

The Oxford Health Alliance: old problems, new approaches

One way to tackle social forces that lead to disease is to recruit the putative culprits

The world is in the grip of an epidemic of non-communicable disease. We have known this in affluent nations for decades, but have not understood just how large a problem it has become in developing economies.¹ Chronic diseases such as cardiovascular disease (CVD), type 2 diabetes, cancer and obstructive pulmonary disease are increasingly undermining prospects for a stable economic future, especially in lower- and middle-income countries^{2,3} and the poorer segments of society in the developed world.

The origins of these diseases are largely social. What and how much we eat, how physically active we are, and whether we smoke are individual behaviours that we might wish to change but which emerge from a maze of causes, including our job, school, suburb, education, religion, car, and money. Philosophers refer to “wicked” problems — ones of great complexity to which there are no simple or stable solutions⁴ — and non-communicable disease is as wicked as the White Witch, and then some. If only there was a vaccine, if only there was one drug, if only. . .

Yet an inventory of our assets in dealing with these diseases is far from depressing. We Australians have quit smoking in droves; we have developed medical and surgical approaches that stabilise risk and more than halved mortality from CVD.⁵ We have moved death from heart disease from middle to old age. Supermarket shelves relax with the reduced weight of “lite” foods. The success bears scrutiny. Some of it is medical (antihypertensives, lipid-lowering therapies, coronary artery bypass surgery, newer antidepressants, chemotherapy), but not all. Some of it is due to relentless health promotion (Life. Be in it; Quit for life), but not all. Some of it is due to regulation (tobacco tax, seatbelts, and urban planning taxes on developers devoted to healthy suburbs). Some is due to commerce and industry sensing a market advantage in selling healthy products.

On 28 November 2005, the Australian Health Policy Institute at the University of Sydney launched its membership as a major centre in the Oxford Health Alliance. The purpose of the Oxford Health Alliance is to influence the macroeconomic and policy environment to favour fitness, good nutrition and reduced smoking, accepting that these behaviours are social as well as personal phenomena that require community involvement in the widest possible sense.⁶ The Alliance seeks to capitalise on research and to build a global partnership to pursue its mission. It aims to assist institutions, including the World Health Organization, control non-communicable chronic disease. What is unique about the Oxford Health Alliance is its inclusive nature. The Alliance includes not only academia and government, but the private sector and a host of non-government organisations.

The Oxford Health Alliance was established under an academic–industry partnership between the University of Oxford and Novo Nordisk, Denmark, a company whose pharmaceutical branch produces insulin. Novo Nordisk looked with Scandinavian horror upon the rising rates of diabetes worldwide, despite these being excellent for their bottom line. In combination with Professors John Bell and David Matthews at Oxford University and Professor Derek Yach, formerly director of the non-communicable disease cluster at WHO but now working at the Rockefeller Foundation, the nascent Oxford Health Alliance has begun to explore ways to reduce the epidemic of chronic disease. John Bell is Regius Professor of Clinical Medicine at the University of Oxford. As Nuffield Professor of Clinical Medicine, he oversaw the largest research department at Oxford University, which encompassed activities spanning structural biology through to epidemiology. David Matthews is Chairman of the Oxford Centre for Diabetes, Endocrinology and Metabolism and has published extensively in the fields of insulin resistance.

The Alliance has grown steadily. It has supported three annual 3-day conferences: two at Oxford, and one on 31 October 2005 at Yale in New Haven, Connecticut, where 170 people from 25 countries assembled, from a diverse array of backgrounds, including academia, government, the private sector (PepsiCo, Nestlé, McDonalds), non-government organisations, finance and media, consumer organisations, and professional bodies such as the World Nursing Federation, World Medical Association and World Heart Federation. Topics covered included the economic rationale for investing in chronic disease prevention, patient power, the intersection between health and business, the current framing of chronic diseases in the international agenda, and design for a healthy world.

“Oh, my!” said one colleague when he heard that the University of Sydney, through its health policy institute, was joining the Alliance. “So! The Oxford Health Alliance has discovered nutrition!” Fair enough: knowing about risk factors and behaviour is hardly new. The starting point for the Alliance is exactly that: that “discovery” is not enough. Knowing about the nature of risk factors for chronic disease is akin to realising that the pain in your foot is due to an elephant standing on it — moving the elephant is another matter entirely.

Our purpose in the Oxford Health Alliance is to bring to the table those businesses and non-medical interests that traditionally have been seen as the Dark Side. This is not about “selling out to industry”, but seeking points of agreement whereby what is done in future is less harmful to health. Academics at the Alliance meetings have enjoyed beating up the representatives from

McDonalds and PepsiCo: this is a familiar and exciting, if useless, attempt at solving problems. At the meeting at Yale, the baiting had subsided somewhat, especially in response to an impressive list of marketing and product formulation changes presented by industry representatives. McDonalds, for example, now buys more apples than any restaurant chain in the United States.⁷ In Australia, it has introduced a range of salads and now cooks with canola oil. *The Economist*, commenting on PepsiCo’s rising economic fortunes that put it ahead of Coca-Cola for the first time, notes PepsiCo’s diversification “away from a reliance on sugary colas”, deriving only 20% of its revenue from soft drinks, in comparison with 80% at Coca-Cola.⁸

Of course there is a risk: skills in Defence against the Dark Arts would be helpful. (By contrast to big business, academia is, we all know, blessedly free of self-interest — and it rarely makes a profit!) But if we are seeking to modify the major social forces that entrain damage and cause chronic disease, new ways must be found to do this by recruiting the putative culprits. The answer will probably be expressed as policy — a practical, feasible commitment of many players, amid muddle and ambiguity, to a course of action to mitigate a wicked problem. It is a messy process. But for the Oxford Health Alliance, it is core business.

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- 6 The Oxford Health Alliance [website]. Available at: <http://www.oxha.org/> (accessed Jan 2006).
- 7 McDonalds grabs a piece of the apple pie. *The Guardian* [Manchester] 2005; 23 March. Available at: <http://www.guardian.co.uk/food/Story/0,2763,1443677,00.html> (accessed Jan 2006).
- 8 Things go worse with Coke. *The Economist* 2005; 14 Dec. Available at: http://www.economist.com/business/displayStory.cfm?story_id=5308326 (accessed Jan 2006). □

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