Public Health Guidelines:

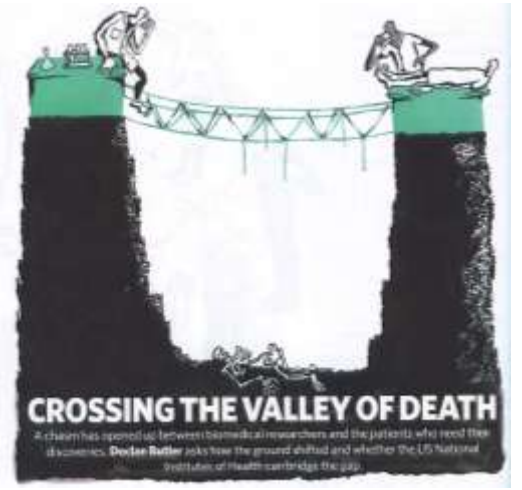
a need for international standards?

Professor John McCallum, HEAD

Research Translation Group NHMRC

Canberra AUSTRALIA

Our task is to bridge the gulf between Research and Health Practice



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PUBLIC HEALTH EVIDENCE IS DIVERSE IN TOPIC, SCIENCE, METHOD AND VOLUME

1. Some is very like clinical evidence: based on exact data, with sufficient good studies for meta-analyses, addresses professionalised groups in well organised workplaces eg *levels of lead in the environment, epidemics and health protection of the population*
2. Others are not so well researched but have less good quality data but it can be worked with like *Diet* or *homeopathy* without a 'disciplined' profession
3. However still others like *health effects of wind turbines* have very limited evidence and no possibility of consensus statements.

HOW CAN AN INTERNATIONAL COLLABORATION WORK TO IMPROVE TRANSLATION & WITH WHAT FOCUS?

CASE 1: AUSTRALIAN DIETARY GUIDELINES: (1) Sources of Evidence

1. Previous Dietary Guidelines
2. Targeted questions in a commissioned literature review
3. High quality new articles that appeared after the lit review
4. Government reports – grey evidence

THEN TECHNICAL BASES

1. Australia and New Zealand Nutrient Reference Values
2. A Modelling System - nutrients to whole foods

The evidence base is complex, historically and technically 'layered' – typical for 'big' PH guidelines
Complex evidence is an easy target for disputes!

AUSTRALIAN DIETARY GUIDELINES: (2) grading the body of evidence

The body of evidence for 'a topic' was Graded from A to D on the basis of: quantity, level and quality of evidence , consistency of results; clinical impact; generalisability; and applicability in Australia – our Australian NHMRC Processes since 1999:

A = the body of evidence can be trusted to guide practice

B = the body of evidence can be trusted to guide practice in most situations

C = the body of evidence provides some support for the recommendations but care should be taken in it's application

D = the body of evidence is weak and any recommendations must be applied with caution.

Note: Level D was not used in recommendations but is useful for 'myth busting'. and was included when there were 5+ publications

CASE 2: HEALTH IMPACTS OF WIND TURBINES

Characteristics of the evidence base:

1. A 'new' technology and a new field of research
2. Complex health conditions claimed – restlessness, sleep apnoea, depression, elevated Blood Pressure
3. Potential mechanisms are new and controversial – infra-sound
4. Accoustic epidemiology and measurement are limited
5. Very little peer-reviewed, published evidence,
6. A lot of peer reviewed research is industry funded by necessity
7. Some high profile publications were not peer reviewed,
8. No chance of consensus between groups

What do we do when absence of evidence for effects is immediately interpreted as evidence of absence of effects?

The case for accepted international standards for Guidelines

Dietary Guidelines: (1) have been criticised in the press and media and they haven't been released! – on suspicion and speculation!

2. Some interested parties are engaged in 'disinformation'

3. The negative reporting has impacted on government funders

1.The Guidelines would be more defensible legally and politically if they meet accepted international standards

& Wind Turbines

1. Those opposed to wind turbines criticised the NHMRC and went Parliamentary Committee of Inquiry

2. Land values are being affected by nearby turbines – not health?

3. Industry used our Statement as support around the world

If they're used internationally they should meet international standards!

What international standards do we want? Our priorities?

1. **Different standards for different themes:** (1) for Dietary Guidelines around WHO and (2) for emerging areas with little literature?
2. Consistency in evidence tables and recommendations would assist translation to different countries
3. **Just do evidence tables to international standards and let people do their own thing**

   In a global health setting we should meet international standards! But this is complex for public health.

"I often say a great doctor kills more people than a great general"
Baron Gottfried Wilhelm von Leibnitz 1646-1716

AND THAT'S WHY WE NEED TO IMPLEMENT GUIDELINES! EVEN A GREAT DOCTOR CAN'T DO IT STANDING ALONE.