SCPHRP

Scottish Collaboration for Public Health Research & Policy

SPRING EDITION 2014

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SCPHRP magazine is published three times a year. If you would like to submit an article, or be added to our distribution list, please contact Sam Bain at samantha.bain@ed.ac.uk. The next edition of the magazine will be published in August 2014. Contact us with ideas for stories before 1 June 2014

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MESSAGE FROM SCPHRP

SCPHRP is pleased to announce that the Director, Prof John Frank, has been asked by the Scottish Government to chair a newly formed multi-stakeholder Steering Group on "Preventing Teenage Pregnancy and Supporting Young Parents. The first meeting of the Group is set for early June. This initiative by the SG is timely, since teenage pregnancies, although they have fallen significantly in frequency for some years now, in both the UK as a whole and Scotland, remain more common than in most of Europe. Many studies over recent decades have demonstrated that children born to teenage parents are statistically at higher risk of worse health, child-development, and educational outcomes. There is fortunately much scientific evidence that these risks are not inevitable, and can be mitigated by affordable strategies to provide better support - and especially appropriate, accessible services -- to both teens at risk of pregnancy, and to young parents, once a baby is born to them.

SCPHRP looks forward to working with diverse other stakeholders across Scotland, to develop a new strategy to address this ongoing public health challenge, based on scientific evidence applied to Scotland's current realities, over the coming year.

EVENTS & NEWS

Public Health: Use of evidence in health inequalities policy.

RCPE Symposium Edinburgh
8 May 2014

Social connections and health across the lifecourse.

A SCPHRP event: 21 May 2014
Social connections are concerned with the interactions between people and/or groups of people, occurring within a range of settings, including communities, families and peer groups or friendship networks. There is growing evidence that these are important drivers of health and wellbeing throughout the lifecourse and through a variety of mechanisms. This is reflected in national policy, which increasingly refers to connectedness as a health asset within communities. For more information and to register CLICK HERE

Exploring continuity of care in maternity and post-natal services

A SCPHRP event: 27 May 2014
Currently, there is growing evidence that continuity of care improves maternal and child care outcomes. This is reflected in the Scottish Government's health policy, which indicates that all pregnant women in Scotland should have a named midwife who provides continuity of care through the antenatal period. However, there may be continuity of care issues in maternity services and around care-handoff from midwives to health visitors. For more information and to register CLICK HERE

Young STAND Awards.

10 June 2014 - at the Royal Lyceum Theatre.
STAND is a joint initiative between Mentor and SCPHRP, the aim of which is to recognise and reward community and school based projects working to prevent alcohol and substance misuse in Scotland.

Papers and Publications

John Frank and Ruth Jepson have signed a contract with OUP to publish a book on Preventative Medicine, suggested title: " Prevention: A Critical Guide".

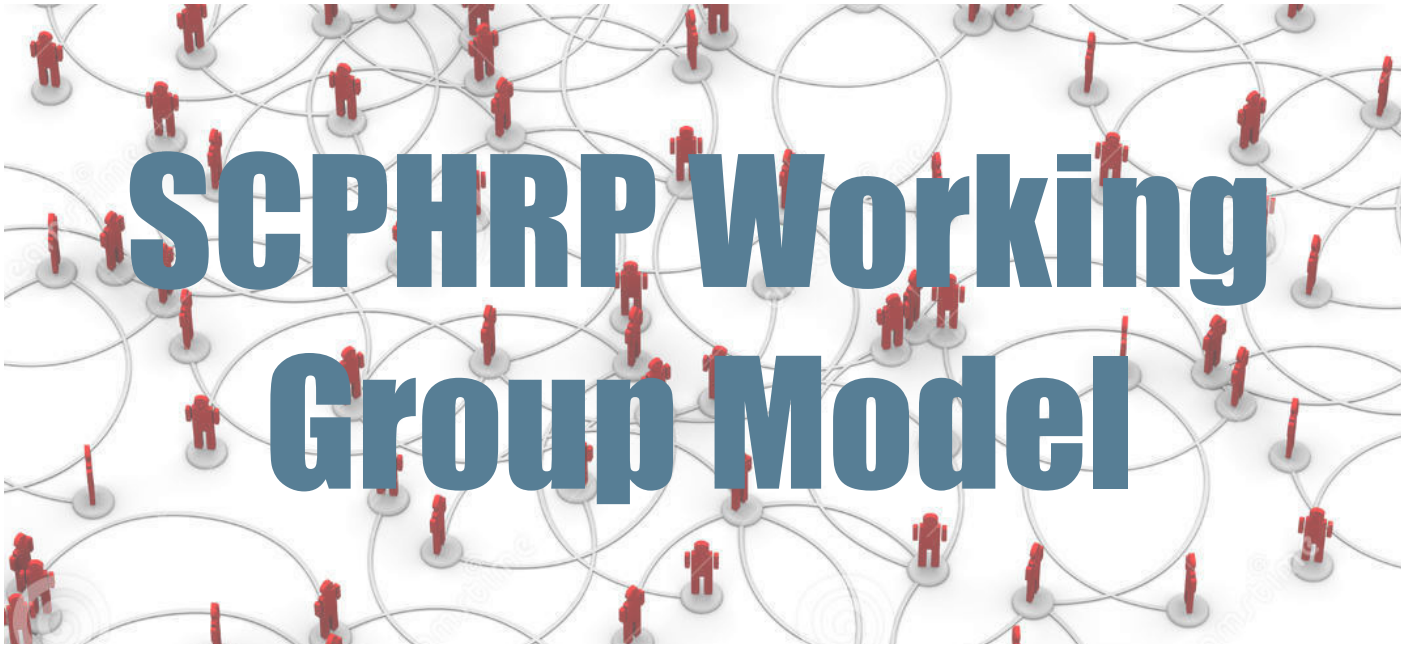
Interviews

SCPHRP got the chance to speak with Dr Margaret Thomas who is the project lead for the 'National Evaluation of the National Partnership Agreement on Preventive Health' in Australia, about her experiences with evaluation and public health - both in Europe and in Australia. WATCH HERE

Filmed Events – Theresa Marteau: Reducing Health Inequalities: A Behavioural Science Perspective. WATCH HERE.

We film most of the events we host. You can watch past events on our YouTube Channel. VISIT THE YOUTUBE CHANNEL.

FOR MORE INFORMATION ABOUT SCPHRP's NEWS & EVENTS VISIT US AT *WWW.SCPHRP.AC.UK*



SCPHRP Working Group Model

As well as continuing to foster an environment that supports the design, implementation and evaluation of innovative, evidence-based, public health policies and programmes, in 2013-18, SCPHRP aims to:

1. Identify drivers, patterns and consequences of health outcomes, via novel analyses of Scottish surveys and cohorts, to inform our Working Groups' development of new programmes and policies

2. Identify and validate broader health and non-health outcomes

3. Measure health impacts and outcomes of policy interventions using secure cross-sectorial data linkage

To achieve these aims SCPHRP has created four Working Groups. Each Working Group is focused on Scottish public health priorities within the four life-stages of early life; adolescence and young adulthood; working age/adult life; and later life.

The SCPHRP Working Group model uses a network of people from various disciplines, including researchers, decision-makers and practitioners to help meet these aims by:

1. Catalysing strong researcher/research-user collaboration around solving a shared problem

2. Sharing ideas and knowledge on specific topic areas, particularly around new policies and innovations

3. Collaborating on projects/grants, and developing novel policy/practice ideas to benefit Scotland and reduce inequalities.

Research fellow role

For the Working Groups and sub-groups to prosper as a collaboration, it is key that group members take an active role in, and develop a sense of ownership over, the groups' activities. To help this process, especially in the early stages, each Working Group is assigned a SCPHRP Research Fellow, whose role is to support the activities of the Working Groups and sub-groups (e.g. arrange meetings; highlight relevant events/literature/funding; contact prospective members) and keep the groups up-to-date with activities in the other Working Groups and at SCPHRP.

Early Years

Research Fellow **Larry Doi**

The Early Years Working Group focuses on public health issues from conception up to the age of 12 years. The Working Group has subdivided into three sub-groups based on members' research interests. These three sub-groups are:

'Partnerships for Health and Wellbeing' - focusing on understanding and improving the relationship between school nurses and educational staff in order to enhance outcomes of health promotion programmes in Schools.

'Effective Universal Support Services' - focusing on better promotion of antenatal and postnatal services to ensure improved health outcomes for mothers and babies. Currently, the group is planning to deliver a symposium in June 2014 around the topic of 'continuity of antenatal and postnatal care'.

'Changing Environment, Context and Structures' - focusing on the design and evaluation of a programme that links food co-op activities at the community level to the nursery settings with the view of maximising access to healthy foods for families.

If you would like more information about the Early Years Working Group and the sub-groups, and/or would like to join any of the groups, please email

Larry Doi (larry.doi@ed.ac.uk)

Adolescence and Young Adulthood

Research Fellow **John McAteer**

The Adolescence and Young Adulthood Working Group focuses on public health issues affecting teenagers and young adults, aged 13-25 years.The Working Group currently comprises four sub-groups.

'Working with Existing Structures to Improve Young People's Health' – focusing on embedding interventions into existing policy structures. The group is currently examining the health and wellbeing component of the Curriculum for Excellence and how this is delivered in secondary schools.

'Social Connectedness' – focusing on connectedness within families, peer groups and the wider community, and the role it plays in adolescent and young adult health. The group is currently conducting a brief scoping review to guide selection of a research project in this area. (See related seminar: 'Social connections and health across the lifecourse').

'Protecting Young People in Transition' – focusing upon the impact of transition on young people's health, with a view to developing an intervention. Currently, the group wish to focus on school-leavers and their subsequent destinations, exploring issues such as unemployment and welfare reform. A symposium related to this topic will be held later in the year.

'Improving School Attendance' – focusing on understanding and improving school attendance in Scotland. The group are currently sourcing Scottish data relating to school absenteeism, and plan to develop an intervention.

In partnership with Mentor Scotland, SCPHRP set up a national award scheme for community and school-based alcohol and substance misuse prevention projects across Scotland – the Young STAND Award Scheme. In 2014, the STAND Awards Event will be held at the Lyceum Theatre in Edinburgh on the 10th June.

If you would like more information about the Adolescence and Young Adulthood Working Group and the sub-groups, and/or would like to join any of the groups, please email

John McAteer (john.mcateer@ed.ac.uk).

Working Age / Adult Life

Research Fellow Tony Robertson

The Working Age/Adult Life Working Group focuses on the health of the adult population, spanning the ages of (approximately) 18 to 65 years. The Working Group has subdivided into three sub-groups, each with a different substantive focus. These three sub-groups are:

'The Economy & Health' - focusing on the impact of welfare reform, austerity, the recession and macro-level economic influences on health. Tony is currently leading on some initial scoping work around current welfare reforms in the UK and Scotland and the potential health impact. This work will utilise the knowledge and networks of the group to identify and then synthesise not only the academic evidence available, but also the 'grey literature' in the form of reports and evaluations from the health services, government (local and national) and the third sector. The evidence generated will be used to initially inform potential research directions of the group, as well as being disseminated to other key academic-, public sector- and community-stakeholders.

'Ageing Well: Healthier Futures' – focusing on multimorbidity (physical and mental) and community-based projects dealing with related issues

'Social Change & Health' – focusing on learning from, and interacting with, community-based initiatives that aim to reduce health inequalities.

Currently, the 'Ageing Well' and 'Social Change' sub-groups have joined forces to help deliver a symposium in June 2014 where we aim to bring community-based project workers, researchers, health workers and policy makers together to learn about current community-based initiatives that aim to reduce health inequalities. The aim of the day will be to identify common themes across projects that can help inform future research/interventions within the sub-groups and help generate new collaborative and multidisciplinary networks to lead on such work.

If you would like more information about the Adult Life/Working Age Working Group and the sub-groups, and/or would like to join any of the groups, please email

Tony Robertson (tony.robertson@ed.ac.uk).

Later Life

Research Fellow Currently being recruited

The Later Life Working Group focuses on the health of people towards, and at the end of, the working life (around 65 years) onwards with the aim of 'reducing frailty and dependency inequalities in the elderly'. The Working Group has subdivided into three sub-groups, each with a different substantive focus. These three sub-groups are:

'Social Connectedness' – focusing on the intergenerational synergy between older people and the early years as well as social and community interventions for the older population such as the 'Casserole club' and lunch clubs in Dumfries & Galloway.

'Multimorbidity/Complexity' – focusing on upstream prevention of disease/infirmity, rather than the process of decline and dependency per se i.e. something that would actively encourage people to keep as healthy as possible for as long as possible. It was discussed that such an intervention would have to be inexpensive, scalable to the national level and without the need for health professionals; an exemplar would be one that would boost social connectedness to, in turn, boost health. It was discussed that co-production, i.e. having the involvement of older people and communities, would be optimal to the intervention. It was suggested that there was a need to build networks/support for carers too.

Further discussion alighted upon physical activity as a good type of intervention, both to build social connectedness and to improve physical and mental health outcomes. As the multimorbidity/ complexity subgroup has discussed similar concepts to the 'social connectedness' sub-group, it is expected that there will be some crossover both between the work of these two sub-groups and other lifecourse Working Groups.

Quality of End-of-Life – focusing on end-of-life options, aiming to develop a novel intervention to address issues in the current quality and applicability of end-of-life care to socially and economically deprived groups.

While we await the recruitment of the Later Life Fellow, if you would like more information about the Later Life Working Group and the sub-groups, and/or would like to join any of the groups, please email **Larry Doi (larry.doi@ed.ac.uk) or Tony Robertson (tony.robertson@ed.ac.uk).**

COMMUNITIES TALK: LEARNING FROM COMMUNITY PROJECTS TO HELP IMPROVE HEALTH AND WELLBEING IN SCOTLAND

As part of the Adult Life / Working Age Working Group, SCPHRP's Tony Robertson and members of the 'Ageing Well: Healthier Futures' and 'Social Change and Health' sub-groups are currently organising a workshop to take place later this year. This workshop aims to bring academic and community partners together to: discuss our understandings of health and wellbeing in Scotland; provide a platform for learning and interaction; and generate new partnerships where community groups and academics can work together to improve the health of the nation and reduce health inequalities.

From initial discussions at the sub-groups it was apparent from the academics, community workers and NHS workers in the groups that there was a desire to engage further, especially for academics to learn from community projects in terms of what works and what does not work 'at ground level'. Through discussions with academics, we also hope to develop methods for strengthening the evidence base within community projects to help inform local and national policy. Over the next few months, the organising committee will be finalising the plans for the day, with the aim to have a series of roundtable discussions where community workers, health workers, policy-makers and researchers can have honest and frank discussions about the realities of improving health and wellbeing, identifying novel methods being employed; identifying issues in translating evidence from community health projects; and identifying gaps in our knowledge.

This workshop will also hopefully generate new ideas and opportunities for future knowledge exchange events between all the relevant stakeholders interested in improving the health and wellbeing of the people of Scotland, facilitated by SCPHRP.

Straight talk with fast food vendors

by Michelle Estrade

In May 2013 the Scottish Government issued a draft framework, entitled Supporting Healthy Choices1, which encourages the food industry to take action towards offering healthier food choices to Scottish consumers. The voluntary recommendations include guidance on promotional activities, healthier cooking practices, and types and portion sizes of foods offered. As part of a collaborative study between the University of Aberdeen, SCPHRP, the University of Glasgow, and the Glasgow Centre for Population Health, I sat down with owners of independent fast food shops in deprived areas of Aberdeen, Edinburgh, and Glasgow to discuss how they felt about offering healthier menu options. They shared many thoughts on tradition, individual responsibility, and customer demand – views that may well be common to food vendors everywhere. However, concerns more specific to the deprived neighbourhood context were also expressed, suggesting that small food vendors in disadvantaged areas would need additional incentives and assistance in order to implement healthy menu guidelines and ensure that their customers don't miss out on potential benefits.

The shop owners I talked to took pride in their menus and used words like traditional, proper, and fresh to describe their food. However, because they felt food was being prepared the "proper" way, there was a sense of reluctance to change cooking methods.

"We use beef dripping, and it's just purely on taste… I mean how can we say we're traditional if we're cooking in palm oil or rapeseed oil?"

Healthy behaviours and food choices were consistently described by the fast food vendors as individual responsibilities. Every vendor I spoke to felt they already provided opportunities for healthy eating, but that customers who purchase the less healthy options would not change their food preferences. In addition, most food shops I visited had a well-developed sense of niche, which was implicated in the argument for offering only certain types of foods and not others.

"People prefer to go to a sandwich shop for sandwiches and come to a chipper for chipper food… they're not coming here because they want fruit."

The shop owners felt that they needed to respond to customer demand in order to keep their clients, as competition was harsh and their fear of losing business was tangible. They described a constant struggle to cope with the economic pressure of rising food costs and tightening profit margins. Adding to the burden were more deeply-rooted and enduring characteristics of the neighbourhoods in which they did business.

"The prices have gone up so much where our profit margin... we're just barely making a profit just now. If we were anywhere else we'd be able to charge more, but in [this neighbourhood], most of our customers are on a limited budget. We're just pared right down to the bone."

In many cases, price was viewed as a major barrier to offering healthier options to current clientele.

"I don't allow my kids to have fizzy juice, so I dinnae really like having it. I'd like to buy fresh juice, but it's so expensive, you wouldn't make any money. With the price you would have to charge, they would nae want to buy it."

Furthermore, most of the fast food vendors I spoke to were not keen to seek publicity for healthy menu options, as they did not feel it would have any positive impact on their business or customers' perceptions.

"If you're sitting on Princes Street, posh people walking in and they see this [Healthy Living Award2] sticker in the window: yes, they pick like that. Yes, it does matter, because they want to see those sort of things. But the area we live in... they don't care what you display."

TAKE HOME MESSAGE:

Independent food shops in lower-income areas may face more barriers to offering healthy food choices than those in other areas. Voluntary guidelines for healthy menus may inadvertently exclude shops in more deprived neighbourhoods from participation, potentially widening current inequalities.

This study was funded by the Scottish School of Public Health Research.

Supporting Healthy Choices: A draft framework for voluntary action. Scottish Government; May 2013. Available at ***http://www.scotland.gov.uk/Resource/0042/00422516.pdf.***

Healthy Living Award. NHS Health Scotland. Available at ***http://www.healthylivingaward.co.uk/.***

Donald Henderson, Head of Public Health Division, Scottish Government

Donald Henderson has been Head of Public Health Policy at The Scottish Government since June 2011, leading the Scottish Government's response in Scotland to alcohol abuse, smoking, obesity and diet, and public health risks such as immunisation programmes, and blood borne diseases.

How did you first become involved in public health?
It wasn't part of some long considered career path. The civil service often works in weird and wonderful ways. I was finishing my previous post in Brussels after 3 years there and was talking to people about

> *"In many ways this is a tougher nut to crack than previous public health challenges,*

my next post. At the same time Derek Feely, then Chief Executive of the NHS in Scotland, and Harry Burns were looking for someone to head the Public Health team in Edinburgh. Derek thought I had the skills for the job. As it happened Harry Burns was trying to get me to offer me the post on the same day as I was trying to get him to talk about what we were going to be doing with minimum pricing for alcohol following the 2011 election.

What do you think is/are the biggest challenge(s) for Scotland in terms of public health?
I'm not alone in thinking that non communicable disease is the main challenge. involving complex consumer behaviour change and the severing of inter-generational transmission which is so evident in too many of our communities.

How do you think this/these challenge(s) can be solved?
Complex problems never have a simple or single solution. We have to work over the long term to further improve people's understanding of how their behaviour contributes to health risks, but also continue to work with business and retailers so that they understand the impact their products are having, what alternatives could be offered while still leaving them with a profitable business. Lastly and very selectively, we will need to continue to look at the affordability, acceptability and availability of the products or behaviours which are most injurious to health.

Should researchers be public health advocates?

If what is meant is advocating the benefits of positive health, certainly. But I am personally more wary of researchers using advocacy against the causes of bad health. Researchers need to be able to present facts and be trusted that their evidence is not skewed one way or the other. That is not to say that researchers should exist in a moral vacuum, but they have a different role than pressure groups or lobbyists.

What is the piece of work you are most proud of?

So much. We are making a real difference in the areas of tobacco control (having the strictest display regulations in the UK; continuing to press for legislation on standardised packaging even when that was a less popular policy in some other parts of the UK; the strength and comprehensiveness of our tobacco strategy). Minimum price for alcohol remains one of the most innovative health improvement policies being pursued anywhere in the world. We work hard to use the leverage a nation of 5 million can have on food production and retailing. Scotland's recent work in improving organ donation and transplantation rates has transformed lives. In health protection, the huge expansion in immunisations – pertussis in pregnant women, rota virus in young children, zoster in older people etc – is making a real difference to people's lives. I could go on. I am immensely proud of the work that is done in the various public health teams in Scottish Government.

What would people be surprised to know about you?

That I can never think of anything to say when asked what would surprise others about me..

What do you do when you're not working?

I splash in puddles with my 2 year old (touchingly, she thinks that's what I do at work as well).

healthier scotland
SCOTTISH GOVERNMENT

STAND YOUNG SCOTS TACKLING ALCOHOL AND DRUGS

Mentor and SCPHRP are delighted to launch the 2nd year of The Young STAND Awards 2014.

On 10 June at Edinburgh's prestigious Royal Lyceum Theatre, Mentor and SCPHRP will launch the 2nd year of The Young STAND Awards (Scots Tackling Alcohol and Drugs).

The Young STAND Awards is an innovative awards scheme aimed at recognising and rewarding projects in Scotland that can help prevent children and young people from misusing alcohol and drugs – both now and in their future lives.

We believe that these projects deserve recognition for their hard work and it enables us to share practice about what works in helping to make a real difference in young people's lives across the country.

Projects might be as diverse as, for example, young people developing their own websites, classroom work in schools, sports schemes, drama or mentoring projects in the community.

Awards will be made in two categories:

- for work in schools
- for work in the community

Last year's awards witnessed an extensive range of inspiring projects from across Scotland which highlighted the value of youth involvement. The top 6 of these wowed our selection panel at our Awards event in Edinburgh.

Last year's winners were DRC Generations and The BIG ShoutER. For more information about the 2013 Awards go to *https://www.scphrp.ac.uk/stand.*

SCPHRP Scottish Collaboration for Public Health Research & Policy
Mentor

What is data linkage?

The term 'data linkage' refers to the connection of data about an individual, institution or area from at least two sources (e.g. health service and educational records). The purpose of such data linkage is usually for research or service planning.

Take 5 minutes … with SCPHRP's Andrew Williams and DATA LINKAGE

Why does data need to be linked?

Our health is not purely determined by our internal biology and genetics but by the social context and environment within which we live (Dahlgren and Whitehead, 2007; Lyons et al., 2013). There is therefore a need to research the influence of factors like education, employment and housing on health, but no single agency routinely collects data on all these factors and health. Consequently, data linkage enables data from several agencies to be brought together, so that, for example the social determinants of health can be researched without the need for bespoke data collection.

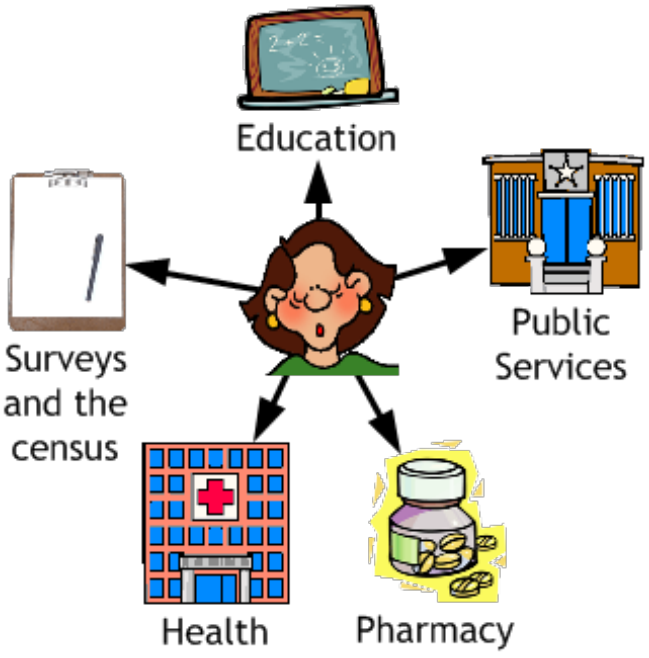


Image 1:The multitude of data collected about us

What are the advantages and disadvantages of data linkage?

ADVANTAGES:

- It is possible to analyse data on a wide variety of factors from a large number of people.
- It can be possible to research factors and people across long periods of time (longitudinally).
- As data are routinely collected certain ethnic and socioeconomic groups which are hard to reach using normal research methods are included.
- Cheaper than primary data collection.

DISADVANTAGES:

- Data linkage is only useful where suitable routinely collected data are available.
- There are problems with evaluating interventions using observational data *(see my article in the Autumn/Winter 2013 SCPHRP Magazine pages 4&5).*

How have linked data been used?

There are many uses for linked data, listed below are a few illustrative examples from across the United Kingdom.

- To generate cohorts of people in order to explore; the health of people in specific circumstances or with specific conditions (e.g. Walker et al., 2013), health across generations (e.g. Reynolds et al., 2013), the impact of life events (e.g. MacKay et al., 2010) or circumstances on health and related outcomes.
- Evaluating interventions related to clinical (e.g. Payne et al., 2014) and public health (e.g. Fone et al., 2012) practice.

How is data linked?

The ScottisH Informatics Programme (SHIP) has seen Scotland has taken the lead on data linkage in the United Kingdom. The decision in Scotland in the 1970s to allocate every person registered with a general practice a unique centrally maintained identifier known as the Community Health Index (CHI), enables the linking of health data. While personal identifiers like name, date of birth, address can then be used to link health data to other sources e.g. education (Wood et al., 2013). However, it is not appropriate for these personal data to be shared outside of the organisation which collected the data. Subsequently a secure linkage process was developed within SHIP which is now facilitated by the Electronic Data Research and Innovation Service (eDRIS). The secure linkage service ensures accurate linkage while maintaining patient confidentiality to generate anonymised data sets, further details of the process can be found on the SHIP website.

Furthermore researchers wishing to use linked data are required to have passed a course in information governance, and have been given permission by the data custodians (Caldicott Guardians), ethics committee and Privacy Advisory Committee (PAC).

Therefore the public should be reassured that every effort is made by academic institutions and public bodies to protect their rights and confidentiality.

Image 2: Data linkage

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USEFUL WEBSITES

Administrative Data Liaison Service: *http://www.adls.ac.uk/* **eDRIS:** *http://www.isdscotland.org/Products-and-Services/EDRIS/* **Farr Institute @ Scotland:** *http://www.farrinstitute.org/centre/Scotland/3_About.html*
PAC: *http://www.nhsnss.org/pages/corporate/privacy_advisory_committee.php* **SHIP:** *http://www.scot-ship.ac.uk/*

HEALTH WARNINGS FROM 'THATCHERISM' IN A TIME OF 'AUSTERITY'

An article from Kat Smith, Global Public Health Unit at Edinburgh University

The Spanish philosopher, poet and novelist George Santayana (1863-1952), famously remarked that 'those who cannot learn from history are doomed to repeat it'. Yet public health, which draws on a wide range of methods and disciplines, appears to have been remarkably reticent at learning lessons from historical experiences. Whilst policy case studies from the past can never offer precise predictions regarding the impact of contemporary or future policy changes, they can provide broad lessons about the likely impacts of combinations of particular kinds of policies.

With this in mind, Alex Scott Samuel, Clare Bambra, Chik Collins, David Hunter, Gerry McCartney and I recently published an article in the International Journal of Health Services which analyses the health impacts of the policies implemented under Margaret Thatcher (UK Prime Minister from 1979-1990). We argue not only that a better understanding of the impacts of these large-scale policy changes can help us understand the public health burdens we are dealing with today, but also that this period of history offers some compelling lessons regarding the likely health impacts of the reforms currently being implemented under the banner of 'austerity'.

To assess the impacts of the multitude of political, economic and social changes associated with 'Thatcherism' **(see Box 1)** we sourced data from over 70 existing research papers, many of which focused on the impacts of more specific policy changes in this era and/or examined a range of public health statistics. Considered collectively, these various sources indicate that, as a result of unnecessary unemployment, welfare cuts and damaging housing policies, the former prime minister's legacy "includes the unnecessary and unjust premature death of many British citizens, together with a substantial and continuing burden of suffering and loss of well-being." Examples of the damaging health impacts include the rise in chronic liver disease and cirrhosis which, towards the end of the 1980s, had risen to around 500 excess deaths. There was also a rise in deaths resulting from drug use, violence and suicide. These examples are likely to represent just the tip of an immense iceberg of sickness and suffering resulting from the policies implemented under Thatcher.

Box 1: Summary of key policy changes implemented under Thatcher

- Deregulation of labour and financial markets (including the "Big Bang" deregulation of the City of London in 1986);
- Privatization and marketization of the main utilities (water, gas, and electricity) and state enterprises (e.g., British Steel, British Rail, and British Airways);
- Promotion of home ownership (including the widespread sale of public housing stock under the "right to buy" scheme);
- Curtailing of workers' and trade union rights;
- Promotion of free-market ideology in all areas of public life (including health care and the civil service);
- Significant cuts to the social wage via welfare state retrenchment (e.g. removal of 16- to 18-year-olds from entitlement and reductions in state pensions);
- Acceptance of mass unemployment as a price worth paying for the above policies; and
- Large tax cuts for the business sector and the most affluent (e.g., during Thatcher's premiership, the rate of income tax for the top tax bracket was reduced from 83% to 40%).

The article also cites evidence regarding the increase in income inequality that occurred under Thatcher: the richest 0.01% of society had 28 times the mean national average income in 1978 but 70 times the average in 1990, and the rise in UK poverty rates from 6.7% in 1975 to 12% in 1985. It argues that Thatcher's governments "wilfully engineered an economic catastrophe across large parts of Britain" by dismantling traditional industries such as coal and steel. This ultimately fed through into growing regional disparities in health standards and life expectancy, as well as greatly increased inequalities between the richest and poorest in society.

Although Thatcher's governments famously felt constrained in terms of how they could reform the NHS (due to widespread public support for the service), they were able to introduce market principles into NHS management. They also outsourced hospital cleaners which removed "a friendly, reassuring presence" from hospital wards and, over time, contributed to increases in hospital acquired infections. These kinds of reforms laid the ground for the growing involvement of the private sector under future governments.

Overall, it seems clear that Thatcher's wholesale changes to the British economy, combined with revisions to social, welfare and health policies, created massive regional and social inequalities. These changes are continuing to have a direct impact on people's health and many of the policies being pursued by the current UK Coalition government suggest history is now repeating.

Writing for a general audience *by Renee Ingram*

Writing for a general audience is an important part of making sure your work becomes relevant beyond the walls of academia. Yet, it can be a struggle to explain complex ideas to those without knowledge of the topic area.

Below you will find some advice on ways to effectively and clearly communicate your ideas to the public.

No Waffle:

The key to effectively conveying your message is to cut the 'waffle'. This means getting rid of any words which do not contribute to the delivery of information. For instance:

"The Unsolicited Electronic Messages Act is currently under legislative review. It is hoped that the review will be completed by late June 2014"

Could be communicated as:

"The projected completion date of the Unsolicited Electronic Messages Act legislative review is late June 2014."

Assume that your reader is time-poor and try to deliver your information in a quick and clear way. Ask yourself: "is every word necessary?" and "does the reader need to know this?".

Lay Your Cards on the Table:

It is better to reveal your cards upfront and all at once, than to reveal them slowly. Put your conclusions in the introduction of your piece. Doing so will help you structure your article, and will help 'set the scene' for your reader.

You should refer back to the introduction often to make sure you are delivering the information you set out to provide. This will help you avoid 'waffle' and keep you on point.

Be Your Own Editor/The Red Pen is Your Friend:

It can be difficult to cut a sentence, or paragraph, that to you reads beautifully but does not convey information that the reader needs. In these situations you should try to detach yourself from the writing and become 'The Editor'. Pretend you have been handed an article and asked to ensure it is both succinct and faithful to the points outlined in the introduction.

Now, find a red pen and start crossing things out or putting comments in the margins ("is this relevant?"... "explain"... "so what?" etc.), just like an editor would.

Your Friend is Intelligent But No Expert:

You should not 'dumb down' your article, or neglect to include relevant information, because you assume your audience won't understand. Instead, you need to be willing to explain concepts clearly.

Pretend you are explaining your work to a friend who is capable of broadly understanding concepts and drawing informed conclusions but is unfamiliar with the subject area - what would you say to them? What examples would you use to explain your work? Use this as a guide for communicating with your audience.

The SCPHRP team writing retreat 13th-16th April 2014

SCPHRP retreated to the Perthshire countryside recently, to find inspiration and peace to catch up on their academic writing and other writing activities that are often difficult to finish in the normal working day. Everyone came armed with a computer, a backlog of writing, and a contribution to the event including home baking, knitting and meditation techniques. The days began with early morning meditation in the hayloft, followed by breakfast and then a period of writing, interspersed with walks along the river Tay, or birdwatching in the local area. In the evenings we all cooked together and then relaxed by playing games.

It was a great team building event, as well as being a productive time for all of us.

And many thanks to Michelle for these great photos.

colour

image by Michele Estrade

noun

1. the property possessed by an object of producing different sensations on the eye as a result of the way it reflects or emits light.
   synonyms: hue, shade, tint, tone, tinge, cast, tincture

We all live in a world where at some point, colour will be a part of, and effect us in our every day lives. Colour in everyday life is very diverse, from knowing that a fruit is ripe to eat, to understanding how Colour can affect our moods.

"Colour is fun, colour is just plain gorgeous, a gourmet meal for the eye, the window of the soul." Rachel Wolf