STAKEHOLDER NARRATIVES OF ‘PROBLEMS’ AND ‘SOLUTIONS’: ANALYSING THE 2018 HEALTH AND SOCIAL CARE COMMITTEE ANTIMICROBIAL RESISTANCE SUBMISSIONS IN THE UNITED KINGDOM

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We identified the dominant and biosecurity narratives that were used by the various actors who submitted evidence. We then compared the narratives, framing, and language used by the private sector with public and third sectors, and academia. We subsequently analysed the three main promoted remedies to the AMR problem and categorised them within a ‘market paradox’ framework.

We found that, irrespective of sector, the submissions presented the problem of AMR similarly. The solutions, however, diverged dramatically. The relevant industries use particular discursive strategies to achieve their aims, including the development of market paradoxical positions; on the one hand, asking for subsidies and incentives, but on the other hand explaining that regulation would be detrimental to ‘innovation’. We expand on these paradoxes, and catalogue the tactics used to achieve them discursively, including: obfuscating funding sources, stake inoculation, and lobbying for influence. Learnings from the unhealthy commodities industry allowed us to critically appraise the framing of industries involved in AMR.

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OP60  NATIONAL IMPLEMENTATION OF AN INTEGRATED DIABETES PROGRAMME IN IRELAND: REALIST EVALUATION

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Background ‘Integrated care’ for chronic conditions is considered central to international health system reform. However, models of integrated care work differently in different circumstances. In Ireland, the National Diabetes Programme aimed to integrate diabetes care across primary, secondary and tertiary settings based on patient complexity through the introduction of new clinical posts and guidance for diabetes care. We conducted a realist evaluation to determine how and why the implementation of the programme worked (or not) across the country.

Methods Through documentary analysis and qualitative interviews (n=19) with a purposive sample of national stakeholders, we developed an initial theory on how the programme was expected to work. We then refined this theory in semi-structured interviews (n=39) with professionals purposively sampled to represent different clinical disciplines involved in implementation. We applied a realist logic of analysis and synthesis to iteratively build CMO configurations.

Results National stakeholders assumed that: 1) introducing guidance would formalise and standardise how care was provided, 2) that professionals would ‘buy in’ and align their work with new ways of working, and 3) that the new clinical posts would become catalysts for service changes at local level. At a national level, important contexts included varying levels of awareness about the programme, no plan for communicating service changes, and no established approach to implementation or professional oversight. Locally, experience delivering diabetes care, resource demands and familiarity with the intended purpose of the new clinical posts were important contextual factors. The extent to which integrated care was adopted and implemented depended on judgements made by health professionals (GPs, nurses, specialists and podiatrists) working in these contexts, specifically; judging the relative advantage of the programme and whether to engage in negotiations to legitimise their roles in diabetes care.
Conclusion Theory-based evaluations are better equipped to deal with the complexity of introducing multi-component interventions into dynamic health systems. This study suggests that, given a disconnect between responsibility for programme design and implementation, in the absence of systematic communication about the nature of changes and lack of clarity around governance and reporting structures, professionals used their judgment to adopt, implement and adapt interventions to match their priorities and circumstances.

Background The term ‘Nanny State’ has become a more prominent theme in debates on public health and policy across all media platforms. Arguments reflect both valid and less valid concerns about the government’s role to protect and promote the public’s health. However, there is limited research on how the term is portrayed in the media and how this may influence public opinion and thus political action. To better understand the role of the media in this debate, we therefore analyzed the portrayal and usage of the term ‘Nanny State’ in UK print and online media articles in relation to food, alcohol and tobacco; in order to identify key messages, and determine the implications for public health policy and advocacy.

Methods Using the Nexis UK Database, we conducted a systematic media analysis of all relevant articles that mentioned ‘Nanny State’, ‘Nanny Statism’ or synonyms in the 5.5-year period from January 2014 to June 2019. Articles that met the inclusion criteria were coded in Excel using a pre-piloted, two-part coding framework. We undertook a content analysis to examine and compare the major themes, key messages, prominence and slant, and how Nanny State was argued for or against in the articles.

Results We identified 265 articles published between January 2014 and June 2019 in 13 different mainstream national newspapers and their Sunday counterparts. 186 articles met full inclusion criteria and 79 (30%) were excluded for lack of relevance. Coverage was greatest in 2016, with three peaks coinciding with major public health announcements. Fiscal interventions into dynamic health systems. This study suggests that, given a disconnect between responsibility for programme design and implementation, in the absence of systematic communication about the nature of changes and lack of clarity around governance and reporting structures, professionals used their judgment to adopt, implement and adapt interventions to match their priorities and circumstances.

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