



**UK Health Forum, Royal Society for Public Health and Institute for Healthcare
Management submission to Welsh White Paper**
Listening to you: Your health matters

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About the UK Health Forum

The UK Health Forum (UKHF), a registered charity, is both a UK forum and an international centre for the prevention of non-communicable diseases (NCDs) including coronary heart disease, stroke, cancer, diabetes, chronic kidney disease and dementia through a focus on up-stream measures targeted at the four shared modifiable risk factors of poor nutrition, physical inactivity, tobacco use and alcohol misuse. UKHF undertakes policy research and advocacy to support action by government, the public sector and commercial operators. As an alliance, UKHF is uniquely placed to develop and promote consensus-based healthy public policy and to coordinate public health advocacy. UKHF works to encourage integrated policy approaches that link prevention of NCDs with sustainable development, climate stabilisation, human rights and the reduction of health inequalities.

About Royal Society for Public Health

The Royal Society for Public Health (RSPH) is an independent health education charity, dedicated to protecting and promoting the public's health and wellbeing. Our vision is that everyone has the opportunity to optimise their health and wellbeing. We are the world's longest-established public health body with over 6000 members drawn from the public health community both in the UK and internationally. Our operations include an Ofqual recognised awarding body, a training and development arm, health and wellbeing accreditation, and a certification service. We also produce a wide-variety of public health conferences; our publishing division includes the internationally renowned journal *Public Health*; and we are developing policy and campaigns to promote better health and wellbeing.

About Institute for Healthcare Management

The Institute for Healthcare Management (IHM) is the leading, independent, membership organisation for health and social care managers, supporting personal development and driving change to improve health and wellbeing for all. With over 3000 members spanning the health and care sector, IHM works to promote and support good practice in health and social care management, developing and supporting partnerships and networks concerned with leadership and management and speaking out on issues of importance to healthcare managers.

We welcome the opportunity to respond to the White Paper and look forward to responding to the Futures Generations Bill in due course.

Health of the People of Wales – Summary of Interest

The UKHF has been involved with and interested in the future of public health in Wales for some time and in February 2013 hosted an all-day seminar in Cardiff with the Royal Society for Public Health, Institute of Healthcare Management and the Institute for Welsh Affairs to discuss the Green Paper *A consultation to collect views about whether a Public Health Bill is needed in Wales* and the value of public health law. In addition to numerous responses to the Green Paper, this meeting served as the impetus for a commissioned paper on public health law and NCDs, which UKHF published in partnership with RSPH and IHM in summer 2013 (please see Appendix 1).

We welcome the recognition by the Welsh Government that ‘among the levers available legislation can be one of the most powerful’¹, and that it is now, following consultation on the Green Paper which indicated strong support for legislation as a way of driving further improvements in people’s health across Wales, developing proposals for a Public Health Bill and ensuring health is key element in the forthcoming Future Generations Bill.

The Welsh Government’s proposal for a Public Health Bill in Wales was a crucial first step in addressing the ill-health challenges and inequalities 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 take action on health across various sectors through legislation for children and young people, housing and active travel.

Globally, NCDs are increasingly responsible for serious health and economic burdens to governments. 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 approximately 18.9 lost years in life expectancy in Wales between the highest and lowest socio economic classes.² Wales is one of the highest ranking NCD burdened countries on global comparative league tables. However, with the right legislative powers this could be addressed and place it well ahead of other nations who fail to take such action.

There are many effective ways in which policy and 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.³ The key points which we encourage the Government to consider with regards to public health in Wales are:

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

¹ Pg 2. Welsh Government. *Listening to you: Your health matters*. White Paper. April 2014.

² Lozano R, Naghavi M, Foreman K et al. 2012. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. *The Lancet*.380: 2095–128.

³ Galbraith-Emami, S. Public Health Law and Non-communicable Diseases. UK Health Forum. July 2013.

- Legislation can renew focus on prevention and wellbeing.
- The ability to efficiently introduce necessary health protection – inclusive of environmental, communicable and non-communicable hazards – in secondary legislation or reserved powers.

A Preamble

Any preamble should include the following within a concise and clear statement of the principles, aims and intent of the legislation:

- Current public health legislation for Wales 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 new health threats, promote good health and wellbeing and prevent disease.
- The state needs to legally define its duties and responsibilities to secure and protect the health of the people of Wales.
- The state must recognise the need to balance at times, the collective good achieved by public health regulations with resulting infringements of individual or commercial rights and freedom.
- 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.

Note: This section is taken from UKHF, RSPH and IHM's joint response to the Green Paper: A consultation to collect views about whether a Public Health Bill is needed in Wales (2013).

Summary of comments

- We support and are strongly encouraged by Wales' emphasis on Health in All Policies and the forthcoming Future Generations Bill.
- We support the proposal to create a tobacco retailers' register.
- We acknowledge electronic cigarettes as a new and evolving public health issue.
- Current voluntary smoking bans for hospital grounds, school grounds and children's playgrounds are not sufficient. Legislation should be considered.
- We strongly support the introduction of a minimum unit price for alcohol at the suggested level of 50p/unit.

- To tackle obesity, Wales requires policies that set public-health based food standards and address the relative affordability of food, and the development of local environments that support everyday physical activity.
- We strongly encourage Wales to pursue the introduction of standardised tobacco packaging.

Response

Tobacco

Wales should strive to implement and support policies that remove tobacco products from the market and move the country closer to achieving an end game for tobacco. Marketing and promotion of tobacco products will have to meet updated health warning requirements and other measures coming into effect under the EU Tobacco Products Directive.⁴

With regards to electronic cigarettes, in particular a proposed ban on their use in enclosed public places, we acknowledge that this is a new and quickly evolving area for governments and public health. We recognise there are a range of views within our membership and partners and have not yet had the opportunity to agree a position with our members on this specific issue. For this reason, we have not commented on the consultation questions regarding the proposed enclosed public places ban (including work places) for e-cigarette use.

Even before any proposed legislative changes, we encourage Wales to promote and support comprehensive monitoring of e-cigarette use (inclusive of all issues related to these products i.e. as a cessation tool; potential gateway to tobacco products; potential health risks; etc.). **If Wales goes forward with banning e-cigarette use in enclosed public places we strongly encourage Wales to ensure this measure is closely and comprehensively monitored and evaluated as it will serve as important evidence for this evolving topic.**

As a partnership, we do support the position that e-cigarettes should be regulated as medicinal products and made subject to robust and comprehensive marketing restrictions that provide the highest level of protection to children and young people, avoid any confusion with smoked tobacco products or tobacco brands and always be presented clearly as an alternative to tobacco. Wales will need to move swiftly on this issue when the EU Tobacco Products Directive comes into effect.

The current voluntary smoking bans for hospital grounds, school grounds and children's playgrounds are not sufficient. Legislation should be considered to mandate these bans.

Questions

Q1. Do you agree with the proposal to create a tobacco retailers' register for Wales under the terms outlined?

Yes. Introducing a registration scheme will enable Trading Standards Officers to more easily identify tobacco retailers for test purchasing purposes and to check compliance with the point of sale display

⁴ European Commission: http://ec.europa.eu/health/tobacco/products/index_en.htm

regulations. We believe that this is both a workable and proportionate measure and is an important means to help reduce the number of young people in Wales who become smokers.

Q2. Do you consider that the creation of such a register will (i) assist in attempts to reduce under age sales of tobacco products, and (ii) assist in the enforcement of the display ban?

Yes. According to Action on Smoking and Health (ASH), Trading Standards Officers have already advised that the existence of a register will make it easier for them to identify whether a retailer sells tobacco once the display ban on tobacco products comes into force for small shops in 2015. Data from England shows nearly half (44%) of young smokers reported they were able to acquire tobacco from retail premises despite the ban on the sale of tobacco products to under 18s.⁵ It is likely that children in Wales are also getting tobacco from shops. We welcome and encourage any measure that helps to reduce the likelihood of underage tobacco sales.

Q3. Do you consider the proposed fee structure to be reasonable?

Yes. We do not believe the fee will impose an excessive cost to small retailers. The requirement for annual registration will ensure that records are kept up-to-date for purposes of monitoring and enforcement.

Q4. Do you consider the proposed enforcement and penalty arrangements for the tobacco retailers register to be appropriate?

Yes. We note that the detail of penalties associated with failure to register to sell tobacco will be subject to additional legislation. Any new penalties introduced should be: easy to enforce; provide clear guidance for enforcement officers and magistrates, and should be a sufficient to deter breaches of the new requirements.

Q5. Are there any other features of a tobacco retailers' register that we should consider?

No.

Q9. Do you consider legislation would assist in the enforcement of the existing Smoke-Free requirements and reinforce the message that smoking is no longer the norm? Please provide evidence to support your answer, if available.

Yes.

Alcohol

Wales needs comprehensive national policies which reflect the collective recommendations made in *Health First: an evidence based alcohol strategy for the UK*.⁶ Public health and public safety need be given priority in public policy making above the influence of the alcohol industry.

We strongly support the introduction of a minimum unit price (MUP) for alcohol. The suggested level of 50p/unit for all alcohol sold in Wales would be in alignment with Scotland's adoption of the

⁵ Health and Social Care Information Centre. Smoking, drinking and drug use among young people in England in 2012. 2013.

⁶ *Health First: an evidence-based alcohol strategy for the UK*. University of Stirling. March 2013.

policy. Canada has implemented MUP and has already seen an 8% reduction in consumption and a 9% reduction in hospital admissions attributable to alcohol.⁷

We would also encourage Wales to introduce – where able – strict controls on alcohol advertising, promotion and sponsorship (including sports sponsorship) – specifically marketing targeted at or likely to appeal to and impact on children and young people.

A comprehensive review of licensing legislation and powers in Wales with the aim of empowering local licensing authorities to tackle alcohol-related health harm by controlling the total availability of alcohol needs to be conducted. Similar research on local powers has been conducted for England.⁸

Questions

Q15. Given the evidence base and public health considerations, do you agree that the Welsh Government should introduce a Minimum Unit Price for alcohol?

Yes. Whilst overall alcohol consumption has declined in the last few years, in the UK we are still drinking over 40% more litres per head of population than we were in 1970.⁹ Alcohol is currently 61% more affordable than it was in 1980, largely because duty rates and therefore retail prices have not risen in line with disposable income. This increased affordability is reflected by increased levels of consumption and alcohol related harms.

MUP is an effective, proportionate and targeted approach. It targets cheaper, stronger drinks known to be consumed by harmful/young drinkers. It focuses on the problems caused by cheap, high-strength alcohol and on those who suffer the greatest harms.

Q16. Do you agree that a level of 50 pence per unit is appropriate? If not, what level do you think would be appropriate?

Yes. Based on the best available evidence, we believe that the MUP should be at least 50p per unit which would result in a significant reduction in alcohol-related harms whilst ensuring that alcohol remains affordable to moderate drinkers. Additionally, a MUP of 50p would create consistency with Scotland, who have already passed legislation to implement MUP of 50p per unit, with Northern Ireland and the Republic of Ireland are also considering implementing a joint MUP of 50p per unit.¹⁰

Q17. Do you agree that enforcing Minimum Unit Pricing for alcohol would support the reduction in alcohol related harms? Please provide evidence to support your answer, if available.

⁷ Stockwell, T. 2013. *Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol*. British Columbia.

⁸ Martineau, F. P., Graff, H., Mitchell, C. and Lock, K. 2013. "Responsibility without legal authority? Tackling alcohol-related health harms through licensing and planning policy in local government". *Journal of Public Health*. Faculty of Public Health.

⁹ British Beer and Pub Association. Statistical Handbook 2013. 2013.

¹⁰ Royal College of Physicians and the Alcohol Health Alliance. Minimum Unit Pricing Bill, Scotland. AHA UK Consultation Response. 2011. Available at: www.rcplondon.ac.uk/sites/default/files/documents/aha_response_to_draft_bill_on_minimum_unit_pricing_scotland_decebt_2011.pdf

All evidence suggests that implementing a minimum unit price would support a reduction in alcohol related harms.

Q18. Do you think any level of Minimum Unit Pricing set by the Welsh Government should be reviewed and adjusted over time? Please provide evidence to support your answer, if available.

Yes. A MUP will only be effective if it is regularly reviewed and updated to take into account the impact of inflation and rising incomes.

Q19. As the Welsh Government cannot legislate on the licensing of the sale and supply of alcohol, what enforcement and/or penalty arrangements do you think should be in place to introduce Minimum Unit Pricing for alcohol in Wales?

We would urge the Welsh Government to thoroughly investigate whether it may be possible to introduce MUP through legislation, for example through its responsibility for health.

In order to allow Responsible Authorities the necessary powers to permit enforcement of any MUP, then legislation must specify specific offences in regard to the sale and supply of alcohol below the designated MUP, and specify tariffs and range of fine and additional powers applicable to enable prompt and effective enforcement.

Obesity

Wales needs to develop a comprehensive approach to food and physical activity that will promote a healthy environment and help combat the growing problem of overweight and obesity and the drivers of NCDs. This will require **policies that set public health-based standards for the food supply, address the relative affordability of healthy food, and the protection and development of local environments that support physical activity beyond sport through everyday activities and active travel.**

With regards to the food environment and nutritional standards, we strongly encourage Wales where able to:

- Explore the use of taxes on unhealthy foods, starting with sugar sweetened beverages, as both a lever to support behaviour change and as a means for raising revenue for health promotion.¹¹
- Support the further introduction of nutritional standards in specific public sector settings – beyond schools and hospitals – through secondary legislation and/or guidance.
- Consider introducing universal school meals, ideally providing them for all primary school children (not just to infants in reception and years 1 and 2 as in England) in line with the School Food Plan.¹²

¹¹ Landon, J. and Graff, H. *What is the role of health-related food duties?* National Heart Forum. November 2012.

¹² School Food Plan. 2014. Accessed 23 June 2014: <http://www.schoolfoodplan.com/>

- Address unhealthy food promotion in the retail environment.
- Recognise and address the cost of a healthy diet and the inability of many low income groups to afford healthy foods.

The introduction of the *Active Travel (Wales) Act* in 2013 was a significant step by the Welsh government.¹³ We would encourage the Welsh government to not stop there and recommends:

- Support for the implementation of a national standard for 20mph speed restrictions on non-main thoroughfares in residential areas.¹⁴
- Ensure that existing and planned developments and infrastructure are required to be 'health checked' to ensure that walking, cycling, play, active recreation and other forms of physical activity are prioritised.
- Ensure Wales meets its legal duty, as part of the UK, to protect the population from the harmful affects of air pollution under EU regulation. Current levels of particle pollution and gas emissions, particularly in urban centres, undermine the health benefits of time spent outdoors walking and cycling.¹⁵

We also highlight the concern raised by ourselves and others that there are no specific questions on physical activity in the consultation and it is not referred to outside of the context of obesity. Issues relating to physical inactivity and sedentary behaviour should be given greater prominence as the legislation moves forward.

Questions

Q21. Do you agree that nutritional standards should be introduced in the settings we are proposing, that is, pre school settings and care homes?

Yes. Like schools, pre schools and care homes (either public or private) should meet basic nutritional standards in line with public health nutrition based guidelines for healthy diets.

Q22. Do you think there are any other public sector settings that should be considered in relation to mandatory nutritional standards?

Yes. All public sector settings should be considered for mandatory nutritional standards. This should include anywhere that provides or sells food (including vending machines) such as government and local authority offices, prisons, courts, libraries, sports facilities, etc.

¹³ National Assembly for Wales. 2013. *Active Travel (Wales) Act 2013*. Accessed 15 March 2014: <http://www.senedd.assemblywales.org/mglIssueHistoryHome.aspx?lId=5750>

¹⁴ Bristol City Council. 2012. *Where widespread 20mph limits have been introduced levels of walking and cycling increased by 20%*. Citywide Rollout of 20mph speed limits: Bristol City Council Cabinet.

¹⁵ King's College London. 2014. *London Air: What is the Government doing?* Accessed 21 March 2014: <http://www.londonair.org.uk/LondonAir/guide/GovernmentAction.aspx>

Additional comments

We strongly support the introduction of standardised tobacco packaging. We have welcomed the UK Government's amendment to the Children and Families Bill which will allow the introduction of standardised packaging of tobacco products and we would urge the Welsh Government to introduce this measure as soon as possible.

Given the forthcoming Scientific Advisory Committee on Nutrition (for England) consultation report on carbohydrates and health, we encourage the Welsh Government to pay close attention to this report and its recommendations. **Up-to-date evidence regarding nutrition should be considered in any legislation which might impact food supplies and availability, and nutritional standards.**

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Public Health Law and Non-communicable Diseases

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Acronyms

| | |
|------|---------------------------|
| EU | European Union |
| HIA | Health Impact Assessment |
| HiAP | Health in All Policies |
| NCDs | Non-communicable diseases |
| WHO | World Health Organization |

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Executive summary

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

There are many effective ways in which public health law can be utilised 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 for individual local governments to pursue these types of legislation on their own, in the absence of more over-arching powers. This paper instead concentrates on four types of potential legislation highlighted in the recent Welsh consultation on public health law. These include: 1) extending the requirement to use Health Impact Assessments; 2) imposing a statutory duty on a range of bodies to reduce health inequalities; 3) legislation to bring about a renewed focus on prevention of ill health; and 4) legislation to strengthen community action around health protection and health improvement.

The paper examines a number of pieces of legislation in each of these four areas, from different jurisdictions in the UK and other countries in Europe, and in the United States, Canada, Australia and New Zealand, 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 have been 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 as ways of enabling local governments to effect changes in NCD rates, for three reasons: they are relatively less politically controversial than other possibilities; they are multi-sectoral approaches; and they focus on health inequalities.

1 Introduction

Non-communicable diseases (NCDs) create a serious health and financial burden for local and national governments. NCDs can be defined as diseases that are not infectious. These diseases may result from genetic or behavioural factors and include coronary heart disease, stroke, hypertension (high blood pressure), type 2 diabetes, kidney disease, certain forms of cancer, respiratory and liver diseases, and overweight and obesity, as well as certain mental health conditions. Most NCDs can be linked to the modifiable determinants of tobacco use, harmful use of alcohol, poor diet and lack of physical activity.

Legislation is one key tool to address these risk factors and 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 also been used to address non-communicable disease.

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 over-arching themes of multi-sectoral engagement and the reduction of health inequalities. The first such option is legislation requiring Health Impact Assessments – tools that help decision-makers identify the public-health consequences of proposals that potentially affect health. The second involves imposing a statutory duty on a range of bodies to address and reduce health inequalities. The third is the use of legislation to bring about a renewed focus on prevention of ill health, both within and outside the health sectors. Fourthly, the use of the legislation to strengthen community action around health protection and health improvement will be reviewed.

2 Background to non-communicable diseases and public health law

2.1 The burden of disease

Non-communicable diseases (NCDs) include coronary heart disease, stroke, hypertension, type 2 diabetes, kidney disease, certain forms of cancer, respiratory and liver diseases, overweight and obesity, and mental health conditions such as vascular dementia. These diseases, which are often treatable but not always curable, are responsible for sizable economic burdens on governments. Most NCDs can be linked to the modifiable determinants of tobacco use, harmful use of 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.ⁱ In 2008, nearly two-thirds of all deaths – 36 million – resulted from NCDs, comprising mainly cardiovascular diseases, cancers, diabetes and chronic lung diseases.ⁱⁱ NCDs disproportionately impact young and middle-aged adults, and on a global scale they are quickly becoming dominant causes of death and disability.ⁱⁱⁱ Within the WHO European Region, NCDs account for 86% of deaths and 77% of the disease burden.^{iv} In the UK, NCDs are the leading cause of death, and in 2008 there were 518,400 deaths from NCDs, of which 23.75% were among the under-70s.^v

The economic burden of NCDs is sizable. A 2011 projection of costs carried out by the World Economic Forum and Harvard School of Public Health suggests that the cost of NCDs to the global economy will amount to \$47 trillion over the next two decades, approximately 75% of the 2010 global GDP.^{vi} The cost of diabetes and related complications to the NHS in England and Wales amounts to an estimated £9 billion a year,^{vii} and over half of these cases could have been prevented. 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”.^{viii}

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 World Health Assembly Resolution of May 2012, governments pledged to adopt a global target of a 25% reduction in premature mortality from NCDs by 2025.^{ix} NCDs are related to sustainable development issues including nutrition and energy, and there have also been calls to integrate NCDs carefully into the United Nations’ Sustainable Development Goals as well as the post-2015 Millennium Development Goals.^x

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

2.2 NCD risk factors and interventions

As stated above, the proximate causes of NCDs across all countries include tobacco use, harmful use of alcohol, the over-consumption of saturated fat, sugar and salt, and lack of physical activity. 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.” These are listed in Table 1.

Table 1: 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
- 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
- Reducing salt intake and salt content of food
- Replacing trans fats in food with polyunsaturated fat
- Promoting public awareness about diet and physical activity, including through mass media.

Source: World Health Organization, 2011^{xi}

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 on healthy diet, exercise and reduction of smoking was implemented in the early 1970s. Between 1972 and 2006, North Karelia witnessed an 85% decrease in annual mortality rate from coronary heart disease.^{xii} More recently, in New York City, a five-year-old Health Department regulation banning trans fats has reduced the consumption of trans fats among fast-food customers from about 3 grams to 0.5 grams per purchase – showing also that local health regulations can significantly influence public consumption.^{xiii}

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, labelling requirements, taxation and minimum unit pricing measures. A key example is the WHO's Framework Convention on Tobacco Control – developed in response to the globalisation of the tobacco epidemic and the cross-border effects of many factors – which has made substantial progress in reducing tobacco consumption.^{xiv} One advantage of the four approaches outlined in this paper – and which will be appealing 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.

2.3 The importance of public health law in improving population health

A central question in public health law and policy is what degree of intervention 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.^{xv} 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 the population to make healthy choices, access to medical services and a reduction of health inequalities.^{xvi}

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”.^{xvii}

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; authorising 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 non-governmental health activities.^{xviii}

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 is 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. Table 2 below, adapted from a WHO Regional Office for Europe document on public health law, reflects some of the benefits and disadvantages of each approach.

Table 2: 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 public health legislation. Good opportunity to raise public awareness about public health issues and to educate policy-makers. | Need to amend all impacted legislation. |

Source: Chichevalieva, 2011^{xix}

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:

- *In separate acts and regulations:* In 2009, a Portuguese law established standards to reduce the salt content in bread, set a maximum limit of salt content in bread and encouraged information on salt content on the labelling of pre-packaged foods.^{xx} Denmark has brought in a tax on trans-fatty acids, Hungary a 'junk food tax' and France a tax on all sweetened drinks.^{xxi}
- *Law 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.^{xxii}

The purpose of public health law may vary considerably from country to country. Table 3 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.

Table 3: Purposes of public health laws

| Public health law | Purpose |
|---|--|
| CANADA British Columbia Public Health Act 2008 ^{xxiii} | This act replaces the outdated legislation, supports improved health and wellness of British Columbians and helps 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. |
| AUSTRALIA New South Wales Public Health Act 2010 ^{xxiv} | To protect and promote public health. <ul style="list-style-type: none"> • To control the risk to public health. To promote the control of infectious diseases <ul style="list-style-type: none"> • To prevent the spread of infectious diseases. • To recognise the role of local governments in protecting public health. |
| NORWAY Norwegian Public Health Act 2011 ^{xxv} | To contribute to societal development that promotes public health and reduces social inequalities in health. Public health work will 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. |
| AUSTRALIA Queensland Public Health Act 2005 ^{xxvi} | To protect and promote the health of the Queensland public. |
| SCOTLAND The Public Health etc. (Scotland) Act 2008 ^{xxvii} | To re-state 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. |
| AUSTRALIA South Australian Public Health Act 2011 | To provide a modernised, flexible legislative framework, so South Australia can better respond to new public health challenges as well as traditional hazards. |

The number of public health law instruments within Europe is 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.^{xxviii} At the national level, there is increasing interest in legislation that can improve public health and avoid the fiscal and economic burdens associated with costly treatment of NCDs and loss of productivity.

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

As explained in section 2.2, the risk factors for NCDs fall primarily into four categories: tobacco use, harmful use of alcohol, poor diet and lack of physical activity. Although public health law can be an effective mechanism for NCD prevention, two potential political obstacles include: firstly, strong public and political resistance to laws intended to influence choices and behaviours, with a perception of NCD risk factors being a matter of personal choice; and secondly, that effective interventions are difficult politically because it means challenging the rights of profitable businesses to manufacture and sell potentially harmful products.^{xxix} 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.^{xxx}

There are a number of ways in which law can influence behavioural risk factors for NCDs. These fall into the following categories: health infrastructure and governance; shaping the informational environment; creating economic incentives and subsidies; designing or altering the built environment; addressing health inequalities through economic policies; and command and control regulation, i.e. directly regulating persons, professionals, businesses and other organisations.^{xxxi}

For example, improved infrastructure might be accomplished through the establishment of structures or institutions that support whole-of-government approaches to NCD risk factors. An improved informational environment could include restrictions on advertising of harmful products, inclusion of health warnings, or nutritional labelling. 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 built environment could mean smoke-free places, zones with restrictions on sales of tobacco, alcohol or certain foods, improved school food, or environments facilitating physical activity.^{xxxii}

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 NCDs have proved to be an effective and central component of comprehensive prevention and control strategies. Magnusson et al, in an Australian paper, wrote:

“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.^{xxxiii}

The next four sections of this paper 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.^{xxxiv} They are:

- extending the requirement to use Health Impact Assessments (section 3)
- imposing a statutory duty on a range of bodies to reduce health inequalities (section 4)
- legislation to bring about a renewed focus on prevention of ill health (section 5), and
- legislation to strengthen community action around health protection and health improvement (section 6).

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3 Extending the requirement to use Health Impact Assessments

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 by the WHO and the EU.

3.1 Background to Health Impact Assessments

In keeping with the emphasis on a multi-sectoral approach, Health Impact Assessments (HIAs) 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."^{xxxv} The National Research Council (in the United States) 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."^{xxxvi} The Health in All Policies (HiAP) approach likewise recognises and addresses the fact that many of the determinants of health lie outside the health sector, and encourages governments to take a more inclusive approach through inter-sectoral and 'whole-of-government' policy and governance.^{xxxvii}

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.^{xxxviii} HIAs may also be effective in promoting accountability for decision-makers whose policies may have negative impacts on health. This aspect may explain why HIAs are also increasingly used by international organisations such as the World Bank and the International Monetary Fund as a condition for loans, and by international industry, for example 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 Table 4.

Table 4: Links between policy decisions in various sectors and the risk factors for NCDs

| Sector | Relation to NCDs |
|--------------------------------------|--|
| Health and social protection systems | NCD-related illness and disability can destabilise these systems. However, measures such as promoting access to preventive health services, screening and early detection, and healthy aging can reduce the costs of treatments and disability. |
| Food and agriculture | Because of the role of unhealthy diets as a key NCD risk factor, food/agriculture industry measures around production, trade, manufacturing, retail, labelling, pricing, and taxation options can all impact dietary choices, especially through the reduction of salt, sugar and saturated fat in prepared foods. |
| Urban transport and urban 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 choices among children can be promoted through the creation of healthy environments, education of 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. These can result in reduced healthcare costs, as well as increased employee productivity and improved corporate image. |
| Telecommunications and media | These sectors can highlight features on healthy living. Also, telehealth and mobile phones can further health promotion, offer treatment reminders, and connect individuals with NCD-related information and resources. |

Source: Pan-American Health Organization^{xxxix}

3.2 The legal basis for a statutory duty to promote Health Impact Assessments

One means of ensuring that the public-health impacts of decisions taken in other sectors are considered is to impose a statutory duty on organisations 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”; and 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”.^{xi} 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.^{xii}

Another precedent can be found within UK legislation, where HIAs form part of the mandatory ‘Impact Assessment’ required by Government for all relevant policies, with the aim of developing better, evidenced-based policy by careful consideration of the impact on the health of the population.^{xiii} 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 apply to primary and secondary legislation, as well as codes of practice or guidance.^{xliii}

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 the 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 that, 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.^{xliv}

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 assign staff to other departments to help them consider the health impacts of their activities.^{xlv}

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 would typically not otherwise be considered. Sectors included were environment and energy, transportation, agriculture, and waste disposal and recycling.^{xlvi} Only 22 of the 36 jurisdictions surveyed had laws requiring or facilitating HIAs. The authors highlighted that the laws that most clearly

facilitate HIAs feature two criteria: 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 “They call for studies or assessments that are used to inform public policy, programs, projects, regulations, or decision making”. Other, less ‘strong’ laws may simply allocate funding for or authorise evaluations of health impacts without making the link to policy decisions. One example cited was an Oregon statute authorising the state’s health authority to survey and investigate how the production, processing or distribution of agricultural products may affect the public’s health.^{xlvi}

Summary

Health Impact Assessments are increasingly being required in a number of jurisdictions. In the case of Québec, an examination over ten years has shown that, while government departments were reluctant to work inter-sectorally 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 undertakings (and to which ones?), or should they also apply more broadly to private-sector projects which also contribute to the NCD risk factors to which a given community is exposed?

4 Imposing a statutory duty on a range of bodies to reduce health inequalities

According to Marmot et al:

“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 and places that are sociable and congenial, of high social capital, that feel safe from crime and disorder, and have access to green spaces, adequate transport options, and opportunities for healthy living.”^{xlvi}

There is a clear link between social inequalities and ill health, both because disadvantaged groups have poorer access to services, and also fewer resources in education, employment, housing, and transport, and reduced participation in civic society to make healthy choices. NCDs have a strong link to health inequalities, since opportunities to make healthy choices may be affected by social determinants including socioeconomic status, gender, ethnicity or education. Health inequalities are costly: UK estimates suggest that the consequences of 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.^{xlix}

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 the 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 socioeconomic 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).ⁱ

A focus on health inequalities may serve to better inform public health choices about the types of interventions used. For example, tobacco use and poor diet are major risk factors for cardiovascular disease, and a high-risk approach to cardiovascular disease prevention usually involves population screening, with those individuals above a particular risk threshold being given advice on behaviour change and/or medication 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, and statin and anti-hypertensive prescribing and adherence, and that a population-wide approach which legislates for smoke-free public spaces or for reducing salt intake could be more effective and reduce health inequalities.ⁱⁱ 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.^{lii}

Table 5 shows the guiding principles relating to equity in public health legislation in various countries.

Table 5: Guiding principles relating to equity in selected public health legislation

| | |
|---|---|
| BULGARIA Bulgarian Health Act 2004 ^{liii} | “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 Health Care Act 2010 ^{liv} | “The objective of this Act is to ... (2) reduce health inequalities between different population groups;” (Section 2) |
| GREECE 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 Norwegian Public Health Act 2012 ^{lv} | The purpose is to “contribute to societal development that promotes public health and reduces social inequalities in health”. |
| AUSTRALIA South Australian Public Health Act 2011 ^{lvi} | “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.” (Part 2, section 13) |
| SWEDEN 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 2010 Health Care Act was designed in response to equity challenges in healthcare services, and contains provisions that give a number of new rights to patients. For example, patients can access health services outside their municipality, and each patient has the freedom to choose his or her own health setting and specialised healthcare unit (from 2014).^{lvii} 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.^{lviii}

Under the New Zealand Public Health and Disability Amendment Bill 2010 (which amends the New Zealand Public Health and Disability Act 2000), the objectives of the district health boards include: to reduce health disparities by improving health outcomes for Maori and other population groups; and to 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”.^{lix} The Act imposes explicit duties on the Secretary of State, the 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.^{lx}

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 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.

5 Legislation to bring about a renewed focus on prevention of ill health

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.

5.1 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, for example, in Scotland’s 2008 Public Health Law which contains a provision prohibiting operators from allowing minors to use sunbeds.^{lxi} Two relatively novel approaches can be found in the British Columbia Public Health Act and the South Australian Public Health Act.

The British Columbia Public Health Act (2008) not only allows the Minister of Health to require development of public health plans for health promotion and protection to address issues such as chronic disease prevention or inclusion of mental health and substance services in communities. It 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 the South Australian Public Health Act 2011 (Prevention of non-communicable conditions), the Minister of Health 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 enforceable compliance notices being issued. Additionally, there is a specific regulation-making power for taking measures to manage any non-communicable condition.^{lxii}

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.

5.2 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 the Ministries of Agriculture, Education and Communications.^{lxiii}

In Article 6 of Greece’s Law on Public Health (2005), the Centre for the Control of Special Communicable Diseases was renamed the Hellenic Center for Disease Control and Prevention (KEELPNO) and its mission broadened to include NCDs, accidents, environmental health, a central public health laboratory, and the evaluation of health services.

In Iceland, amendments made in 2011 to the Medical Director of Health 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.^{lxiv} 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; and sponsoring and organising public health initiatives.^{lxv}

Similarly, the South 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.^{lxvi}

5.3 Increasing budgets for prevention of ill health

Investments in prevention and in protecting and improving the population’s overall physical and mental health will have positive consequences in terms of healthcare spending and productivity. 2006 OECD data suggest 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.^{lxvii} Since prevention is a cost-effective measure, government intervention to shift resources towards prevention will result in long-term benefits.

The US Affordable Care Act establishes a Prevention and Public Health Fund (Section 4002). The 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 Health and Human Services has the authority to transfer amounts from the Fund to increase funding for any programme authorised 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 decade 2013-2022. The Fund also supports the Community Transformation Grants that support local initiatives for chronic disease prevention.^{lxviii}

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.^{lxix}

Summary

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 specific activities relating to the financing of prevention, there are a number of recent developments that may be of interest to governments. These include: British Columbia’s and the 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 having funds earmarked for prevention through the Prevention and Public Health Fund under the 2010 Affordable Care Act.

6 Legislation to strengthen 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 Noncommunicable Diseases*, which endorses empowerment and the ‘whole-of-society’ as key principles.^{lxx} ‘Empowerment’ means that all public health and healthcare 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 healthcare decisions.^{lxxi} Strategies like this are intended to facilitate patients to manage disease, adopt healthy behaviours and use health services effectively.

This section will focus on three interpretations of this type of legislative action: 1) using Health Impact Assessments as a support for community action; 2) mandates or programmes to share information about NCDs with communities; and 3) increasing the role of local government.

6.1 Using Health Impact Assessments as a support for community action

Clearly, this is closely linked to the discussion on HIAs in section 3, 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 organisers of a given project are eager to listen to, involve and respond to community members.^{lxxii}

6.2 Sharing information about NCDs with communities

The concept of legislation to strengthen community action 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 healthy choices. Legislative precedents – and innovative policy and incentives – can be found in the United States, the UK, Finland and South Australia:

- *United States* – Title IV of the US Affordable Care Act (2010)^{lxxiii} 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 programmes to promote individual and community health and prevent the incidence of chronic disease.

- *UK* – The UK Health and Social Care Act (2012) endorses the principle of “No decision about me, without me”. The phrase describes a vision of health care where the patient is an active participant in treatment decisions. To this end, legislative changes include: strengthening the voice of patients; imposing additional duties on Commissioning Groups, Monitor (the health care regulator) 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.^{lxxiv}
- *Finland* – The Health Care Act (2010), section 11, states: “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.”
- *Australia* – Principle 11 of the South Australian Public Health 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.”^{lxxv}

6.3 Increasing the role of local government

A broader interpretation of the objective of strengthening community action would be to involve local government more in making public health decisions and policy. For example:

- *Finland* – The 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 its residents and to compile relevant statistics during terms of office.^{lxxvi}
- *Sweden* – Twenty county councils have the responsibility for the organisation of health care, and are also 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.^{lxxvii}
- *UK* – Similarly, in the UK, the Health and Social Care Act (2012) grants new responsibilities to local authorities for improving the 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 more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations.”^{lxxviii}

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 multi-sectoral and community-oriented approach through inclusive processes, such as through the HIA process, or sharing information with communities (e.g. through the UK Healthwatch or the US Community Transformation Grants programmes); while others strengthen the role of local governments in health promotion and disease prevention (e.g. in Finland and the UK).

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7 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: extending the requirement to use Health Impact Assessments; imposing a statutory duty on a range of bodies to reduce health inequalities; legislation to bring about a renewed focus on prevention of ill health; and legislation to strengthen community action around health protection and health 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 Québec study suggesting that mandatory HIAs will lead to better inter-sectoral 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 in, for example: the Finnish act which gives new choices to patients; the New Zealand act which sets out the responsibilities of district health boards; or the UK act which requires bodies to consider the reduction of inequalities when commissioning health services.

Legislation can bring about a renewed 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 are: British Columbia's and the South Australian legislation granting health ministries the ability to respond flexibly to NCD concerns as they arise; and refocusing national health institutions to consider NCDs or earmarking funds for prevention, as in the US 2010 Affordable Care Act.

Fourthly, public health law can strengthen community action promoting health protection and improvement. This can be through programmes which endorse a multi-sectoral and community-oriented approach such as HIAs, community-based information-sharing programmes such as UK Healthwatch or the US Community Transformation Grants programmes, or increasing the 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 multi-sectoral approaches and of reducing inequalities. This paper has set out a few of the many precedents for ways in which public health law can be used to reduce risk factors for NCDs.

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