**Chapter 8 Improving population health – answers**

Self assessment

Question 1 of 5

Answer E – smoking cessation support after heart attack. This is rehabilitation after a disease event, hence this is tertiary prevention.

Health education of school children on lifestyle, genetic counselling before marriage and measles immunisation are examples of primary prevention. Cervical cancer screening is an example of secondary prevention

Question 2 of 5

Answer B. The differences in health status due to inequalities are where the biggest gains in health are available (**Rose, G.** *The Strategy of Preventive Medicine.* Oxford : Oxford University Press, 1992). Cancer drugs, lowering cholesterol levels, improving post-operative mortality rates and increasing activity levels all improve health outcomes, but reducing inequalities would have a bigger overall impact.

Question 3 of 5

Answer C – smoking. Smoking is a direct cause of many diseases, including cancer.

All of the other options listed are physiological variables and not direct causes of disease. Question 4 of 5

Answer C – a governmental strategy to reduce inequalities includes a political element and can be described as an issue of social justice. This gives it a societal focus. Treating disease falls into a bio-medical model and changing behaviours with messages or reminders focusses on individuals.

Question 5 of 5

Answer C – fluoridation of water to prevent dental caries. This is a population approach which derives maximum benefit and achieves universal change.

Chlamydia screening adopts a high-risk approach, targeting young women at risk. As TB is very rare in the UK, a high-risk approach is also more appropriate here. Smoking cessation clinics need to be targeted at smokers who would benefit from the intervention.

Short answer questions

Question 1 of 3

Your answer should include a discussion of health improvement action relevant to each of the forces in the model. The forces interact and a sophisticated answer will draw on this model within an identified ethical framework to draw evidence based and nuanced conclusions. Use the prompt questions in Table 8.1.

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| **Pencheon & Bradley model force** | **Examples for discussion** |
| Dynamic societal and technological innovation and societal disruption | Advertising campaigns including social media and influencers, messaging reminders via technological solutions, impact of climate change, relevance during conflict and relationship with malnutrition |
| Contested impacts of political and economic systems | Legislation around advertising and food, production/manufacture, taxation, political manifestos, advocacy and lobbying, environmental impacts of farming and other food production modalities, urban design, healthcare funding and prevention/treatment availability, surveillance models |
| Diverse social and cultural factors | Cultural and behavioural changes (diet, activity levels etc) including cultural, family and peer norms, public education and behaviour techniques, economic affects on food and behaviour choices, charity influences |
| Basic needs and determinants | Availability of cheap, high energy foodstuffs, affects of overweight and obesity on mental and physical wellbeing, the biology of weight management and availability of medical interventions or behavioural support. |

Question 2 of 3

There are two general strategies for the primary prevention of cardiovascular disease (CVD); the ‘high-risk’ approach and the population approach. In the high-risk approach, individuals at high risk of disease are identified and targeted for preventive treatment, and in the population approach, the whole population is targeted for risk factor reduction. One of the disadvantages of the high-risk strategy is that most CVD cases occur not amongst the small number of individuals at greatest risk, but amongst the much larger numbers of individuals at lower levels of absolute risk.

Question 3 of 3

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| **Action** | **Who might do this** | **Examples** |
| Act to ensure that national policy, whatever the topic area, is seen as an opportunity to improve health | Civil servants  Lobbyists  Professional groups e.g. Medical Royal Colleges | Road planning and its effects on community displacement and availability of green spaces  Lobbying local politicians for sugar taxation  Generation of consistent, affordable treatment algorithms for tertiary prevention |
| Be instrumental in designing better health and care services and promote health in other public services | Health and care commissioners  Health care managers and clinicians  Public libraries providing health information | Clinical audit on inequalities in access to medical services  Outreach medical or psychological services |
| Establish health-enhancing initiatives for communities or workplaces and design services that support healthier choices and lifestyles | Workplace health coordinators, human resources, occupational health  Commercial companies  Health and care commissioners | Healthy food choices in vending machines  Water availability  Health checks in the workplace  Mental health champions  Showers, cycle parks, walking buses, guided walks, walking meetings |
| Raise public awareness of health issues and signpost individuals towards opportunities for self-help | Charities  Health and social care workers  School teachers and managers  National and local media  National and local government information campaigns | Social prescribing scheme promotion  Information campaigns  Childhood weight measurement (surveillance)  Signposting to weight management services during consultations |
| Act as advocates for public health and adopt healthier, more sustainable lifestyles | Everyone | Minimise waste  Eat healthily  Undertake physical activity  Moderate drinking alcohol  Cycle or walk more |