A consultation to collect views about whether a Public Health Bill is needed in Wales

Consultation Response

Welsh Government

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Health of the People of Wales Bill

"The National Heart Forum (NHF) is a leading UK charitable alliance of 70 organisations working to reduce the risk of coronary heart disease and related conditions such as stroke, diabetes and cancer. NHF is both a UK forum and an international centre for non-communicable disease prevention. Our purpose is to co-ordinate public health policy development and advocacy among members drawn from professional representative bodies, consumer groups, voluntary and public sector organisations. Government departments have observer status. The views expressed here do not necessarily reflect the opinions of individual members of the forum." *National Heat Forum*

"The Royal Society for Public Health is an independent, multidisciplinary organisation, dedicated to the promotion and protection of collective human health and wellbeing. Through advocacy, empowerment, knowledge and practice we advice on public health and health and wellbeing policy, as well as encouraging scientific research and its publication and dissemination. Around 100,000 students pass RSPH qualifications every year. In 2012, the RSPH joined with the Institute of Healthcare Management (IHM), the leading professional body for health and care managers in the UK. At the heart of its organisation, the IHM believes that a commitment to continuous professional development and ethical management by health and care managers will ensure the highest quality of management in the NHS and throughout the healthcare sector and result in the best levels of care for patients." *Royal Society for Public Health & Institute for Healthcare Management*

"The Institute of Welsh Affairs is an independent, membership-based think tank, dedicated to promoting the economic, social, environmental and cultural well-being of Wales. It owes no allegiance to any political or economic interest group. Its only interest is in seeing Wales flourish as a country in which to work and live. It believes that can be done only by the effective mobilisation of all Wales's intellectual resources." *Institute of Welsh Affairs*

I. Introduction

The Welsh Government's proposal for a Public Health Bill in Wales is a crucial first step in diffusing the culture of ill health in Wales - recognising that *health* is much more than *health services.* Better health is the responsibility of all sectors and the Welsh Government has already taken steps to infuse health into various sectors through legislation for children and young people, housing and active travel.

Globally, non-communicable diseases (NCDs) are increasingly responsible for serious health and economic burdens to governments. NCDs stem from the common risk factors of tobacco use, harmful use of alcohol, lack of physical activity and poor diet. Because treatment of these diseases is expensive, prevention is highly cost-effective.

Unchecked, NCDs will create exponentially unsustainable demands on health and social care services and be a major risk to sustainable and economic development, leading to a mal-distribution of health and social inequalities. Inequalities account for 18.9 lost years in life expectancy in Wales between the highest and lowest socio economic classes. Wales is one of the highest ranking NCD burdened countries on global comparative league tables. However with the right legislative powers this could be fundamentally addressed and place it well ahead of other nations who fail to take such action.

There are many effective ways in which public health law can be utilized to influence NCD determinants including litigation against industry, advertising or marketing restrictions, or financial

measures, all of which have proven remarkably effective in reducing risk factors. The *Health of the People of Wales Bill* will need to have a strong preamble and be both comprehensive in its scope and mandate while remaining flexible and accountable.

This response was informed in part by a seminar hosted by NHF, RSPH, IHM and IWA in Cardiff on 4 February 2013 and a commissioned paper on public health law and non-communicable diseases. (Please see Appendix 1)

Key points

- Any legislation the Government proposes should begin with **a clear and simple preamble which sets out the goals and principles of the law.**
- The Government needs to consider all areas and options available under UK and EU law.
- **Mandating Health Impact Assessment used by all policy makers can ensure that HIA is measured and reported in a consistent way**.
- The measures under new legislation would provide the social conditions and impetus for shifts in culture and environment needed **to support health and reduce inequalities**.
- Legislation can renew **focus on prevention and wellbeing.**

II. Bill Preamble

The bill preamble should include the following in a concise and clear statement on the purpose of the legislation:

- Current public health legislation is not capable of dealing with the health challenges of the 21st century.

- The state has the ultimate legal and moral responsibility for the welfare and future prospects of new generations. Health is a public good and defined by the UN as a human right.

- The state has the responsibility to protect the population from these new health threats, promote good health and wellbeing and prevent disease.

- The state needs to legally define its role and powers to secure and protect the health of the people of Wales.

- The Bill should ensure that the Welsh Assembly and its executive is obliged to consider the impact on the health of the population in developing and appraising social, economic, fiscal and environmental policy (or policy in all Government areas). Health concerns need to be owned across Government and its executive.

III. The most important and appropriate areas for further considerations by the Welsh government (Consultation questions 1&2)

Proposed structure for Bill:

1. Develop a process to develop and agree "strategic legislation" for Health of the People of Wales Bill.

2. Draft a preamble to the bill - a declaratory statement - which sets outs the principles, aims and intent of the legislation including (Please see section I above):

- define the special responsibility and duties of government to protect the nation and the citizen (the protective state);
- improve and promote and assure the conditions for the health of the people in participation and in collaboration with affected communities but recognising the need to balance at times; and
- the collective good achieved by public health regulations with resulting infringements of individual rights and freedom.

3. Establish in draft legislation the general duties on Welsh Ministers to assure the health of the people of Wales by:

- setting out standards;
- legal rationalisation based on general human rights to public health;
- protection from hazards and the right to information about hazards;
- ensuring comprehensive public health structures;
- duties, accountabilities, and the leadership role of Ministers to set out clear standards on law enforcement; and
- making the Government responsible for all aspects of public health fully transparent and in line with UK and EU public health laws such as IHR.

4. Draft and consult on specific aspects of public health, such as making HIA mandatory, making the bill an effective platform to reduce health inequalities and how the new bill can promote preventive action to secure overall health and well being in Wales.

5. Use the public health bill to achieve consolidation of legislation for public health as well as links with other legislation such as the Wales Active Travel bill.

In short, we recommend a Scotland Public Health Bill *plus* for Wales which adds to its health protection measures the new challenges of NCDs.

Additional areas for further consideration:
- Monitoring and evaluation of the legislation following implementation in the form of a *post-legislative assessment* should be mandated.

- To the extent possible, potential unintended consequences of any legislation should be considered. Duties set on agencies and organisations should be realistic and achievable as to not create undue burden.

IV. Make Health Impact Assessment (HIA) a mandatory requirement as an effective way of ensuring that the impact of policies on health is assessed in a consistent and effective way in Wales (Consultation questions 5&6)

- By requiring mandatory use by all policy makers the Welsh Government can ensure that HIA is measured and reported in a consistent way.

- All public bodies and private companies would be required to conduct a HIA when making applications or permissions or funding.

HIAs are widely used internationally and nationally by public (and private) sectors. WHO notes that the benefits of HIAs include the promotion of cross-sectoral cooperation, a participatory approach

which values community views, provision of the best available evidence to decision-makers, improvement of health and reduction of inequalities, the possibility to strengthen the features of a proposal which will positively impact population health, flexibility and links with sustainable development and resource management.[1]

Public transparency in the process and reporting of HIAs is crucial. The evidence collected should be publically available and utilised in the decision making process following the completion of any HIA. Appropriately managed, HIA findings can be a tool to mitigate competing inter-agency demands.

V. A new Bill could provide an effective platform for reducing health inequalities in Wales (Consultation question 7)

The measures under new legislation – if set-up appropriately – would provide the social conditions and impetus for shifts in culture and environment needed to support health. A focus on structural changes and prevention will shift the burden of both financial and human capacity away from the NHS and healthcare delivery and on to the wider society.

Many public health laws in a number of countries list reducing inequalities as a key principle – particularly in Scandinavian legislation. *The Finish Health Act 2010* objective is to reduce health inequalities between different population groups as does *New Zealand Public Health and Disability Act 2010* which inter alia aims to reduce or eliminate health outcome disparities between various population groups. In the *UK Health and Social Care Act 2012* there are requirements to consider reduction in inequalities when commissioning health services including public health services.

VI. A new Bill could be an effective way of promoting the importance of preventative action to overall health and wellbeing in Wales (Consultation question 8)

Legislation can renew focus on prevention work though measures including flexible approaches to the risk factors, the creation of bodies charged with disease prevention or through specific activities relating to the financing of prevention. Legislation in *British Columbia Public Health Act 2008* and *South Australia Public Health Act 2011* grant their health ministries the ability to respond flexibly to NCD concerns as they arise. Refocusing national health care institutions to consider NCDs or earmark funds for prevention as in the *US 2010 Patient Protection and Affordable Care Act*.

VII. Answers to remaining specific consultation questions

Question 3 - If we were to explore placing a statutory duty on bodies to consider health when developing new policies, which bodies should such a duty apply to?

All public bodies including joint ventures with private sector companies when the venture affects the life or the people of Wales.

Question 4 - Do you think it would be reasonable to limit any legislative requirements to 'major' policies, which would need to be defined by a new Bill?

No

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[1] WHO Health Impact Assessments: Why Use HIA's? at http://www.who.int/hia/about/why/en/index1.html

Question 9 - How do you think an increased focus on empowering local people to influence their health and wellbeing would best be achieved through legislation?

This question relates closely to the mandatory requirements for HIA as through effective process communities will ideally play a critical role in identifying the health consequences of a given proposal. A participatory approach, enshrined in legislation that values the views of the community, treating them as relevant stakeholders would reinforce the empowerment of local people to influence their health and wellbeing. The *Swedish Public Health Act* based on extensive research put as the first principle involvement in and influence in society- building social capital. The UK Cabinet Office recognised in its publication *Excellence and Fairness: Making Government Work Better* that the Swedish health system is one of the best in world performing highly on OECD criteria through high levels of citizens empowerment, significant amount of devolution to local government organised according to the needs of local citizens, government enabling change though incentives and support without micro-management and transparent thus enabling the citizen to hold the government to account.

Question 10 - Do you think it is preferable for us to progress our efforts to improve the health of people in Wales in a way other than introducing a new Bill? If so, why?

No

Business as usual is not an option as obesity and other chronic conditions will be costly in terms of public health, loss of productivity and without prevention and control of risk factors our health system in Wales will be overwhelmed to breaking point.

Law matters and is an important instrument of social change. However a new bill is required because as the Law Commission put in their *Ninth Programme of Law Reform* (March 2005) the law is in need of modernisation and that existing laws are largely based on 19th Century social conditions and 19th Century understanding of science behind the spread of disease.

If there is to be Welsh legislation it needs to be wisely drafted and accompanied by strong leadership and effective management at all levels and all governments – local, national and UK. Above all political determination will still be required not least around the cabinet table to bring about change as all ministers have an interest in health.

Question 11 - If you think we should do something different to introducing a new Bill, what do you think would be a more effective approach?

N/A

Question 12 - Please let us have any further comments you wish to make about the issues raised in this Green Paper.

N/A

Public Health Law and Non-Communicable Diseases

UNPUBLISHED – WORKING PAPER

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Executive Summary:

Non-communicable diseases (NCDs) are increasingly responsible for serious health and economic burdens to governments around the world. NCDs in all countries stem from risk factors including tobacco use, harmful use of alcohol, lack of physical activity, and the overconsumption of salt, sugar and saturated fat. Because treatment of these diseases is expensive, prevention is highly cost-effective. One way for governments to respond to the NCD epidemic is through the use of public health law in order to reduce exposure of its populations to these risk factors.

There are many effective ways in which public health law can be utilized to influence these risk factors; these may include litigation against industry, advertising or marketing restrictions, or taxation or pricing restrictions, all of which have proven remarkably effective in reducing risk factors. However, it may be politically difficult or unfeasible, especially for local governments, to pursue these types of legislation exclusively. This paper instead concentrates on four types of potential legislation highlighted in the recent Welsh consultation on public health law. These include (1) Expanding the use of Health Impact Assessments; (2) Imposing a statutory duty on a range of bodies to reduce health inequalities; (3) Bringing about a renewed focus on prevention work and (4) Strengthening community action around health protection and health improvement.

The paper examines a number of pieces of legislation from different jurisdictions in each of these four areas, in order to provide precedents and, where available, feedback about success or challenges of each given approach. Throughout these approaches, the themes of multi-sectoral approaches and equity appear repeatedly. Faced with the growing burden of NCDs, governments are finding effective and in some cases novel ways to use public health law to address relevant risk factors over the last decade. The four focuses of legislation listed above may be particularly appealing for local governments to effect changes in NCD rates due to their being relatively less politically controversial than other possibilities, their mult-sectoral approaches and their attention to health inequities.

Introduction:

Non-communicable diseases (NCDs) pose a serious health and financial burden to local and national governments. NCDs can be defined as diseases which are not infectious; these diseases may result from genetic or lifestyle factors and include cardiovascular disease, stroke, type 2 diabetes, cancer, overweight and obesity, respiratory disease and hypertensive disease, as well as mental health. These are linked by common risk factors, underlying determinants and opportunities for intervention – high blood pressure, tobacco use, harmful use of alcohol, high blood cholesterol, overweight, unhealthy diets and physical inactivity - hugely increased by lifestyle and demographic changes.

Legislation is one key tool to address these determinants. While traditionally public health law has addressed issues of communicable diseases, the changing global burden of disease means that in recent decades it has been used to address non-communicable disease as well.

There is a broad spectrum of ways in which public health law can address the determinants of non-communicable diseases; however, this paper will address four specific options in light of the overarching themes of multisectoral engagement and the reduction of health inequalities. The first such option will be legislation requiring Health Impact Assessments, tools which help decision-makers identify the public-health consequences of proposals that potentially affect health. Other potential legislation involves the imposition of a statutory duty on selected bodies to address and reduce health inequalities. The third discussion is the use of legislation to bring about a renewed focus on prevention work, both within and outside of the health sectors. Finally, the use of the legislation to strengthen community action promoting health protection and improvement will be reviewed.

Non-communicable diseases and public health law

The burden of disease

Chronic non-communicable diseases (NCDs) include heart disease, stroke, hypertension, diabetes, kidney disease, cancers, respiratory and liver diseases and mental health conditions such as vascular dementia. These diseases, often treatable but not always curable, are responsible for sizable economic burdens on governments. Within Europe, most NCDs can be linked to tobacco, alcohol, poor diet and lack of physical activity.

Over the past few decades, global health has witnessed a shift in the burden of disease from communicable to non-communicable diseases; worldwide, the contribution of different risk factors to disease burden has changed substantially, with a shift away from risks for communicable diseases in children towards those for non-communicable diseases in adults.[2] In 2008, nearly two-thirds of all deaths – 36 million - resulted from NCDs, comprising mainly cardiovascular diseases, cancers, diabetes and chronic lung diseases.[3] NCDs disproportionately impact young and middle-aged adults, and on a global scale are quickly becoming dominant causes of death and disability.[4] Within the WHO European Region, non-communicable diseases account for 86% of deaths and 77% of the disease burden.[5] In the UK, NCDs are the leading cause of death– in 2008, there were 518,400 deaths from NCDs, of which 23.75% were among the under-70s.[6]

The economic burden of NCDs is sizable. A 2011 projection of costs carried out by the World Health Organization and the World Economic Forum suggest that the cost of NCDs to the global economy will amount to $47 trillion over the next two decades, approximately

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[2] Lim S et al, A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet, Volume 380, Issue 9859, Pages 2224 - 2260, 15 December 2012 doi:10.1016/S0140-6736(12)61766-8

[3] World Health Organization, Global Status Report on Non-communicable Diseases 2010 (2011), p. 106: http://www.who.int/nmh/publications/ncd_report_full_en.pdf

[4] Vos T et al. Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010 *The Lancet* - 15 December 2012 (Vol. 380, Issue 9859, Pages 2163-2196) DOI: 10.1016/S0140-6736(12)61729-2

[5] WHO EURO. Action Plan for implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases 2012−2016, http://www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf.

[6] World Health Organization, Global Status Report on Non-communicable Diseases 2010 (2011), p. 106: http://www.who.int/nmh/publications/ncd_report_full_en.pdf, accessed 15 January 2013.

75% of the 2010 global GDP.[7] British Heart Foundation statistics show that the cost of diabetes and related complications to the NHS in England and Wales amounts to an estimated £9 billion a year; over half of these cases could have been prevented.[8] According to the World Health Organization: "Investing in prevention and better control of this broad group of disorders will reduce premature death and preventable morbidity and disability, improve the quality of life and well-being of people and societies, and help reduce the growing health inequalities they cause".[9]

Though too rich and complex to explore comprehensively in this paper, there has been a sizable international response to the problem of NCDs. One of the most notable was the September 2011 UN High-level Meeting on Non-communicable Diseases which generated substantial global attention for the problem of NCDs. Similarly, in a May 2012 World Health Assembly Resolution, governments pledged to adopt a global target of a 25% reduction in premature mortality from NCDs by 2025.[10] NCDs are related to sustainable development issues including nutrition and energy, and there have also been calls to integrate NCDs carefully into the Sustainable Development Goals as well as the post-2015 Millennium Development Goals.[11]

Clearly, governments have much to gain - and certain targets to meet - through the implementation of effective prevention techniques.

NCD risk factors and interventions

As stated above, the proximate causes of NCDs across all countries include tobacco use, harmful use of alcohol, lack of physical activity, and the overconsumption of salt, sugar and saturated fat. While many interventions may be cost-effective, WHO has classified some as 'best buys' – meaning "actions that should be undertaken immediately to produce accelerated results in terms of lives saved, diseases prevented and heavy costs avoided."[12]

The World Health Organization's 'Best Buys' for NCD interventions:

- Protecting people from tobacco smoke and banning smoking in public places;
- Warning about the dangers of tobacco use;

[7] World Economic Forum/Harvard School of Public Health, The Global Economic Burden of Non-communicable Diseases (2011): http://www.weforum.org/reports/global-economic-burden-non-communicable-diseases, accessed 15 January 2013.
[8] C3 Health. Non-communicable diseases in the UK: A briefing paper prepared for the UK Parliament (House of Lords) September 2011 at http://www.c3health.org/wp-content/uploads/2009/09/NCDs-briefing-paper-20111010.pdf, accessed 15 January 2013.
[9] WHO EURO. Action Plan for implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases 2012−2016, at http://www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf, accessed 15 January 2013.
[10] World Health Assembly Resolution A65/54 (25 May 2012)
[11] NCD Alliance Submission: Lessons learned from the adoption of the International Development Targets and the Millennium Development Goals, in particular how effective has the MDG process been to date?, at http://www.publications.parliament.uk/pa/cm201213/cmselect/cmintdev/writev/post2015/m67.htm, accessed 15 January 2013.
[12] World Health Organisation, Global status report on non-communicable diseases 2010; Geneva: WHO, 2011

• Enforcing bans on tobacco advertising, promotion and sponsorship;

• Raising taxes on tobacco;

• Restricting access to retailed alcohol;

• Enforcing bans on alcohol advertising;

• Raising taxes on alcohol;

• Reduce salt intake and salt content of food;

• Replacing trans-fat in food with polyunsaturated fat;

• Promoting public awareness about diet and physical activity, including through mass media.

There is substantial evidence of the success of preventive interventions. Frequently cited is the case of Finland's North Karelia province, where a policy focused upon healthy diet, exercise and reduction of smoking was implemented in the early 1970's. Between 1972 and 2006, North Karelia witnessed an 85% decrease in annual mortality rate from chronic heart disease.[13] More recently, in New York City a five-year-old Health Department regulation banning trans-fats has reduced the consumption among fast-food customers from about 3 grams to 0.5 grams – showing also that local health regulations can significantly influence public consumption.[14]

It should be noted that corporate interests have markets to protect and legislation restricting advertising, marketing or use of alcohol, tobacco and unhealthy foods may face numerous legal and political obstacles. Certain interventions require a cross-border approach; these may include advertising restrictions, labeling requirements, taxation and minimum unit pricing measures. A key example is the WHO's Framework Convention on Tobacco Control, developed in response to the globalization of the tobacco epidemic and the cross-border effects of many factors, which has made substantial progress in reducing tobacco consumption.[15] One advantage of the four approaches outlined in this paper - and their appeal to national and local governments - is that the general and multi-risk factor NCD prevention strategies may be less likely to incur this kind of industry opposition.

[13] World Bank, The Growing Danger of Non-Communicable Diseases: Acting Now to Reverse Course ; Washington, DC: World Bank, 2011 (p 11) http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/WBDeepeningCrisis.pdf, accessed 13 January 2013.

[14] Angell SY et al. Change in Trans Fatty Acid Content of Fast-Food Purchases Associated With New York City's Restaurant RegulationA Pre–Post Study. Annals of Internal Medicine. 2012 Jul;157(2):81-86.

[15] http://www.who.int/fctc/about/en/index.html, , accessed 13 January 2013.

The importance of public health law in improving population health

A central question in public health law and policy is the degree of intervention which is appropriate to improve population health. In response to this, in 2007 the Nuffield Council on Bioethics presented a vision of the stewardship role of the State[16]. Under this model, it is understood governments have a "duty to look after important needs of people individually and collectively". Goals of public health programmes in this perspective should encompass reduction of risk, environmental protections, protections for vulnerable populations, health promotion, enabling population to make healthy choices, access to medical services and a reduction of health inequalities.[17]

Public health law can be defined as "the study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty or other legally protected interests of individuals for protection or promotion of community health".[18]

Law can be used to advance public health in a number of different ways. A 2011 report from the WHO Regional Office for Europe sets out four major roles: defining the objectives of public health and influencing its policy agenda; authorizing and limiting public health action with respect to protection of individual rights, as appropriate; serving as a tool for prevention; and facilitating the planning and coordination of governmental and nongovernmental health activities.[19]

While in most European countries public health legislation is contained in separate acts and regulations because of the scope of the issues and stakeholders; another approach to develop a law specifically addressing public health. In practice, most jurisdictions use a combination of the above approaches, with a specific public health law as well as provisions integrated into other legislation. The table below, adapted from a WHO EURO document on public health law, reflects some of the benefits and disadvantages of each approach:[20]

[16] Public health: ethical issues. London: Nuffield Council on Bioethics, 2007.
[17] Id, Chapter 2, paragraphs 2.34–2.40.
[18] Snezhanna Chichevalieva, Developing a Framework for Public Health Law in Europe. WHO EURO, Copenhagen (2011), citing Gostin LO, Hodge JG. Oregon public health law − review and recommendations. Washington DC, Georgetown University Law Center, 2000 (http://www.publichealthlaw.net/Resources/ResourcesPDFs/Oregon.pdf, accessed 10 January 2011)
[19] Snezhanna Chichevalieva, Developing a Framework for Public Health Law in Europe. WHO EURO, Copenhagen (2011), at http://www.euro.who.int/__data/assets/pdf_file/0004/151375/e95783.pdf, accessed 13 January 2013.
[20] Snezhanna Chichevalieva, Developing a Framework for Public Health Law in Europe. WHO EURO, Copenhagen (2011), at http://www.euro.who.int/__data/assets/pdf_file/0004/151375/e95783.pdf, accessed 13 January 2013.

Table 1: Advantages and disadvantages of public health law structure

	Advantages	**Disadvantages**
In separate acts and regulations	A wider constituency may be benefited when public health provisions are inserted into legislation outside the health sector	Difficulty of ensuring coverage of all legislative aspects relevant to public health
Law specifically addressing public health	Ease of enactment and adoption, without the need for multiple amendments to existing legislation Good opportunity to raise public awareness about public health issues and educate policy-makers	Need to amend all impacted legislation

The legal system and public health situation will determine which of these options are most appropriate for a given government. Examples of each relevant to NCDs can be found within Europe:

Separate acts and regulations: In 2009, a Portuguese law established standards to reduce the salt content in bread and set a maximum limit of salt content in bread and encouraging information on salt content on the labelling of pre-packaged foods[21]. Denmark has brought in atax on trans-fatty acids; Hungary a "junk food tax" and France a tax on all sweetened drinks.[22]

Specifically addressing public health: The Netherlands Public Health Act (2008) created a single instrument bringing together the previously separate Public Health (Preventive Measures) Act, the Infectious Diseases Act and the Quarantine Act, as well as provisions for the obligatory storage of digital data in the context of health care for young people.[23]

The purpose of public health law may vary considerably from country to country. Table 2 compares the stated purposes of a number of recent acts; these vary in specificity as well as in the extent to which they focus on communicable versus non-communicable diseases.

[21] Martins L, Nazare J, Pinto F, et al. Portuguese action against salt and hypertension (PAASH). From research to a national policy and regulatory law on food salt content. European Meeting on Hypertension 2009; June 12-16, 2009; Milan, Italy. Abstract LB3.7

[22] National Heart Forum. What is the role of health-related food duties? A report of a National Heart Forum meeting held on 29 June 2012.

[23] Act of 9 October 2008, regulating public health care matters (Public Health Act), at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127977.pdf, , accessed 13 January 2013.

Table 2: Purposes of public health laws

British Columbia Public Health Act 2008 [24]	Replaces the outdated legislation, supports improved health and wellness of British Columbians and assists to address current public health issues including new challenges in infectious disease control like SARS or pandemic influenza, environmental toxin exposures, prevention of chronic disease, injuries, and poisonings and bioterrorism threats
France Public Health Act 2004	To improve the health of the population by establishing a more effective administrative system in public health and by reinforcing the implementation of national and regional programmes
New South Wales Public Health Act 2010 [25]	Protect and promote public health • Control the risk to public health • Promote the control of infectious diseases • Prevent the spread of infectious diseases • Recognise the role of local governments in protecting public health
Norway Public Health Act 2011[26]	To contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders or injuries.
Queensland Public Health Act 2005[27]	To protect and promote the health of the Queensland public
Scotland's Public Health Act 2008[28]	To restate and amend the law on public health; to make provision about mortuaries and the disposal of bodies; to enable the Scottish Ministers to implement their obligations under the International Health Regulations; to make provision relating to the use, sale or hire of sunbeds; to amend the law on statutory nuisances; and for connected purposes.[29]
South Australian Public	To provide a modernised, flexible legislative framework, so South Australia can better respond to new public health

[24] Notice letter at http://www.health.gov.bc.ca/phact/pdf/Public%20Health%20Act%20Notice%20Letter.pdf, accessed 13 January 2013.
[25] http://www.legislation.nsw.gov.au/sessionalview/sessional/act/2010-127.pdf, accessed 13 January 2013.
[26] Chapter 1, section 1 at http://www.regjeringen.no/upload/HOD/Hoeringer%20FHA_FOS/123.pdf, accessed 13 January 2013.
[27] http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf, accessed 13 January 2013.
[28] http://www.scotland.gov.uk/Resource/0039/00398162.pdf, accessed 13 January 2013.
[29] http://www.legislation.gov.uk/asp/2008/5/introduction, accessed 13 January 2013.

Health Act 2011	challenges as well as traditional hazards.

Public health law instruments within Europe are on the rise. A recent literature review found over 400 legally binding instruments in the area of public health at global and European levels, reflecting the expanding and complex nature of such a system in recent years.[30] At the national level, there is increasing interest in legislation which can improve public health and avoid the fiscal and economic burdens associated with costly treatment of NCDs and loss of productivity.

How public health law is used to address NCDs and their risk factors

As explained above, the risk factors for NCDs fall primarily into four categories: tobacco, alcohol, poor diet and lack of physical activity. Though public health law can be an effective mechanism for NCD prevention, two potential political obstacles include: (1) strong public and political resistance to laws intended to influence choices and lifestyles, with a perception of NCD risk factors being a matter of personal choice, and (2) that effective interventions are difficult politically because it means challenging the rights of profitable businesses to manufacture and sell harmful products.[31] One Canadian article points out that despite the public health crisis around NCDs, jurisdictional disputes, legal challenges, ideological opposition and doubts about effectiveness can all serve to forestall legislation in this area.[32]

There are a number of ways in which law can influence behavioural risk factors for chronic disease. Categories for influence include health infrastructure and governance; shaping the informational environment; creating economic incentives and subsidies; designing/altering the physical environment; addressing health inequalities through economic policies; and command and control regulation, i.e. directly regulating persons, professionals, businesses and other organisations. [33] Improved infrastructure might be accomplished through the establishment of structures or institutions which support whole-of government approaches to NCD risk factors.

Fiscal strategies might include increasing excise taxes on tobacco and alcoholic beverages to reduce demand and grants to encourage other levels of government to fund worthwhile interventions. An improved "informational environment" could include restrictions on advertising of harmful products, inclusion of health warnings or nutritional labelling. An improved "built environment" could mean smoke-free places, zones with restrictions on sales of tobacco, alcohol or certain foods, improved school foods, or environments facilitating physical activity.[34]

[30] http://repositorio.insa.pt/bitstream/10400.18/1037/1/PH-tools-and-Instruments-rev-ENG.pdf, accessed 13 January 2013.
[31] Presentation of R Magnusson at http://www.idlo.int/DOCCalendar/GHLPresentations/6-1.pdf, accessed 13 January 2013.
[32] Ries NM and von Tigerstrom B. Roadblocks to laws for healthy eating and activity. CMAJ : Canadian Medical Association Journal. 2010 Apr 20; 182(7)687-692.
[33] Magnusson, Roger and Colagiuri, Ruth, The Law and Chronic Disease Prevention: Possibilities and Politics (April 2008). Medical Journal of Australia, Vol. 188, No. 2, pp. 104-105, 2008; Sydney Law School Research Paper No. 08/34. Available at SSRN: http://ssrn.com/abstract=112120 (table adapted from Perdue WC, Mensah GA, Goodman RA, Moulton AD. A Legal Framework for Preventing Cardiovascular Diseases. American Journal of Preventive Medicine 2005, 29(5S1):139-145. And Gostin LO. Law and Ethics in Population Health. Australian and New Zealand Journal of Public Health 2004, 28:7-12)
[34] http://www.idlo.int/DOCCalendar/GHLPresentations/6-1.pdf, accessed 13 January 2013.

In recent years in Europe, public health laws have often been introduced in response to specific disease threats, or to strengthen national public health institutes. However, as NCDs become an increasing burden on economies through treatment costs and loss of productivity, more and more governments are exploring how public health law can best manage NCD risk factors. Current laws relating to chronic disease have proved to be an effective and central component of comprehensive prevention and control strategies.

> *Although governments are increasingly using law in innovative ways to support chronic disease prevention, law's role remains controversial. The food, tobacco and alcohol industries have lucrative markets to protect and there is a pervasive assumption that the solution to galloping rates of obesity, diabetes and other lifestyle diseases lies in individuals exercising greater self-control. But preaching self-control will not work if healthy choices are constantly undermined by other, more powerful influences. While law is not a complete answer, it can help to create supportive environments for changing the average behaviour of populations*.[35]

The four sections which follow outline how the approaches identified in this discussion have been and can be used as tools in public health law. These four were selected as they are the focus of a current Welsh consultation on public health law and are: 1) Expanding the use of mandatory Health Impact Assessments; (2) Imposing a statutory duty on a range of bodies to reduce health inequalities; (3) Bringing about a renewed focus on prevention work and (4) Strengthening community action around health protection and health improvement.[36]

I. The Health Impact Assessment Approach

There has been increasing recognition that addressing public health issues effectively is a multi-sectoral undertaking – i.e. that public health agencies and the health care delivery system need support to adequately address the social, economic and cultural environments which impact health. This approach has been endorsed by many national governments, as well as the WHO and the EU.

In keeping with the emphasis on a multi-sectoral approach, Health Impact Assessments provide a means to assess all policy development in terms of its health impact – for example, transport, housing or education policy may all potentially protect or damage people's health. WHO defines HIA as "a combination of procedures, methods and tools by which a policy, programme, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population." The National Research Council (US) defines HIA as "a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population." The Health in All Policies (HiAP) approach likewise recognizes and addresses the fact that many of the

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[35] Magnusson, Roger and Colagiuri, Ruth, The Law and Chronic Disease Prevention: Possibilities and Politics (April 2008). Medical Journal of Australia, Vol. 188, No. 2, pp. 104-105, 2008; Sydney Law School Research Paper No. 08/34. Available at
SSRN: http://ssrn.com/abstract=112120, accessed 13 January 2013.
[36] http://wales.gov.uk/consultations/healthsocialcare/publichealth/?l, accessed 13 January 2013.ang=en

determinants of health lie outside of the health sector, encouraging governments to take a more inclusive approach through inter-sectoral and 'whole of government' policy and governance.[37]

HIAs are widely used internationally and nationally by public (and private) sectors. WHO notes that the benefits of HIAs include the promotion of cross-sectoral cooperation, a participatory approach which values community views, provision of the best available evidence to decision-makers, improvement of health and reduction of inequalities, the possibility to strengthen the features of a proposal which will positively impact population health, flexibility and links with sustainable development and resource management.[38] HIAs may also be effective in promoting accountability for decisionmakers whose policies may have negative impacts on health; this aspect may explain why HIAs are also increasingly used by international organizations such as the World Bank and the International Monetary Fund, as a condition for loans and by international industry, especially mining.

In terms of NCDs, there are clear links between policy decisions in sectors such as agriculture, energy, housing and transportation and the risk factors for disease. These include, for example, agricultural policies which promote healthy food production; energy and housing policies which relieve fuel poverty and reduce the risk of respiratory and heart diseases; and transport policies which facilitate physical activity, helping to combat rates of obesity and diabetes. Some of these links are set out in the table below:

Table 3: PAHO Issue Brief on Non-Communicable Diseases in the Americas: All Sectors of Society Can Help to Solve the Problem[39]

Sector	Relation to NCDs
Health and Social Protection Systems	NCD-related illness and disability can destabilize these systems; however, measures such as promoting access to preventive health services, screening and early detection, and healthy aging can reduce costs of treatments and disability.
Food and Agriculture	Because of the role of unhealthy diets as a key NCD risk factor, food/agiculture industry measures around production, trade, manufacturing, retail, labeling, pricing, and taxation options can all impact dietary choices, especially through the reduction of salt, sugar, and saturated fat in prepared foods.
Urban Transport/Design	With growing populations in urban areas, public transit, cycling and pedestrian routes, green spaces and similar transport/design initiatives can impact physical activity, a key risk factor for NCDs.
Education	Healthier lifestyle choices among children can be promoted through the creation of healthy environments, education of

[37] http://www.globalhealtheurope.org/index.php?option=com_content&view=article&id=469:health-in-all-policies&catid=35:institutions&Itemid=55, accessed 13 January 2013.
[38] WHO Health Impact Assessments: Why Use HIA's? at http://www.who.int/hia/about/why/en/index1.html
[39] http://new.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=16221&Itemid, accessed 8 February 2013.

	children about healthy living, provision of safe spaces for physical activity, and access to nutritious foods.
Employers	Workplace health promotion programmes may include wellness checks, healthy food and exercise options, and smoke-free workplaces; this can result in increased employee productivity, improved corporate image, and reduced healthcare costs.
Telecom and Media	These sectors can highlight features on healthy living; furthermore, telehealth and mobile phones can further health promotion, treatment reminders, and connecting individuals with NCD-related information and resources.

The legal basis for a statutory duty to promote HIAs

One means of ensuring that the public health impacts of decisions taken in other sectors are considered is to impose a statutory duty upon organizations and authorities to promote or to require HIAs.

At the European level, Article 152 of the Amsterdam Treaty states that "A high level of health protection shall be ensured in connection with the formulation and implementation of all Community policies and all Community measures"; Health 21 lists as one of its key strategies that "multisectoral strategies tackle the determinants of health, taking into account physical, economic, social, cultural and gender perspectives and ensuring the use of health impact assessment".[40] The adoption by the EU of a White Paper on HiAP (Health in All Policies) requires the European Commission and the Member States to ensure that health concerns are better integrated into all policies at Community, Member State and regional level, including in environment, research and regional policies, regulation of pharmaceuticals and foodstuffs, and governance of tobacco taxation and foreign policy.[41]

Another precedent can be found within UK legislation, where HIAs form part of the mandatory 'Impact Assessment' required by Government for all relevant policies for developing better, evidenced-based policy by careful consideration of the impact on the health of the population.[42] Impact Assessments are obligatory for all UK Government interventions of a regulatory nature that affect the private sector, civil society organisations and public services, and to primary and secondary legislation, as well as codes of practice or guidance.[43]

[40] http://www.who.int/hia/about/why/en/index2.html, accessed 13 January 2013.

[41] Commission White Paper of 23 October 2007 'Together for Health: A Strategic Approach for the EU 2008-2013' [COM(2007) 630 final - Not published in the Official Journal]. , accessed 13 January 2013.

[42] Department of Health, Health Impact Assessments at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Healthassessment/index.htm. , accessed 13 January 2013.

[43] HMGovernment, Impact Assessment Guidance at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/31607/11-1111-impact-assessment-guidance.pdf, accessed 13 January 2013.

Section 54 of Québec's 2001 Public Health Act (implemented in 2002) requires government ministries and agencies proposing laws or regulations to first undertake an HIA. This obligation aims to ensure that legislation does not negatively impact population health, and, concomitantly, to allow Minister of Health and Social Services the capacity to share health-related concerns with other government ministries or agencies as necessary. A 2012 assessment found, while initially there had been resistance to the measure from the affected ministries and agencies, there has been a consistent trend towards acceptance of the HIA process, with 519 requests for consultations between 2002 and 2012.[44]

At the federal level in the United States, legislation proposed in January 2013 contains measures on Health in All Policies, which would require the Department of Health and Human Services to carry out HIAs of major non-health legislative proposals and to detail staff to other departments to assist them with consideration of health impacts of their activities.[45]

While HIAs are increasingly popular within the United States, they are rarely legislatively mandated at State or local level. A 2012 US study commissioned by the Health Impact Project looked at 36 selected jurisdictions where existing laws offered opportunities for health to be factored into a range of decision making in which it typically would not otherwise be considered; sectors included were environment and energy, transportation, agriculture, and waste disposal and recycling.[46] Only 22 of the 36 jurisdictions surveyed had laws requiring or facilitating HIAs. Authors highlighted two criteria of these laws: either they "refer to a broad range or description of health impacts, such as effects on public health, safety, general welfare, environmental health, health disparities, social or economic well-being, or effects that are borne disproportionately by vulnerable populations…[or] call for studies or assessments that are used to inform public policy, programs, projects, regulations, or decision making".[47] Other, less "strong" laws may simply allocate funding for or authorize evaluations of health impacts without making the link to policy decisions; one example cited was an Oregon statute authorizing the state's health authority to survey and investigate how the production, processing, or distribution of agriculture products may affect the public's health.[48]

In summary, Health Impact Assessments are increasingly being required in a number of jurisdictions. In the case of Quebec, an examination over ten years has shown that while government departments were reluctant to work intersectorally at first, eventually the HIAs were accepted and collaboration from the health sector sought out. One issue for discussion is the extent to which HIAs are used: should they apply only to government

[44] Briefing note: Implementation of Section 54 of Québec's Public Health Act (preliminary version) athttp://www.ncchpp.ca/docs/Section54English042008.pdf, accessed 13 January 2013.
[45] http://www.help.senate.gov/newsroom/press/release/?id=982287e5-5f32-49f4-b5fd-717870d4ba1c&groups=Chair, accessed 13 January 2013.
[46] Legal Review Concerning the Use of Health Impact Assessments in Non-Health Sectors, at http://www.healthimpactproject.org/resources/body/Legal_Review_of_HIA_report.pdf, accessed 13 January 2013.
[47] Legal Review Concerning the Use of Health Impact Assessments in Non-Health Sectors, at http://www.healthimpactproject.org/resources/body/Legal_Review_of_HIA_report.pdf., at 25, accessed 13 January 2013.
[48] Legal Review Concerning the Use of Health Impact Assessments in Non-Health Sectors, at http://www.healthimpactproject.org/resources/body/Legal_Review_of_HIA_report.pdf., at 26.

undertakings (and which ones), or more broadly to private sector projects which also contribute to the risk factors to which a given community is exposed?

II. Statutory duty on a range of bodies to reduce health inequalities

> *The lower people are on the socioeconomic gradient, the more likely they are to live in areas where the built environment is of poorer quality, less conducive to positive health behaviours and outcomes, and where exposure to environmental factors that are detrimental to health is more likely to occur…People who live in areas of high deprivation are more likely to be affected by tobacco smoke, biological and chemical contamination, hazardous waste sites, air pollution, flooding, sanitation and water scarcity, noise pollution, and road traffic. These people are less likely to live in decent housing, in environments that are sociable and congenial, to feel safe from crime and disorder, and have access to green spaces, adequate transport options, and opportunities for healthy living*.[49]

There is a clear link between social inequalities and ill health, both because disadvantaged groups have poorer access to services, but also fewer resources in education, employment, housing, transport, and reduced participation in civic society to make healthy choices. NCDs have a strong link to health inequalities, since opportunities to make healthy lifestyle choices may be affected by social determinants including socioeconomic status, gender, ethnicity or education. Health inequalities are costly: UK estimates suggest that inequalities in illness account for productivity losses of £31-£33 billion per year and lost taxes and higher welfare payments in the range of £20-£32 billion per year.[50]

Reducing health inequalities is not a straightforward undertaking, and policies should be clear about what is meant by promoting equity in health. One expert classifies policy responses into three groups: those aimed at improving health of poor groups (e.g. by promoting smoking cessation or healthy eating among disadvantaged groups); those which work to narrow the gap between the health of disadvantaged groups and health in the population as a whole; and those which attempt to improve the health gradient with the greatest improvement for the poorest groups, and the rate of gain progressively decreasing for higher socio-economic groups (e.g. a smoking cessation intervention which is available to the whole population but which is actively promoted via additional services for less advantaged groups, with the most intensive support for the most disadvantaged groups).[51]

A focus on health inequalities may serve to better inform public health choices about the types of interventions used. For example, tobacco use and diet are major risk factors for cardiovascular disease (CVD), and a high-risk approach to CVD prevention usually involves

[49] Prof Sir Michael Marmot FRCP,Jessica Allen PhD,Ruth Bell PhD,Ellen Bloomer MSc,Peter Goldblatt PhD,on behalf of the Consortium for the European Review of Social Determinants of Health and the Health Divide
The Lancet - 15 September 2012 (Vol. 380, Issue 9846, Pages 1011-1029)
DOI: 10.1016/S0140-6736(12)61228-8

[50] The Marmot Review, Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England post 2010, February 2010. http://www.ucl.ac.uk/gheg/marmotreview , accessed 13 January 2013.

[51] Economic and Social Research Council Seminar Series: Mapping the Public Policy Landscape. Developing the evidence base for tackling health inequalities and differential effects (2006), at http://www.who.int/social_determinants/resources/esrc_document.pdf, accessed 20 January 2013.

population screening with those individuals above a risk threshold given lifestyle advice and/or tablets to reduce blood cholesterol and blood pressure. However it has been found that this approach exacerbates socioeconomic inequalities, which have been reported in screening, healthy diet advice, smoking cessation, statin and anti-hypertensive prescribing and adherence, and that a population-wide approach which legislates for smoke-free public spaces or reducing salt intake could be more effective and reduce health inequalities. [52] A 2012 American study suggested that after adjustments for demographics, health care access, and physiological distress, the level of education attained and financial wealth remain strong predictors of mortality risk among adults with diabetes.[53]

Table 4: Guiding Principles Relating to Equity in Selected Public Health Legislation

Legislation	Principle
Bulgarian Health Act (2004)[54]	"The protection of the citizens' health as a condition of full physical, mental and social wellbeing is a national priority and it shall be guaranteed by the government through the application of the following principles: …equality in the use of health services…"
Finland's Health Care Act (2010)[55]	"The objective of this Act is to…(2) reduce health inequalities between different population groups;" (Section 2)
Greece's Law on Public Health (2005)	"Action to support vulnerable groups and to reduce socioeconomic inequalities in health is an essential part of public health" (Article 2)
Norway's Public Health Act (2012) [56]	The purpose is to "contribute to societal development that promotes public health and reduces social inequalities in health".
South Australia Public Health Act (2011)[57]	"Decisions and actions should not, as far as is reasonably practicable, unduly or unfairly disadvantage individuals or communities and, as relevant, consideration should be given to health disparities between population groups and to strategies that can minimise or alleviate such disparities." (Pt 2, 13)

[52] Capewell S, Graham H. Will cardiovascular disease prevention widen health inequalities? *PLoS Med* 2010;7(8):e1000320.
[53] Saydah SH, Imperatore G, Beckles GL. Socioeconomic Status and Mortality: The Contribution of Health Care Access and Psychological Distress Among United States Adults With Diagnosed Diabetes. Diabetes Care published ahead of print August 28, 2012,doi:10.2337/dc11-1864, accessed 20 January 2013.
[54] Bulgarian Health Act (2004, implemented 2005) Part I , at http://solicitorbulgaria.com/index.php/bulgarian-health-act-part-1, accessed 20 January 2013.
[55] No. 1326/2010 Health Care Act , Issued in Helsinki on 30 December 2010 at http://www.stm.fi/c/document_library/get_file?folderId=5064551&name=DLFE-17718.pdf, accessed 20 January 2013.
[56] http://www.regjeringen.no/upload/HOD/Hoeringer%20FHA_FOS/1234.pdf, accessed 20 January 2013.
[57] South Australian Public Health Act 2011 :An Act to promote and to provide for the protection of the health of the public of South Australia and to reduce the incidence of preventable illness, injury and disability; to make related amendments to certain Acts; to repeal the Public and Environmental Health Act 1987; and for other purposes, at http://www.legislation.sa.gov.au/LZ/C/A/SOUTH%20AUSTRALIAN%20PUBLIC%20HEALTH%20ACT%202011/CURRENT/2011.21.UN.PDF, accessed 20 January 2013.

Swedish Health and Medical Services Act (1982)	Lists as the overall objective of health and medical care: *"Good health and care for the whole population on equal terms".*

In Finland, the 2011 Health Care Act was designed in response to equity challenges in healthcare services, and contains provisions which give a number of new rights to patients. For example, they can access health services outside of their municipality; have the freedom to choose his or her own health setting and specialised healthcare unit (from 2014).[58] Patients enjoy similar benefits under the Swedish 2011 Patient Care Act which provides the right to choose care providers, the right to health care within a certain time and a free choice of health centre.[59]

Under the New Zealand Public Health and Disability Amendment Bill 2010 (which amends the New Zealand Public Health and Disability Act 2000), objectives of the District Health Boards are to inter alia reduce health disparities by improving health outcomes for Maori and other population groups; reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.

One approach suggested in the Welsh consultation on public health law is the imposition of a statutory duty on selected organisations to reduce health inequalities. For example, health boards could be required to address why take-up rates of health services may be lower in deprived groups. Section 1C of the UK Health and Social Care Act 2012 addresses the “Duty as to reducing inequalities” and provides that “In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service”.[60] The Act imposes explicit duties on the Secretary of State, NHS Commissioning Board and clinical commissioning groups to have regard to the need to reduce inequalities in the benefits which can be obtained from health services. The duty applies to both NHS and public functions, and incorporates access to and benefits from health care services.[61]

In summary, many public health laws explicitly consider the issue of inequities. This could be either as a general principle to be applied in interpretation of the entire act, as well as specific duties such as the Finnish act which gives new choices to patients; the New Zealand act which sets out responsibilities to District Health Boards, or the UK act which requires bodies to consider the reduction of inequalities when commissioning health services.

[58] Health Care Act- bridging the gap at http://www.publicservice.co.uk/feature_story.asp?id=17547, accessed 20 January 2013.
[59] Government Offices of Sweden: Health and Medical Care in Sweden at http://www.government.se/sb/d/15660/a/183490, accessed 20 January 2013.
[60] http://www.legislation.gov.uk/ukpga/2012/7/section/4/enacted, accessed 20 January 2013.
[61] http://www.dh.gov.uk/health/files/2012/06/C2.-Factsheet-Tackling-inequalities-in-healthcare-270412.pdf, accessed 20 January 2013.

III. How to renew the focus on prevention through legislation

Legislation may support prevention through reduction of risk factors, through the creation of bodies charged with disease prevention, or through specific activities relating to the financing of prevention.

Flexible legislation to reduce risk factors

While the category of "legislation to reduce risk factors" could be construed quite broadly, this paper will focus specifically on public health laws which provide flexibility to address current and future NCD threats. This type of flexibility is another approach to dealing with particular threats as they arise – which we might see in, for example, Scotland's 2008 Public Health Law containing a provision prohibiting operators from allowing minors to sunbeds. [62] Two relatively novel approaches can be found in the British Columbia Public Health Act and the South Australia Public Health Act.

The British Columbia Public Health Act (2008) not only allows the minister to require development of public health plans for health promotion and protection to address issues such as, *inter alia,* chronic disease prevention or inclusion of mental health and substance services in communities, but also enables the development of health impediment regulations, which address matters that adversely affect public health from long-term, cumulative exposures that: cause significant chronic disease or disability; interfere with the goals of public health initiatives; or are associated with poor health in the population (e.g. foods high in trans fats).

In Part 8 of South Australia's 2011 Public Health Act (Prevention of non-communicable conditions), the Minister is vested with the power to declare a particular non-communicable condition to be of significance to public health, which then allows the Minister to develop a code of practice in relation to preventing or reducing the incidence of the non-communicable condition. Such a code of practice can relate to an industry or sector; a section or part of the community; or an activity, undertaking or circumstance. It may relate to goods, substances and services; advertising and marketing; manufacturing, distribution, supply and sale; building and infrastructure design; or access to certain goods, substances or services. While not mandatory, performance reports can be published and breaches of a code of practice may result in the issuance of enforceable compliance notices. Additionally, there is a specific regulation-making power for taking measures to manage any non-communicable condition.[63]

These two laws grant Ministers of Health the powers to creatively and flexibly regulate those products and activities that impact the public health – a potentially valuable tool for reducing the risk factors for NCDs. This kind of flexibility can make it easier to respond to public health threats as they emerge and as evidence becomes available, without needing to resort to lengthy legislative processes.

[62] http://www.scotland.gov.uk/Resource/0039/00398162.pdf, accessed 20 January 2013.

Creating bodies and expanding mandates to tackle NCDs

Finland has merged the National Public Health Institute (KTL) and the National Research and Development Centre for Welfare and Health (Stakes) into one large and comprehensive entity, the National Institute for Health and Welfare (THL), which "provides the government with broad background research and expertise to serve public health and welfare and to support health and social services with expert advice, development, and monitoring and to help protect and promote the welfare of Finnish people by active communication and interaction in Finnish society." This supports a multi-sectoral approach to health and has led to increases in alcohol and tobacco tax, a new soft drink and sweets tax, strengthening of tobacco control legislation and discussions with Ministries of Agriculture, Education and Communications.[64]

In Article 6 of Greece's Law on Public Health (June 2005), the Centre for the Control of Special Communicable Diseases was renamed the Centre for the Control and Prevention of Disease (kE.El.P.NO) and its mission broadened to include NCDs, accidents, environmental health, a Central Public Health laboratory and the evaluation of health services. (p103)

In Iceland, amendments made in 2011 to the Chief Medical Officer and Public Health Act incorporated the Public Health Institute of Iceland into the Directorate of Health, and expanded the mandate of the Directorate of Health to include public health measures and health promotion[65]. Functions include advising the Minister of Welfare and other Government bodies, health professionals and the public on matters concerning health, disease prevention and health promotion; sponsoring and organizing public health initiatives. [66]

Similarly, the Australian Public Health Act establishes a South Australian Public Health Council (SAPHC). This is the successor body to the Public and Environmental Health Council established under the previous Act. The principal difference between these two bodies is that the SAPHC has an expanded membership that reflects the broader scope of contemporary public health. The Act also provides terms of reference for the SAPHC that define a high-level strategic advisory role.[67]

Increasing budgets for prevention

Investments in prevention, protecting and improving the population's overall physical and mental health will have positive consequences in terms of healthcare spending and productivity. 2007 OECD data suggests that spending on prevention currently amounts to an average of 3% of OECD Member States' total annual budgets for health, as opposed to 97% spent on healthcare and treatment.[68] Since prevention is a cost-effective measure,

[64] Puska P, Ståhl T. Health in all policies-the Finnish initiative: background, principles, and current issues. Annu Rev Public Health. 2010 ;31:315-28 3 p following 328. doi: 10.1146/annurev.publhealth.012809.103658, accessed 20 January 2013.
[65] Medical Director of Health and Public Health Act, No. 41/2007 at http://eng.velferdarraduneyti.is/acts-of-Parliament/nr/20099, accessed 20 January 2013.
[66] http://www.landlaeknir.is/english/, accessed 20 January 2013.
[67] Fact Sheet: South Australian Public Health Council, at http://www.sahealth.sa.gov.au/wps/wcm/connect/6cc766004d5c3c6ab8c2bdd08366040b/SAPCHFactSheet-phcs-20121107.pdf?MOD=AJPERES&CACHEID=6cc766004d5c3c6ab8c2bdd08366040b, accessed 20 January 2013.
[68] OECD Health Data 2006, Statistics and Indicators for 30 Countries. CDROM, Paris 2006.

government intervention to shift resources towards prevention will result in long-term benefits.

The US Affordable Care Act establishes a Prevention and Public Health Investment Fund (Section 4002). The Investment Fund "aims to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs, with a dedicated fund for prevention and wellness". The Secretary of the Department of Health and Human Services has the authority to transfer amounts from the Fund to increase funding for any program authorized by the Public Health Service Act for "prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs." The fund will invest $12.5 billion in prevention activities over the next decade (2013-2022). The fund also supports the Community Transformation Grants which support local initiatives for chronic disease prevention.[69]

This category may also include channelling specified funds into prevention. In Switzerland, the 2009 law on prevention and health promotion *(la loi fédérale sur la prévention et la promotion de la santé)* includes provisions requiring that certain proceeds from the LAMal (health insurance) are used for prevention, health promotion and early detection of diseases. Similarly, tax collected from tobacco producers and importers (destined under a 1969 law for health promotion measures) must be used specifically for tobacco control. (Article 12)[70]

Overall, use of legislation to bring about a renewed focus on prevention work can encompass a variety of measures. In looking at the flexible approaches to the reduction of risk factors, the creation of bodies charged with disease prevention, or through specific activities relating to the financing of prevention, there are a number of recent developments which may be of interest to governments. These include the British Columbia and South Australian Public Health Acts, which allow Ministries of Health to respond flexibly to NCD threats as they arise; the trend towards replacing or expanding the scope of communicable disease institutes to manage NCDs as well; and the recognition by the US government of the importance of funds earmarked for prevention through the Prevention and Public Health Investment Fund under the 2010 Affordable Care Act.

V. Strengthening community action around health protection and health improvement

The fourth and final topic involves giving local communities an opportunity to be more involved in local decision-making on improving public health. Support for this approach can be found in documents such as the Action Plan for Implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases, which endorses

[69] The Prevention and Public Health Fund:Backgrounder and Fact Sheet at http://healthyamericans.org/health-issues/wp-content/uploads/2012/11/PPHF-Background-Fact-Sheet1.pdf, accessed 28 January 2013
[70] http://www.bag.admin.ch/themen/gesundheitspolitik/07492/index.html?lang=fr (see Article 12) , accessed 20 January 2013.

empowerment and the “Whole-of-society” as key principles.[71] “Empowerment” means that all public health and health care activities should support community action, promote health literacy, and respect the patient, while the “Whole-of-society” approach is understood as encouraging cooperation and collaboration between public health and health care and between State and non-State actors, and engaging civil society, businesses and individuals in public health and health care decisions.[72] Strategies like this are intended to facilitate patients to manage disease, adopt healthy behaviours and use health services effectively.

The following discussion will focus on three interpretations of this type of legislative action; (1) Health Impact Assessments as a support for community action; (2) mandates or programmes to share information about NCDs with communities; and (3) an increasing empowerment of local government.

HIAs and community action

Clearly, this is closely linked to the discussion on health impact assessments under section 1, as throughout the HIA process communities will ideally play a critical role in identifying the health consequences of a given proposal. A participatory approach that values the views of the community, treating them as relevant stakeholders, will reinforce this perspective. Furthermore, the HIA process can demonstrate that organizers of a given project are eager to listen to, involve and respond to community members.[73]

Sharing information with communities

The concept is also based upon the principle that communities have the right to receive appropriate information on reducing the risk of NCDs, empowering them to make appropriate lifestyle choices. Legislative precedents – and innovative policy and incentives – can be found in the United States, the United Kingdom and in Finland:

- Title IV of the United States Affordable Care Act (2010)[74] addresses prevention of chronic disease. This contains a section addressing the creation of healthier communities through grants for community initiatives that will support more walkable communities, healthier schools and increased access to nutritious foods in safe environments. One component of this strategy is the use of community transformation grants, which may be used for programs to promote individual and community health and prevent the incidence of chronic disease.

- The UK Health and Social Care Act (2012) endorses the principle of “No decision about me, without me”. The phrase describes a vision of healthcare where the patient is an

[71] WHO EURO. Action Plan for Implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases 2012-2016, at http://www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf, accessed 20 January 2013.
[72] Id.
[73] http://www.who.int/hia/about/why/en/index1.html, accessed 20 January 2013.
[74] The Patient Protection and Affordable Care Act. Public Law 111-114 at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm. , accessed 20 January 2013.

active participant in treatment decisions. To this end, legislative changes include strengthening the voice of patients; imposing additional duties on Commissioning Groups, Monitor and Health and Wellbeing Boards to involve patients, carers and the public; and establishing Healthwatch England, a national body representing the views of service users, the public and Local Healthwatch organisations.[75]

- The Finland Health Care Act (2010), section 11 provides: "When planning and making decisions, local authorities and joint municipal authorities for hospital districts shall assess and take into consideration any effects that their decisions may have on the health and social welfare of residents."

- Principle 11 of the South Australia Act (2012) states: "Individuals and communities should be encouraged to take responsibility for their own health and, to that end, to participate in decisions about how to protect and promote their own health and the health of their communities."[76]

Increasing the role of local government

A broader interpretation of this objective would be to involve local government more in making public health decisions and policy. For example,

- Finland's new Health Care Act aims to give key responsibility for public health promotion to the municipalities in order to improve prevention and to reduce the demand for services which accompanies later stages of NCDs. The Act requires each municipality to monitor the health and welfare of their residents and to compile relevant statistics during terms of office.[77]

- In Sweden, 20 county councils have the responsibility for organisation of health care. They are likewise responsible for health and social care for the elderly. New changes under the 2011 Patient Care Act aim to better protect and involve patients in decisions.[78]

- Similarly, the UK Health and Social Care Act (2012) grants new responsibilities to local authorities for improving health of local populations. Components of the legislation require the engagement of a director of public health, a ring-fenced budget and annual progress-charting reports. The rationale for this move is the notion that "wider determinants of health (for example, housing, economic development, transport) can be

[75] Department of Health Factsheet: Greater voice for patients – The Health and Social Care Act 2012, at http://www.dh.gov.uk/health/files/2012/06/B3.-Factsheet-Greater-voice-for-patients-300512.pdf, accessed 20 January 2013.
[76] South Australian Public Health Act 2011—1.1.2013, at http://www.legislation.sa.gov.au/LZ/C/A/SOUTH%20AUSTRALIAN%20PUBLIC%20HEALTH%20ACT%202011/CURRENT/2011.21.UN.PDF, accessed 20 January 2013.
[77] //www.publicservice.co.uk/feature_story.asp?id=17547, accessed 20 January 2013.
[78] Government Offices of Sweden: Health and Medical Care in Sweden at http://www.government.se/sb/d/15660/a/183490

more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations."[79]

In summary, legislation is frequently used to strengthen community action promoting health protection and improvement. This can give local communities an opportunity to be more involved in local decision-making to improve public health. Some legislative examples come from programmes which endorse a multisectoral and community-oriented approach through inclusive processes such as HIAs sharing information with communities, (e.g. through the UK Healthwatch or the US Community Transformation Grants programmes); others strengthen the role of local governments in health promotion and disease prevention (e.g. in Finland and the UK).

VI. Conclusions

There are a number of tools available to national and local governments in order to address non-communicable diseases. Public health legislation, where appropriate, can be an extremely powerful mechanism in this regard. This paper has explored four legislative options: the implementation or expansion of Health Impact Assessments; the imposition of a statutory duty on selected bodies to address and reduce health inequalities; the use of legislation to bring about a renewed focus on prevention work; and the use of the legislation to strengthen community action promoting health protection and improvement. Precedents in each of these areas, and particularly novel precedents in terms of granting flexibility to health authorities to address NCDs, will help governments to craft their own policy options.

The first discussion showed the increasing use of Health Impact Assessments, and cited a Quebec study suggesting that mandatory HIAs will lead to better intersectoral collaboration.

The second considered the issue of inequities and a statutory duty on bodies to address and reduce health inequalities; many public health laws list reducing inequities as a key principle (particularly in Scandinavian legislation). Furthermore, there are specific duties such as in the Finnish act which gives new choices to patients; the New Zealand act which sets out responsibilities to District Health Boards, or the UK act which requires bodies to consider the reduction of inequalities when commissioning health services.

Legislation can renew focus on prevention work through measures including flexible approaches to the reduction of risk factors, the creation of bodies charged with disease prevention, or through specific activities relating to the financing of prevention. Of particular interest is British Columbian and South Australian legislation granting health ministries the ability to respond flexibly to NCD concerns as they arise; refocusing national health institutions to consider NCDs or earmarking funds for prevention, as in the US 2010 Affordable Care Act.

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[79] UK Department of Health Factsheet: New focus for public health – The Health and Social Care Act 2012, at http://www.dh.gov.uk/health/files/2012/06/B4.-Factsheet-New-focus-for-public-health-250412.pdf , accessed 20 January 2013.

Fourthly, public health law can strengthen community action promoting health protection and improvement. This can be through programmes which endorse a multisectoral and community-oriented approach such as HIAs, community-based information-sharing programmes such as UK Healthwatch or the US Community Transformation Grants programmes, or a stronger role of local governments in health promotion and disease prevention as in Finland and the UK.

Throughout the discussion of the four highlighted legislative options we have repeatedly seen the key concepts of multilateral approaches and of reducing inequalities. This paper has tried to set out a few of the many precedents for ways in which public health law can be used to reduce risk factors for NCDs.