and diet is an extremely sensitive area for any regulator to enter because choice of food and diet is intimately bound up in the heart of family life. The Food Standards Agency (FSA) is a regulator that endeavours to remain careful and sensitive while at the same time ensuring that we retain influence and the ability to have an impact. A regulator that does not tread carefully will very soon become a regulator that is ignored.

It is important to put the nation's diet and the regulation of food standards in the context of a rapidly changing eating culture. Twenty years ago the average preparation time for a meal was an hour, but today it is down to just twelve minutes. Pot Noodles were invented in 1979, which is not that long ago, and now you can get a three-course Chinese meal for four people in a box in virtually any supermarket. Schools used to simply offer pupils a single meal option, but now they are given choice

(that nearly always consists of chips). Schools have moved from serving to offering. The default diet of working people is quick and easy. It is a diet that is high in fat, sugar and salt, and low in fresh fruit, vegetables and fibre. These are significant cultural transformations that have to be understood. Obviously the clock cannot be turned back. Despite the appeal of nostalgic sentiments, most social change has had fantastically important and progressive implications for people. However, we need to take into account what social change has done to our food culture.

The FSA wants to start making the healthier choice the easier choice. The default choice should be one that aids and supports our health rather than undermines it. We cannot achieve this through powers of compulsion, for although we can force foods to be removed if they are found to be poisonous, we cannot undertake such action for nutritional reasons. The FSA needs instead to be proactive in influencing the environment, giving consumers the tools to make choices, enhancing education and working to change the products. Our statutory role is to act proportionately to protect the health of the public and the interests of consumers in relation to food and drink. In practice, that means working with the market to influence it in a healthier direction. The FSA does this in a number of ways.

We try to give people basic information about food and diet. Magazines read by women and teenagers are full of simple but essential eating advice that has come from the FSA. Similar advice has been put into the national curriculum, and our website contains a lot of accessible information.

More controversially, the FSA has done a lot of work on making food labelling clearer and simpler so that consumers can make healthier choices. We have already started to see the effects of this with signpost labelling on the front of packets. Only a few years ago the industry was refusing to even consider putting labels on to the front of packaging and, while there remain disagreements between the FSA and the industry, huge progress has been made.

The third method in which the FSA influences the market is by ensuring that food is available to meet the demand for healthier products. Our campaigns raising awareness of salt contents in processed food operate a dual approach to changing

behaviour. We work with consumer groups, NGOs and public health organisations to raise demand for food that is lower in salt. When groups such as the Women's Institutes start demanding food that is lower in salt, the market quickly responds. At the same time, we work with producers to measure the extent to which salt levels in processed food are being decreased. Producers are starting to offer healthier food and this is making a difference to the market. A new compact between government and industry appears to be developing with some success.

And yet the FSA also has to consider where we might need to intervene much more directly to protect vulnerable consumers, and this will involve regulation (although probably not the FSA's). In 2003 we established beyond reasonable doubt that bombarding children with adverts for food high in fat, salt and sugar would impact on their behaviour and their food choices. The research clearly demonstrates that the advertising and marketing environment affects children and that young children do not comprehend the difference between factual information and advertising.

In response, the FSA developed a 'nutrient profiling tool'. Working with scientists, consumers and the food industry, we designed an evidence base for tougher regulation of broadcast advertising to children. The advantage of nutrient profiling is that it does not demonise food but instead makes sure that the foods that are lower in fat, salt and sugar receive more promotion than the unhealthier products. It also incentivises the production of healthier options. We strongly believe that Ofcom needs to use that profiling model to determine at what times particular foods can be advertised. This will not solve the problem, but will indisputably have an enormous impact on the environment in which children make their food choices.

Eating habits cannot be changed overnight. Neither government nor regulators are able to do that – people choose to do that. As a regulator the FSA is helping create an environment in which the healthier choice is the easier choice. We believe we have a duty to do that because currently the health of the public is perilous. But we are under no illusions that it will be an easy task.

Dr Mike Rayner is Director of the British Heart Foundation Health Promotion Research Group. He is currently Vice-Chair of Sustain: the alliance for better food and farming and a trustee of the National Heart Forum in the UK. Mike is also Chair of the Nutrition Expert Group of the European Heart Network.

The question of what influences our consumption of unhealthy foods is not nearly as simple as it sounds. There are literally hundreds of factors that play a role - the appearance, taste and energy content of food, attitudes, beliefs, cooking skills, age, gender, social class, ethnic origin, education, income, etc. It is very hard to make sense of this complex array of factors that affect what we choose to eat.

There are different types of explanation for why people get fat. On a purely physiological level, if energy intake exceeds energy expenditure people get fat. But this is not going to satisfy many people as the reason why there is so much obesity in this country. It is now clear that if people increase their consumption of energy-dense foods, not just all foods, they are going to get fat. In addition, psychologists tell us that if people are confronted by a range of different foods they will eat more and will thus get fat. There is an increasing availability of different energy-dense foods in our supermarkets. And why is that? Because of increasing economic wealth.

None of these explanations are by themselves sufficient to explain why people get fat. Post-modernists such as Baudrillard argue that people are progressively defined by consumption, and that is one explanation for why people get fat. Religious people, such as Christians, say people are by nature self-interested, and so people get fat. Darwinists actually have much in agreement with Christians here. According to Darwinian evolutionary theory, human beings are adapted to living in situations where people do not have enough to eat, and thus now that people have too much we are going to be getting fat because of the way our genes work.

In assessing how people regard threats to their health it is useful to study psychological models of human behaviour, such as the health belief model. This talks about the perceived susceptibility to and perceived seriousness of a problem, the perceived benefits of a specified action and the perceived costs of a

specified action all having an effect on health-related behaviour. In other words, it is one thing for a person to think that obesity is bad for them and that they are prone to it, but to be proactive in avoiding obesity that person has to believe that cutting down their calorie intake is going to have some effect. Outcome expectations will lead to self-efficacy. It is clearly a completely inadequate theory of obesity, but most health education campaigns work on the basis of this sort of rather simplistic model that increasing knowledge leads to behavioural change.

Sociological models show clearly that other factors affect behaviour, such as how much unhealthy food is available. Economic models show that the price of foods affects the types of food we eat, and thereby our energy intake. Income also affects how much healthy and unhealthy food we eat, because the more money we have the more money we are going to have to buy healthy food.

The regulator can intervene to some extent. Taxes and subsidies affect the price of foods, and clearly the regulator could have some control over how much healthy and unhealthy foods people eat by influencing prices. While the Food Standards Agency does not have sufficient powers, the government – if it were serious about this issue – could impose a ‘fat tax’ on unhealthy foods. We have done some recent modelling that shows that if unhealthy foods in the UK were taxed by 17½%, which is already the VAT on some unhealthy foods such as confectionery, around 2300 lives a year could be saved.

There is a problem with the Common Agricultural Policy; it encourages the production of unhealthy foods. If agricultural subsidies were reformed it would be possible to encourage the consumption of healthy foods. Food labelling and commercial advertising are two other big issues. If there were a concerted EU effort, action could be taken to ban advertising, not just to children but also to adults. There is still much to do to improve food labelling. Signposting on the front of packs is a start but more needs to be done. Giving out health messages to adults who already know the content of those messages is important because it reinforces the point. But it is only part of the problem. There is a lot more the government could do beyond merely social marketing and social advertising campaigns.

Alison Nelson is Food and Health Policy Officer at the British Dietetic Association. She has worked as a dietician since 1978, and prior to taking her current post had been working as part of the public health group of the North West Region as Regional Co-ordinator for the '5 A DAY' programme.

Twenty-five years ago skimmed milk was actually a cheaper product than full cream milk, but at the same time wholemeal bread was not widely available. Some of the changes in our diet have been positive while others have been less desirable.

It is important to be aware of what impact any potential regulation will have on individuals. For example, a 'fat tax' might affect one section of society disproportionately: the people who are buying the cheaper foods that contain high fat and high sugar may end up buying higher-cost foods. We need to be very clear about what the benefits of change are.

Some benefits are not anticipated. The '5 A DAY' programme was established to encourage people to consume at least five portions of fruit or vegetables every day, and the obvious benefits were the raising of awareness about nutritional knowledge and the development of cooking skills. However, there was also the unexpected benefit of a greater sense of social cohesion being created in communities by people working together on the programme. Food was used as a way of engaging with hard-to-reach groups – groups that can then be worked with in other policy areas.

Despite the need for careful consideration of the consequences of regulation, it may well be that regulation is the most effective way of achieving a change in behaviour. A range of organisations has spent an enormous amount of time lobbying for a school meal standard that could be monitored in a meaningful way. We have also been arguing that Ofsted must be involved in the inspection of school meals because it is the one respected body that head teachers take notice of.

That structure is now in place, and the new standards are already having an effect on young people, caterers and food manufacturers. In September sugary drinks are to be banned, so there is a whole range of diluted fruit juices coming on to the market. These are new products for young people developed specifically to be put into schools. There will be no more con-

fectionery, so caterers are inventing low sugar, low fat muesli bars. All these products are in preparation for September.

But Jamie Oliver illustrated in his campaigning work that an unhealthy culture cannot be suddenly and successfully changed by attacking one section of it. Improved school meal standards did not work everywhere and the numbers of children eating meals dropped. The staff who are the lowest paid in school, the school caterers, were the ones who lost hours and their income dropped as a consequence of that. Care and sensitivity about legislation is of the utmost importance.

Where standards have been introduced prior to the September date, children have brought in cans of fizzy drinks, bags of crisps and salt sachets. But gradually things will change. We need to be careful that putting standards into meals does not result in children not eating at school. It is essential that school meals do not become ghettoised; only eaten by those from families on very low incomes.

Healthy food has to be moved away from the fear culture that it is currently embedded in. Healthy food is portrayed as preventing heart disease and cancer. This is a negative message. Instead we must look at how people can be persuaded to enjoy a healthier diet, as opposed to tolerate it. We need to create a culture where people value their food and actually want to be eating healthier produce.

General discussion

The discussion opened by considering the best method available for regulators, government and industry to encourage people to choose a healthy diet. It was stated that while the majority of research clearly demonstrated a link between food advertising and children's diets, there was less evidence of the effectiveness of banning the television advertising of unhealthy food. There were not many restrictions around the world that could be studied, although there were partial bans in Sweden, Norway and Quebec.

One of the speakers asserted that if Ofcom were to enforce stricter guidelines on unhealthy food advertisements targeted at children, it would send a very clear message to parents that the regulatory bodies were prepared to help them improve their children's diet. It was mentioned that children's choices and preferences were influenced not by television advertising alone, but by

the promotional environment in which they exist. One speaker claimed that targeting a single influence, such as television advertising, would not in itself be sufficient to have a significant impact. It was, therefore, necessary to tackle dietary problems on a variety of fronts.

The discussion then deliberated over the public focus on fatty foods and obesity. One speaker reminded the session that the challenge of nurturing a healthier eating culture was not simply about reducing obesity levels. For example, the available evidence base clearly demonstrated that consuming too much salt caused heart disease, so the need to reduce salt intake should also be emphasised, especially as there had been an increase in people's involuntary intake of salt over the past twenty years.

One participant asked how the shared agenda of national regulators, national government and national charities could be pushed ahead at a local level. Increased investment in localised services so that they can provide greater training for health professionals was proposed as a necessity. It was argued that a large amount of resources were needed for training health visitors, school nurses and school cooks to set a positive legacy for future years. The government's Sure Start scheme was cited as a good example of a means of providing people with traditional but essential skills. One delegate claimed that many health programmes concerning food and diet were detached from health services and needed to be mainstreamed into the NHS.

The discussion turned to the specific mechanisms available to assess behavioural change. For example, the national diet nutrition survey, which tracks people's eating and shopping habits as recorded by industry, was used to make sure that positive and worthwhile differences were made. Through measurements such as these, the government, regulatory bodies and industry could ensure that their efforts result in moves toward a healthier eating culture.

Session 4: The Sexual Risk Culture

Speakers:

- Anne Weyman, Chief Executive, Family Planning Association
- Anna Martinez, Coordinator, Sex Education Forum
- Professor Kaye Wellings, Public and Environmental Health Research Unit, London School of Hygiene and Tropical Medicine
- Chair: Helen Knox, founder of SEXplained Ltd and BBC sexual health expert

Anne Weyman, OBE, has been Chief Executive of the Family Planning Association (fpa) since 1996. She is Vice Chair of the government's Independent Advisory Group on Sexual Health and HIV, and a member of the Independent Advisory Group on Teenage Pregnancy. She is a non-executive director of Islington Primary Care Trust and a member of the Board of Trustees of the National Family and Parenting Institute.

Cultural change is a huge challenge in terms of the nation's sexual health. We live in a society that is bombarded with highly sexualised imagery, and yet we cannot bring ourselves to talk to young people in an open and frank way about sex and relationships. This is a topic that is very personal to people. Individual values and attitudes play strongly, affecting not only how the individual thinks they should behave themselves, but also what they think everybody else ought to be doing. Such attitudes can often be found in the media. It is an area full of mythologies and mis-information.

The Family Planning Association (fpa) provides a comprehensive information service to confront ignorance over sexual

health. Facts are essential; people need knowledge. If a person does not know, for example, about the fourteen methods of contraception that are available in this country, they are not in a position to be able to decide which one is best for them. fpa trains professionals in facts such as these, but also explores attitudes, values and communication skills with them. Professionals may not be able to have an impact on individuals who come into contact with them if their own attitudes and values stand in the way of a constructive communication. Every single time somebody has contact with a sexual health professional it is an opportunity to change attitudes and to influence behaviour. It must not be wasted.

Teenage pregnancy rates are a good example of the UK's sexual health problems. We still have the highest teenage pregnancy rate in Western Europe, although there has been a significant decline since 1998. We do know quite a bit now about the factors that influence teenage pregnancy rates, including the need to improve sex and relationships education, service provision and work with parents. There are a whole range of interventions that make a difference to what happens with young people's sexual behaviour. The cultural link is a very significant one. High teenage pregnancy rates are associated with societies – like ours – with highly sexualised environments and a widespread unwillingness to talk to children about sex and relationships. It is very interesting to note that the highest rates are all in Anglo-Saxon, English speaking countries – the United States, Canada, Australia, New Zealand as well as the UK.

The issue of unplanned, unwanted pregnancy is a crucial one that is often ignored. On average, one pregnancy in five in the UK ends in abortion. There are areas of the country where it is one in three. Clearly there is a huge unmet need for high quality contraceptive services to enable women to make the choices that they evidently want to make. These women need to be helped and supported in their decisions, but unfortunately we see varying access to services.

If we are going to be effective in influencing the behaviour of young people we need to start before they become sexually active. Once the pattern of behaviour is set it is much harder to change. Sex education, therefore, needs to start in primary schools. It should be compulsory and it should be a broad sub-

ject. It is vital to ensure that young people grow up with the knowledge, the skills, the confidence and the self-esteem to take control of their lives and to have sex in a safe way.

Community-based programmes are also important, since there are many young people who have little contact with school, and there is also a very important role for parents. fpa runs a programme called Speakeasy that works in the community with parents to help them talk to their children about sex and relationships. The programme has been running for a number of years in all sorts of communities. Its aim is to change the culture surrounding sexual health. We need to create a more open society where parents are enabled to have the confidence to talk to their children about sexual matters, and children have easy access to knowledge and to advice. Evidence shows that in those families where sex is talked about openly, children start having sex later and are more likely to use contraception and to protect themselves against infection.

There are parts of the country where there is a culture of early pregnancy, where adults think it is normal and cannot understand that it is a problem. A Speakeasy programme has been running in such an area and has found that such attitudes are beginning to change. Parents are beginning to see that it is not such a good idea for very young girls to become pregnant. Similarly, this technique of working in small groups in the community is extremely successful in interacting with the most hard to reach and the most at risk young people. fpa community projects across the UK can have remarkably positive impacts on young people; there is a great deal of evaluation evidence that shows this.

In our sexual culture, the negative impact of sex is often seen as the responsibility of the individual. Some choose to insist that the mistakes of an individual in sexual matters can be nobody's fault but their own. This leads to sexual health services being looked upon as the soft target for budget cuts. The Choosing Health money is in many areas not getting through to where it should be, and this is having a detrimental impact on service delivery.

The current financial problems with the National Health Service are resulting in contraceptive services being closed down. However, this does not make financial sense. fpa-spon-

sored research carried out by the University of Newcastle showed that it was economically efficient to fund high quality contraceptive services, particularly those that offer long-acting, reversible methods for the prevention of unwanted pregnancy. These conclusions are supported by guidance from the National Institute for Health and Clinical Excellence (NICE), yet, even so, we are still seeing closures of services.

There is a pressing need to normalise the issues around sex and relationships. Sex is a positive part of life and yet we treat it as something that is negative. The debate must move beyond the current stigma of sexual health. Discussion of sexual health must continue to challenge our sexual culture.

Professor Kaye Wellings specialises in sexual health and works at the Public and Environmental Health Research Unit, London School of Hygiene and Tropical Medicine.

Messages to individuals are difficult to enforce in an area as personal and private as sexual behaviour. Such messages are also difficult to take up if you are an individual and the social context is against you. There is a growing realisation that not all the information pouring out of campaigns with regard to ignorance around sexual matters will be successful. The influences on sexual behaviour are individual to some extent, but environmental factors are much more significant. If influences on sexual behaviour were solely individual then there would not be such a big difference between countries in terms of problems such as teenage pregnancy rates. This big difference underlines the fact that the predominant influences on our behaviour are social and environmental. We are not genetically different. Sex itself is, generally, a situational act. Because we engage in sex with someone else it is immediately social.

It is quite clear from the teenage pregnancy statistics that there is a very close relationship between issues relating to deprivation, poverty and life chances and the extent to which we want to prevent adverse outcomes of sexual behaviour, such as teenage pregnancy. Gender and deprivation conspire to undermine the individual's ability to act and to make sensible decisions about safer sex. Greater deprivation means a person is less aware of their power in a relationship, and this affects women

more than men. All-powerful are the social norms surrounding sexual health in this country, which do more to undermine preventive efforts than anything else. The health services in the UK are actually very good, and there are a lot of very energetic and committed people working in sex education, but the real problem is the resistance that those services meet.

The causes of teenage pregnancy and STIs [sexually transmitted infections] are structural as well as individual. Issues relating to gender, deprivation and social norms must be taken into account. Thus it is necessary that the problems in wider society are addressed if the problems of poor sexual health are going to be successfully dealt with.

As previously mentioned, sex is a very personal and private act, and yet there is a need to adjust social factors. Because it takes place in private, and simply requires the presence of the two people involved, there are very few opportunities for fiscal and legal intervention. Sexual behaviour research has shown that legal intervention is extremely limited in its powers. Many activities that are supposedly illegal are carried out with collusion between two people. They have agreed to take part in a particular act, which actually is illegal, but they are certainly not going to report it. Bedrooms and other places where sex takes place are not really places to be policing behaviour.

If there was not already enough evidence of the multifactorial nature of sexual health, there is now very interesting research from the United States showing just this. A significant drop in teenage pregnancy rates has been achieved in the last twenty years by means of a number of different factors. Depending on the ideological position of the writer, a difference emphasis is placed on each of these factors, but it does seem clear that what has contributed to the drop in teenage pregnancy rates has been increased use of more reliable contraception, abstinence-based sex education (not necessarily abstinence only, but at least the kind of campaigns that may encourage young people to question whether they are truly ready to have sex), and also President Clinton's social welfare reform.

Exactly what level of contribution these factors make depends on the political persuasion of the article reporting them. Some claim that the fall in pregnancy rates is due to abstinence-based campaigns, while others argue that it is attributable

to increased use of more reliable contraception. It is a much healthier perspective, however, to see the fall as a result of a mix of all these factors.

The teenage pregnancy strategy in the UK has been very successful. There has been a drop in teenage pregnancy rates and some of the features of the strategy have very audaciously addressed the social context. To do this successfully, the messages must be consistent. The teenage pregnancy strategy was extremely successful in getting stakeholders signed up at every level. Joint action was another implicit part of that strategy. It is accepted that deprivation, poor life chances and poor educational attainment are part of the problem; therefore it cannot just be dealt with by the Department of Health. The Department for Education and Skills has to join up. The teenage pregnancy strategy is the first public health strategy where an explicit component was joint action at every level: between sectors, between statutory bodies and between local and national agencies.

The teenage pregnancy strategy developed a series of messages advising people not to have sex until they were ready, but if they were having sex to use contraception. The strategy has been successful, but there were a large number of bodies who view sex education from a different political perspective to the sexual health services and have been vigorous in trying to counter them. Unfortunately public health agencies are nervous of saying that sex education is working. The media picked up exclusively on the abstinence message and lambasted the health service for telling people to be virgins. More needs to be done to engage with the media to stop such damaging coverage recurring.

Anna Martinez is the co-ordinator of the Sex Education Forum. Anna's past experience includes working for Haringey Primary Care Trust, where she was part of the local Teenage Pregnancy Team and co-ordinated the Sexual Health Education Project, and working for the UNAIDS in Namibia. She has an MSc in health promotion from the London School of Hygiene and Tropical Medicine.

Over the last eighteen years the Sex Education Forum and its 48 diverse members have worked tirelessly to promote children

and young people's rights to good quality, comprehensive sex and relationships education. Education is a vital cornerstone in any cultural shift in sexual and reproductive behaviours and attitudes.

Evidence from overseas supports this conclusion. In countries that have comprehensive sex and relationship education programmes, such as Holland and some Scandinavian states, trends in teenage pregnancy have been reversed and sexual health has been improved. These societies encourage young people to be responsible within sexual relationships, but also to delay sexual relationships until they are ready. Importantly, they provide positive incentives to delay child rearing.

It is also clear what does not work: very extreme abstinence-only education programmes as adopted by some schools in the US. In many cases these programmes undermine young people's confidence in contraception and leave them dangerously vulnerable and ill-equipped for the future.

It is important that the voices of young people are included in these discussions, for too many have stories of inadequate sex education at school. Not all young people are receiving their entitlement to sex and relationships education (SRE). Despite government guidance being issued in 2000 on SRE, Ofsted has confirmed that the provision of this topic, which is supposed to be taught within personal, social and health education (PSHE), is inconsistent. Some schools deliver it, some schools do not. In many schools it is under-resourced and delivered by non-specialist or poorly prepared teachers.

Often the SRE many young people do receive is too little, too late and overly biological. It is not sufficiently preparing young people for the issues that they will face as they grow up. One of the reasons for this is that schools are only required in statute to teach the biological aspects of sex. Learning about the broader issues, such as sexuality, risk, choice, relationships, safer sex and delay, are all recommended in guidance but are not a requirement. In fact the whole of PSHE is non-statutory.

Information alone is not enough. Young people need to be given an opportunity to develop essential life skills. They need to know how to communicate, how to negotiate within rela-

tionships and they also need to be provided with a space and an opportunity to foster positive attitudes towards their health, be it sexual reproductive health or health in general. Schools have a crucially important role in this.

This education is particularly important today because our culture is changing. We have become much more liberal about sexual relationships and many of the social taboos that existed 30 years ago have all but disappeared. Young people have greater access to information and messages about sexual expectations, relationships and gender roles from sources that did not exist before, such as the internet and text messaging. Whether it is a good or a bad thing, the fact is that the world has changed and children are getting mixed messages. They are not receiving a consistent message about their sexual behaviour.

At the same time, professionals and parents have not evolved and adapted the way they talk to their children about sexual issues. A quick chat about the birds and the bees is simply not enough any more. There is a growing consensus among professionals, parents and young people alike that SRE must move beyond biology and teach a much broader subject. But this topic also needs to be prioritised in all schools. We cannot accept a postcode lottery that some schools do a great job and others do not.

Indeed, 83% of parents who were surveyed recently by the Sex Education Forum thought that schools should teach about the emotional aspects of sex and relationships, while 78% thought that this subject should be part of the national curriculum, which currently the broader subject is not. For this reason, the Sex Education Forum along with a whole host of organisations, such as the Independent Advisory Group on Teenage Pregnancy, the Advisory Group on Sexual Health and HIV, and the UK Youth Parliament, asked government to show real commitment and leadership on this topic. We are calling for PSHE, the broader subject that includes sex and relationships education, to be made statutory.

The long-term cost of ignorance both for individuals and for society is great. Unequal access to this education is absolutely unacceptable. It is time we review how the next generation of children will be supported to become healthy, competent adults. Cultural shifts take time. There may not be huge changes in

young people's health outcomes immediately, but perhaps they will grow up to be parents and professionals who are not afraid to talk honestly to their children about sex and sexual matters.

General discussion

The discussion opened with a delegate commenting on the apparent dichotomy between certain aspects of the speakers' explanations for sexual behaviour, with some focusing on human universals while others concentrated on individual differences. A clearer theoretical understanding of the root causes of poor sexual health culture was called for.

It was then stated that in the United States the group with the highest rates of teenage pregnancies were the Hispanic population, with a teenage birth rate of approximately 94.4 per thousand births. It was pointed out that Hispanic-Americans were the second poorest group of people behind Native Americans within the United States. It was suggested that a comparable socio-economic factor was mirrored in the spread of teenage pregnancy rates in the UK population.

One speaker suggested that women from deprived backgrounds wanted to have families earlier because it was important for them to have their family's support around them, particularly grandparental support. There was agreement that a number of factors, including economic difference and life expectancy, were influential in causing teenage pregnancies.

Cultural factors were presented as especially significant due to their influence not only on individual behaviour but also on public policy: cultural factors affected how government dealt with the issues.

Conclusion

The SMF conference ‘Generating Cultural Change in Public Health’ consisted of four seminars focusing on different aspects of public health. But, despite the separate focus of the seminars, a common theme emerged. Whether the speakers and delegates were discussing the problem of obesity and ‘junk food’, teenage pregnancy and sexually transmitted infections, or binge drinking and alcoholism, a similar message was emphasised: a step change in the cultural attitude towards public health is needed, and will only be achieved if interested sectors of society work together in partnership.

Ultimately it is individuals who effect change in the background conditions of society. Increasingly, people want to be accountable and take responsibility for their own health and the health of their families. This does not mean, however, that responsibility lies solely with the individual. The problems affecting public health are collective and, as such, require a collective response. A shared sense of responsibility, as well as an individual sense of responsibility, is required to bring about a new cultural awareness of health issues.

Individuals make their own choices about their health, but they must not be left to make these choices in a vacuum. Information, advice, guidance and support are very important. If we expect people to make sensible choices about their health, they need to be able to make informed choices. Education, whether provided by the state, the voluntary or the private sector, is a vital cornerstone of any cultural shift.

The media also has an important role in educating the public about health issues and encouraging healthy lifestyles. This is certainly the case with the BBC as a public service broadcaster, but the responsibility extends to the general media. The media

plays a central role in shaping our culture so it is crucial that it engages constructively with the challenge of promoting a more responsible attitude towards public health.

The food, drink and alcohol industry must also take some responsibility for the health of their customers. Clear health information about products is needed, as is choice of product, so that demand for healthy options is met. Regulators can work in partnership with industry to ensure that this is achieved, and if necessary intervene more directly to protect vulnerable consumers.

And of course the government has an important part to play in conveying a clear public health message. The government needs to take the lead and co-ordinate partnerships across society. Joint action at every level is essential – between departments, between sectors, between statutory bodies and between local and national bodies. Effective partnerships are the key to the successful generation of cultural change in public health, and to bringing about progress in public health goals.