Health is Wealth

A Fast Start for
A Covenant for Health

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Preface

In July 2023 our team published *A Covenant for Health*, suggesting how to improve the health of England in five to ten years[1]. This report, *Health is Wealth*, sets out an early action plan on how any new government could make a rapid start to do so[2].

Our nation's poor health damages lives, communities, and our economy. We can no longer ignore acting on this. The good news is that it is possible to improve this and rapidly.

A five-year term is short, so any government that wants to promote a healthier nation needs to start fast, to know what is most important and how to address these priorities. This report suggests 100-day and first-year action plans for doing so.

Our report has not been requested by any political party, though we hope its conclusions would be supported by all of them. It is written to stimulate thinking and action by charities, policy organisations, national bodies, local authorities, civil servants and politicians about a realistic and rapid agenda for change.

The report has been built with great support from many people and organisations, and we are extremely grateful to them, see Appendix 1. These organisations will be key partners to make our nation healthier, so it is excellent that there is a consensus on these priorities. This provides the basis for an alliance across society for change – *A Covenant for Health*.

We will discuss the recommendations with a wide range of people and organisations, to promote a coalition for change and offer support for action to any willing government.

I warmly thank my colleagues who have contributed to this report and Sarah Woolnough, Chief Executive of The King's Fund for her support. See Appendix 2.

Our report is a plea to reject fatalism. We do indeed face demographic, economic and fiscal challenges with increasing demands to treat ill-health. But these must be seen as headwinds not immutable fate. We may not be able to solve all problems but with the courage to act on an agenda similar to our proposals we can help millions of people to have healthier lives and create a better future for our children. It is possible to do so, and it is essential.

Geoffrey Filkin
April 2024

Summary

Health is Wealth but our unhealthy nation leads to damaged lives, and to a smaller workforce, lower growth, and higher costs for health, and welfare. The public are looking for much stronger action to address this[3]. Early in its first year the Prime Minister should host an inspiring launch to show how by working together our society can change this and set out the trajectory for doing so.

Workforce: Three million people are now off work and claiming sickness benefit, with another million forecast by 2029, reducing both our labour supply and tax revenues. To redress this, we must intervene much earlier, to help our children and people in their 20s, 30s and 40s at risk, who smoke, are overweight, have high blood pressure and are inactive, and so risk dropping out of work.

Partners: The mission to change this should be launched as a pan-society goal with explicit support from key partners: civil society, other tiers of government, willing businesses, and the NHS.

The Launch: This should set out how we can live longer in good health if we create healthier environments, a healthier food system, address key risks to our health and focus on our children and the places where health is worst. Policies should apply everywhere; scarce expenditure must be deployed where it is most needed. Agreed priorities are essential.

Five Top Priorities: These five below are possible, affordable, and are well supported. They will generate great benefits. They require investment, innovation, and political backing:

- **Early detection** – detect and treat risks much earlier, including weight, and cardiovascular disease
- **A smoke-free UK** – help every smoker who wants to quit to do so over ten years
- **Healthy food for all** – transform the health of our food environment to prevent obesity
- **A happy, healthy childhood** – so children grow up in good health with healthy lifestyles
- **Leave no one behind** – help people and places with the worst health to live well for longer.

Existing programmes for alcohol, inactivity, mental health, and clean air all need to be accelerated.

Central Government Leadership: The Prime Minister and Chancellor need to affirm their commitment to a healthier nation, that it is essential and relevant across society and across government. A **Healthy Lives Mission Board** should be formed, with key partners, chaired by the Prime Minister.

The Treasury itself needs to become an Agent for Health and use fiscal stimuli to reformulate our food system[4]; reinforce departmental actions; make polluters pay for treating their

harms, not taxpayers; review the five year pay-back rule to ease investments, and launch two initiatives:

- **A Health Transformation Fund** led by the Treasury to support joint departmental innovations to improve health and reduce health inequalities.
- **A Stern Review for Health and Wealth** to support a longer-term view of health, its contribution to economic growth, and how fiscal rules could better support investments for a healthier society and workforce. There are costs to improve population health, but they are smaller than the certain costs of treating the illnesses that could be prevented.

Introduction – Why Act Fast?

Health is Wealth, but our nation is not healthy, and this is unaffordable. It leads to a smaller workforce, lower tax revenues, lower growth, higher demand for health, care, and welfare, and lower productivity. Yet the vast majority of this harm is preventable.

Poor health degrades both the wealth of the nation and individuals' wealth and well-being. The OBR forecasts that the increasing costs of treating illnesses may overwhelm public finances over the next two decades. Poor health reduces the working population, another one million people are forecast to be out of work for health reasons by 2029. This is a social and economic crisis.

Illnesses, many avoidable, reduce our ability to earn, enjoy life, and harm our communities. Preventable illnesses consume far too much NHS resource, and demand will grow with a larger older population. The NHS's late-stage intervention model has failed.

We also face demographic headwinds, the number of people of pensionable age for every 1,000 of working age will increase by 22% in twenty years time; so there will be fewer people to fund pensions and care[5].

The public are looking for stronger action by businesses, communities and government to address this[6]. *Helping people to live in good health for longer is the goal.* It is entirely realistic[7]. Systematically preventing or delaying illnesses until later in life will benefit many of us and reduce our dependency.

A fast start is essential, change is possible, most of these harms are preventable with resolute action – see past successes on clean air, smoking, vaccinations, teenage pregnancies and sexual health. Acting strongly will demonstrate the UK's progress to the UN high-level meeting on noncommunicable diseases in 2025, and to achieving health-related Sustainable Development Goals for Agenda 2030.

This report sets out a blueprint for actions over the first 100 days and the first year of any new government. It has three sections: 1. Launching the Mission; 2. Priorities for a Healthier, Wealthier Nation; 3. Central Government Leadership.

1 Launching the Mission

An inspiring launch is needed in the first 100 days, with a clear sense of direction that highlights the benefits to people and communities. It will need a strong signal from the Prime Minister that this will be a key mission for a new government for five years and longer. Government alone cannot fix the problem, it will require action across society, by business, and by us all as individuals. It will need a commitment by central government to promote this across government plus the devolution of powers and resources to communities to empower local actors.

This positive ambition will help millions of us to be healthy for longer, have a happier life and contribute more, with lower risks of cancer, diabetes, stroke, heart attacks, and dementia. The economy will be stronger, with healthier and more prosperous communities.

So, the launch might suggest that by 2030 our society should aim to have helped 3 million people stop smoking, 300,000 to avoid heart attacks and stroke; up to 4 million to avoid living with obesity, and a generation of our children to have a better future.

Partners for Health

The mission can only be achieved by action across society, so it should be launched as a pan-society goal, not a government project, and with explicit support from the key partners:

- **Each of us** – we all are agents of change, if enabled to live well
- **Civil Society** – communities, charities, faith groups are all vital
- **Places** – Local Authorities building a local ambition for health, convening others to act
- **The NHS** – pivot to prevent and arrest illnesses much more, not just treat them
- **Business** – great power to shape our commercial environments.

Central government itself has a key role, setting the ambition, supporting partners, legislating and developing national policies. But wherever possible the mission should be led locally, in local partnerships with local public support.

The mission launch should set **a vision and targets for society's health** in five to ten years. It should confront the myth that the NHS can make us healthy and that more money and more doctors treating illnesses is alone the answer – we need to prevent illnesses, not just treat them. We need to change the culture around health and give the nation confidence that something can be done, to give energy and support to individual and community actions.

This is an ongoing mission for many years, so build support for it across all parties and all the nations – the UK-wide support for the Tobacco and Vaping Bill shows the benefit from doing so.

Government at the launch should:

- Propose the overall vision and ambition for society and government
- Offer partnerships with the key actors
- Form a **'Health Partnership Board'** with the key partners[8]
- Commit to take the key actions that only government can do.

Ministers too will need to break their addiction to specialist funds and micro-interventions and commit to push powers down to communities to make the interventions that suit people locally.

People

This mission should seek to empower people and support their agency. People want to decide themselves to live a healthy lifestyle, but they need enabling environments and action to address the vested interests which hamper their lives. Embracing preventative technologies, changing environments, for healthier food and more active lives, addressing the national culture around health will all be essential. Government should use citizen's assemblies and polling better to understand the public's priorities and their appetite for stronger action for health.

Government should propose the societal goal: **to make it easy to live well** and that it will act to make our physical, commercial and social environments healthy, to set national frameworks and goals, and to empower local actors. Ideally social movements will develop at local and national levels to reinforce this societal goal, a social movement for healthy eating, a social movement for physical activity, a social movement for change to a town's health, and that connect to people in the most deprived places. We also need to build political consensus and foster cross-party collaboration so that valuable initiatives are not undermined by cheap politics.

As well as the right environments, people need trusted information about how to improve their health. Myths, vaccine scares and snake oil promotions are rampant and harmful. The existing platforms for health information need to go much further, to maximise media and technology, and become a trusted brand, which promotes the information people want for themselves and their children, rebranded as *My Health, My Life*.

Civil Society

Our society has great charities, large foundations and much philanthropy and volunteering – 750,000 people offered to help during the Covid-19 pandemic. Government needs to recognise that actions across civil society will be fundamental for a healthier nation. Communities bring commitment, humanity and understanding to difficult challenges and give a sense of purpose and control, important for good mental wellbeing.

Government should commit at the launch to involve civil society for better health. Faith groups, sports clubs, parents' associations all need to become champions for the goal. Civil

society, fully engaged with healthier lives as a mission, will help develop shared ownership, solidarity, and commitment in way that government cannot.

Charities increasingly work in coalitions to promote health[9]. Many are well placed to inform policy and implementation from their grounded experience. Key charities should be joint partners, bringing lived experience into policy and implementation.

We need to recruit influential figures from the worlds of TV, sport and music to make the case to media and public and to those outside the mainstream of British life, and to challenge toxic narratives that block progress, like "nanny state".

Places

The places where we live and work can nurture health, but can also be harmful. *"We need an ambitious new local/central partnership based on clear and mutually respected roles with a clear unity of purpose"*[10]. Build this on three principles: local communities owning the goal; empowered local leaders free to lead; decentralised powers and resources[11].

Local authorities need more power and freedom to make their environments healthier, to reduce health-harming businesses such as hot food takeaways, gambling and all-night off-licences, and to play a powerful role in the nine topics in this report. Devolving powers, resources, and budgets is essential but will take time. In the meantime, government should agree shared objectives, offer multi-year settlements and build place-based partnerships.

Just Do What Works

NICE and WHO guidance exists on how to address smoking, obesity and unhealthy diets, alcohol harms, physical inactivity, and poor air quality. Government should set up a Working Group with NICE, LGA and ADPH to develop and promote this knowledge[12].

Central Government and the LGA should develop a health partnership accord on:

- The top five priorities, and how to achieve them
- The devolution needed, e.g., health as a fifth licencing objective
- How the LGA and local government will build public support for action
- How to engage the assets of communities and local partners.

The Troubled Families programme showed the value of joint central/local government work.

Business

The immediate crisis of our disappearing workforce has awoken employers and the Treasury to the severe problem of an unhealthy population; staff and skills are missing in all sectors. Toughening welfare eligibility will not fix this; we need to tackle the upstream causes of early exits.

Businesses large and small can have a positive impact on health; enlightened employers do offer benign environments; investors can contribute to healthy environments and products.

The priority for businesses is to help people keep well by ensuring workplaces are healthy. Britain is alone in losing so many vital workers to poor health since the pandemic.

Yet some businesses and sectors promote addictive products, have harsh work cultures or campaign to defend practices which harm our children. At the launch good businesses should show they recognise the moral and commercial case for a healthy population and the need to promote healthy products, and good employment practices. We need a new social contract with business to support a healthier society and workforce and that they will back the necessary changes.

There is a vast potential investment market to support health and intermediaries such as The Impact Investing Institute could help bring investment to make social impact for health.

NHS

We have a late-stage health system which neglects prevention and reducing health inequalities. The NHS still has 90% of its funding and focus on treating illness, with an entrenched clinical view that this is right. It responds to unplanned care demand, not focusing on secondary prevention. This is widely understood, but there is no clear plan to change it. Past efforts failed.

A government must have a plan to change this; we suggest this menu:

- A clear goal nationally and to all ICBs – to *focus on secondary prevention* and reduce chronic diseases with a shared understanding of how and a new focus on primary and community care.
- A clear goal nationally and to all ICBs – to *target the people and places who need it most.*
- New financial flows at ICS level to *reward these outcomes* and accountability for doing so through CQC inspection. See Appendix 3.

NHS/Local Government

There is an urgent need to clarify responsibilities for primary and secondary prevention, where to focus and who is accountable for impact. A comprehensive public health workforce strategy is also needed[13]. Local ICS/local government interventions must understand how to collaborate with a person with several risk factors, and not treat them from separate risk silos.

2 Priorities for a Healthier, Wealthier Nation

The launch should show how we can live longer in good health, if we have healthier environments, lifestyles and address the common risk factors for heart attacks, stroke, cancers, diabetes, and dementia, concentrating especially on people and places where risks are highest and on our children. Resources will be constrained for years, so priorities will be essential.

Policies should apply everywhere, but scarce new expenditure must focus on the people and places that need it most and can yield most benefit.

A new government will have **a mandate to be bold** and should use this mandate to introduce essential policies early, especially if they are controversial. The policies to ban smoking in public places, for seat belts, crash helmets, and clean air were all vociferously opposed by some, all are now seen as essential. Polling data shows strong public support for stronger government action to improve public health[14]. Half of the public say there is not enough government action on smoking; 60% not enough action on obesity; 44% not enough action on alcohol consumption[15].

The launch must promote the gains from healthier environments which support people's own agency around their consumption and habits, and confront the greatest risks and the policies that will reduce them. See Appendix 4.

Begin acting in the first 100 days, set a clear strategic ambition for each priority for five years; set the country on course to achieve a 20-year vision for health and wealth.

To identify the top priorities, we explored the key risks factors for poor health set out in *A Covenant for Health*[16]. For each risk, we looked at the disability-adjusted life years (DALYs) lost because of it from the Global Burden of Disease evidence[17].

A life-course approach is essential, health risks build up from birth, act before symptoms show.

Focus on our Workforce – it is crucial that people do not drop out of work and it can be too late to act when people are ill in their 50s. So, focus on those at risk in their 20s, 30s and 40s – who smoke, are overweight, have high blood pressure and are inactive. Create the right environment, to help them keep in good health and work as long as possible.

Realistic and Affordable – we identified realistic and affordable policies and estimated for each the benefit to an individual's health, how many people might benefit, the impact on health equity, the speed of impact and the cost to government. From this analysis five topics emerged as critical to improve our population health and our economic strength. See Appendix 5.

These five make a priority agenda for action. But policies and regulation alone will not be enough. In Japan, they have worked hard to create a national culture around food, exercise, ageing, and we will need to do the same.

Five Top Priorities for Action

1. **Early detection** – detect and treat risks much earlier – weight, and key metabolic risks.

2. **A smoke-free UK** – help every smoker who wants to quit to do so over ten years.

3. **Healthy food for all** – transform the health of our food environment to prevent obesity.

4. **A happy and healthy childhood** – to grow up in good health with healthy lifestyles.

5. **Leave no one behind** – help people and places with the worst health to live well for longer.

The first three of these address the highest risks for illnesses as shown by the Global Burden of Disease. The last two are population groups with high concentrations of risks – children and the people and places with the worst health. All five topics require investment, innovation, and political backing. Good enough plans exist for many; act on them strongly and fast. They are all possible[18].

Four other topics are also essential: for these we need to accelerate current action on alcohol harms; mental health; physical activity and clean air and focus too where they are worst.

Health in all policies – many other policies impact on health, such as housing, education, employment, the physical environment. Examine how they can benefit health outcomes.

1. Early detection, early prevention

it is crucial for our economy that people do not drop out of work, a critical issue for businesses and government departments, DWP, DBT, HMT. Focus early detection on those who smoke, are overweight, have high blood pressure and are inactive, and offer help much earlier to address these risks.

Ideally, in the future, people's lives and environments will be healthy and so they will not develop many of these risks. There will also be breakthroughs in preventative technologies, and we must optimise the potential of Big Data, database segmentation, diagnostic tools and genomics to identify, target, and intervene earlier. We must also address the toxic workplaces, abusive employment arrangements and dangerous conditions that corrode the health of our workforce.

Above all we must focus on what is important and low cost and so address high blood sugar, high blood pressure, and high cholesterol, these together cause 23% of disability life years lost[19] and are the drivers for cardiovascular disease (CVD) which accounts for 24% of all deaths. Some can be addressed rapidly.

There are about 12 million people with high blood pressure; only half are effectively treated. Pre-diabetes affects about 5 million people. Some 40% of adults have high cholesterol levels. 5 million people have high blood sugar levels, 70% are undiagnosed.

The way to redress these is medically simple and low cost. Reducing them to safe levels would make an enormous difference to the health of the nation and to individual wellbeing. Yet we are failing to do so, the NHS pays far more attention to rare diseases than treating these obvious risks.

We need to build a much better health check system[20]*:*

- To promote evidence-based interventions and key treatments, e.g., statins
- To develop systems and data to identify people at risk and with early onset
- To empower and motivate people to manage their own risks
- To increase access to smoking cessation, and weight loss services
- To build community-based prevention by non-specialist staff in convenient locations
- To ensure all initiatives are targeted to need, e.g., Core20PLUS communities.

Focus this new system on places and people with high risks – where obesity levels are highest[21], and on people at risk of early onset CVD and depression, e.g., Core20PLUS. Reward engagement and persistence. A major expansion of such a new system will need clear responsibility for financing and commissioning it and accountable for its delivery. It must be be integrated with NHS's data and records and align with the existing primary care system but reserve the capacity of GPs for those needing higher levels of healthcare support[22].

The goal is clear, yet the means to deliver is not. DHSC/NHS/LGA/ADPH should launch an implementation working group to develop a much better system to help people address blood pressure, smoking, weight, alcohol, and physical activity. Run pilots with local ownership to build confidence. We suggest a specification for such a new system in Appendix 6.

As William Roberts, CEO of RSPH wrote: *"take more services to the people, do not wait for them to come to you"*.

2. Smoking – stop the start, accelerate the end

Tobacco is the biggest single risk factor for an individual, driving a wide range of illnesses in England, 20% of GBD. It is also a huge driver of household poverty[23]. It is critical that the Tobacco and Vaping Bill is enacted to ensure children do not smoke. Second, over ten years, we should help the 3 to 4 million people who want to quit to have good support to do so. This will reduce child poverty and help many more pregnant women to quit.

Achieve this by boosting specialist stop smoking services from 178,000 attendances to 500,000 a year[24]. Proactively contact smokers with opt-out referrals, swap to stop and mass media campaigns. Focus initially on neighbourhoods where risks are greatest[25]. Multi-media behaviour change campaigns are highly cost-effective too. Secure MRHA clearance on at

least two e-cigarettes, so that GPs can prescribe them. In 10 years, we should be able to halve the smoking rate.

Fund this new programme from an immediate windfall tax on tobacco manufacturers profits, backed up longer-term by a 'polluter pays' levy capping profits on UK sales and later from a tax on tobacco companies' profits.

3. Healthy food for all

Excess weight is the third largest health risk for individuals and our society – 12% of GBD. A quarter of adults are living with obesity, and so have much higher risks of CVD, stroke, cancer, dementia, mental illness, and joint problems. This leads to 3,000 ward admissions every week. Another 4 million people will be living with obesity by 2030 if we carry on as now[26]. The increase in obesity in childhood is critical, 80% of adolescents with obesity grow up to be adults with obesity.

Reducing obesity rates requires changing the food environment, encouraging healthy behaviours, improving early intervention, and better access to weight management services. Pharmaceutical and surgical interventions have a role for some but are not a replacement for upstream interventions to prevent the development of obesity which are more beneficial and cost effective[27]. It is wrong to wait until people are obese before addressing the problem.

Change is possible, Nesta's analysis suggests that reducing the average daily calorie intake by just 8.5% for people living with excess weight could cut population-level obesity by half.

The top priority is to help the 4 million additional adults and children who risk developing obesity by 2030. The success of the Soft Drinks Sugar Industry Levy showed that financial incentives work, it cut the total sugar sold in soft drinks by 34% in four years, nearly 50,000 tonnes less each year. Government's role is to create a healthier food environment to help people keep healthy[28].

A launch plan:

- Announce a national ambition to help children and adults reach and keep a healthy weight
- Seek explicit support from charities, Royal Colleges, LGA, and hopefully retailers
- Frame it as an imperative to save our children
- Focus on preventing obesity and avoid diabetes, and CVD
- First, implement measures that are ready and rapid
- Actively explore Nesta's proposal to stimulate major food retailers to offer healthier foods.

Rapid actions in the first year

Act on a clutch of known policies to make the food sector, the places we shop and the foods we buy healthier, see page 14: First Year Plan for Healthy Food. Mandate reformulation targets for the ten food categories contributing most to calorie consumption[29]. In time, introduce a new salt, sugar, or category-specific taxes, as recommended by the Recipe for Change Initiative.

Nesta's industry targets for healthier food policy

This major proposal is designed to help people reduce their calorie intake by a small amount every day, as doing this works. The policy mandates major retailers to improve the overall healthiness of the food they sell by making it easier for people to choose healthy options, yet lets the retailers choose how to achieve the targets[30].

Nesta estimates this could lead to four million fewer people living with obesity. This system has a low cost to government, limited cost to industry, and little or no cost to the public. Ensure it can work well in the places where change is most needed. See Appendix 7.

Healthy Diet and Healthy Choices

Dietary risks, and high body mass have now become the greatest risks to our health, 23% of GBD combined. These two risk factors drive high levels of high fasting plasma glucose, and high LDL cholesterol. Strongly addressing dietary risks is fundamental to making our society healthier and so able to work for longer.

Sugar: linked to type 2 diabetes, musculoskeletal ill-health, CVD and a range of cancers. Biscuits, confectionery, and desserts alone are responsible for almost 60% of the added sugar that we eat at home. 95% of children exceed sugar recommendations.

Salt: high consumption is strongly associated with high blood pressure, increasing the risk of stroke by 23% and cardiovascular disease by 14%. Over 80% of the salt we eat is already in our food when we buy it. For children, 66% exceed salt intake recommendations[31].

There is a strong case for a new government to address these two but in advance of legislation a clutch of other actions could rapidly be launched, for example:

First Year Plan for Healthy Food:

- Uprate the liability under the Soft Drinks Levy; bring sugary milk drinks into scope
- Restrict unhealthy food advertising
- Introduce mandatory reporting and metrics for large food businesses
- Expand eligibility and improve uptake for Healthy Start
- Change procurement rules for schools, hospitals, for mandatory health standards
- Ensure fruit and vegetables are served in all nursery and primary schools
- Implement HFSS volume promotion restrictions, delayed until 2025
- Revise and mandate food labelling.

Leadership changes are needed: widen remit of FSA England with powers and duty for nutrition and dietary health as in Scotland. The PM should task the FSA to work with DHSC to make our food healthy, addressing marketing, availability, and affordability.

4. A happy and healthy childhood

If our children start adult life in good physical and mental health and with healthy lifestyles, they will be happier, able to work for longer and so better off; our future economy will be stronger and the cost of health, care and welfare not so high. There is a moral, social and economic case for action.

Yet many children live in unhealthy environments, physical, commercial and social. They are exposed to poor diets, risks of obesity, mental ill-health, harms from smoking, vaping, gambling, and social media and low levels of physical activity. Many enter adult life with significant health risks, unhealthy lifestyles and hidden metabolic damage that will later cause serious harms.

A new government needs to launch a societal mission for healthier happier children and involve key partners, and schools, parents and children to achieve it[32]. Develop schools as a key neighbourhood anchor organisation, with health support inputs, so they become a community hub for health.

We suggest five priorities to improve children's health[33]:

i) **Childhood obesity.** Almost one in four children aged 10 and 11 have obesity. The longer the exposure, the greater the risk of type 2 diabetes, cancer, mental illness, and shorter and unhappier lives. Policy initiatives must prioritise the under-fives, and children who are overweight but do not yet have obesity[34]. This crisis makes it essential to get major food retailers to sell healthier foods, and end child-focused marketing of products high in fat, salt and sugar.

ii) **Early years.** The first 1001 days of life is a crucial time to ensure children grow up in good physical and mental health with actions nationally, locally, and by ICSs. For example, prioritise expansion of the public health nursing workforce and an expansion of the health visiting workforce.

iii) **Healthy children's diets.** Announce an immediate agenda for change: more support for breastfeeding; a plan to promote good dietary habits; to make marketing honest – it is indefensible to promote products high in fat, salt and sugar as healthy. Make baby and toddler foods and drinks healthy and develop Eat Better Start Better guidance with early years settings and local authorities.

iv) **Physical activity for children.** Less than half of children have sufficient physical activity for good physical and mental health, for life. Review how best to change this, focus on the greatest need.

v) **Children and young people's mental health.** Mental health resilience is crucial for our children. The school environment is key to support their mental health. Embed the promotion of mental health in the curriculum. More support from the health sector into schools will be needed to ensure children with mental health needs attend school. Expand mental health support teams when possible. Some parents need support on how to raise a mentally healthy infant, target those at the highest risk.

5. Leave no one behind

In the most deprived places people get their first major long-term illness very much earlier than in the least deprived places[35]. Places where many people have multiple long-term illnesses have fewer people in work, less economic growth and higher NHS and welfare costs; this harms us all. If we improve the health of the most deprived places, all the nation will benefit. See Appendix 8.

Health equity must be a goal for every level of government: central government must address health inequity between regions; regional structures must focus on localities with the worst health; local authorities must prioritise the neighbourhoods where health is worst[36].

We suggest a 10-year action plan:

i) **A Goal and a Plan.** Develop with partners a plan to reduce health inequity and narrow the gap between places in two ways: e.g., Blackpool versus other places; also, within Blackpool, on the neighbourhoods where health is worst.

ii) **An Offer and an Ask.** Make three-way agreements with the priority places, each with strong community support, on what they aim to achieve in five/ten years, clarify roles and the policy and define the longer-term funding support they will get.

iii) **Weighted interventions.** All departments will need to analyse the concentration of health risks associated with their policies and propose how they will reduce them. All policies to reduce risk factors and inequalities must apply greatest effort to places with worst health, e.g., Active Travel; air quality improvements; eradication of damp, and better home insulation.

iv) **Support the Change.** Improving health in these places is harder; people live in more harmful social, economic, and physical environments. A new model of intervention by local authorities and ICSs needs to be developed, addressing single risk factors in isolation is not enough. The NHS and local government need to be charged to develop joint integrated wellness services to address concentrations of health behaviours.

   People and places need the agency and ambition to develop a healthier place. DLUHC, DHSC and the LGA should jointly roll out the model behind Local Trust's approach to Big Local and 'left-behind neighbourhoods'. Allocate each targeted area £10m to spend over ten years to invest in community development and community budgets, using the Left Behind Neighbourhoods methodology.

v) **Additional Resources.** Local government will need adequate financing in these places, as elsewhere, to maximise its contributions to close health inequalities and fiscal devolution.

Conclusion on Five Top Priorities

These five priorities address the greatest generators of illnesses. Acting strongly on them will help many people to have healthier lives and so be able to work and contribute.

Four other topics

Much more action is also needed on four other topics – alcohol harms; physical inactivity; mental ill-health and unhealthy air. Existing programmes for these need to be accelerated and to focus on people and places with the worst health.

- **Alcohol**: price measures to reduce harms.
- **Physical activity**: prioritise places where there is local support for active travel.
- **Clean air**: stronger measures nationally and locally where there is support.
- **Mental health**: do what works, build a better evidence base.

See Appendix 9.

3 Central Government Leadership

The most important way to make this agenda succeed will be for the Prime Minister and the Chancellor to demonstrate their political commitment to lead government at all levels to make our nation healthier and so wealthier. We suggest:

i) **A Manifesto priority.** State the mission for health in manifestos. Any new Prime Minister will need to declare personal ownership of this with explicit support from HMT.

ii) **Clear mandates.** Issue clear mandates to each Secretary of State that a healthier nation is relevant to their department and needs their commitment. Changing the structure of government is not desirable. Departments must be required to assess the health implications of their policies to improve health and health equity. Clarify key accountabilities:

- Secretary of State for Health to focus on health, not just the NHS
- FSA to make our food system healthier and affordable, so people can eat well
- DfE and DHSC to ensure children enter adult life in good health
- HMT to use its great powers to support health and health outcomes
- Some topics, such as physical activity, sit across government, appoint a lead department.

iii) **A Healthy Lives Mission Board** should be formed, chaired by the Prime Minister. Local authorities, regions and mayoral authorities, are core to delivery, so representatives should be on the Board.

iv) **Cross-departmental commitment** is essential, the levers sit widely, but other departments have seen this as DHSC's role. They need an explicit mandate to support better health themselves.

v) **Reporting and monitoring.** Delivery plans should be public, and progress reviewed by the NAO.

vi) **Business sectors** need to engage, such as Life Sciences Sector Council, Food and Drink Sector Council. All should have their remit extended to include healthy lives.

vii) **The public.** Engage people and communities in policy-making, use citizen juries to understand public opinion and willingness to act.

viii) **The Cabinet Office** needs to be an active coordinator, to clarify, to strengthen accountabilities, and develop a performance review system.

ix) **Senior ministerial leadership.** Appoint a strong Public Health Minister for five years. They need to be a missionary for change and to work with charities, local authorities, Royal Colleges, health champions to promote the importance of preventing illness.

x) **A centre of expertise.** Government will need a centre of expertise. PHE had this role but was abolished and brought into government as OHID. OHID itself has been disbanded, its staffing cut. A new government needs to rebuild critical capacity.

xi) **External monitoring.** An independent statutory body is desirable to track progress and hold government to account, to conduct independent analysis. This will require legislation.

The Treasury – an Agent for Health and Wealth

We have a national health crisis, the second-highest burden of disease in the G7[37]. The OBR made clear in 2023 that this is unsustainable and that the costs for NHS, social care and welfare will increase still further with an ageing population. The Treasury itself can help address this:

- Do what Wanless proposed 20 years ago – prevent illnesses
- Use its tax powers on tobacco, alcohol, salt, sugar and gambling to promote health
- Use fiscal stimuli to reformulate our food system, as it did with the Soft Drinks Industry Levy
- Reinforce action with PSA-type agreements for better health
- Make polluters pay for treating their harms, not the taxpayer
- Explore changing the five year pay-back rule to ten years to make it easier to invest
- Support Impact Investments opportunities for better health.

The PM and Chancellor together could launch two major innovations:

A Health Transformation Fund – led by the Treasury to support joint departmental bids for investment for innovations to improve health and reduce health inequalities – not just focused on those dropping out of work in their 50s. This could generate much better health and value than merely adding the money into NHS funds, where the effects would be invisible. Second, jointly commission with the PM, a Stern-type review of health and wealth.

A Review for Health and Wealth on:

- Why a healthier nation is essential for the economy and society
- How to take a longer-term view of health and its contribution to economic growth
- How fiscal rules could be adapted to support investments for a healthier workforce
- Targets for health improvement to deliver economic growth and fiscal sustainability
- Defining an economic value for interventions which prevent future high-cost diseases[38].

Funding the Change

There are costs to improve population health, but the agenda suggested in this paper has minor costs compared to the costs of treating illnesses. The costs fall across government, business, and society. Legislation and regulation have mostly once-off costs. Some changes, such as active travel, have mostly capital expenditure. Harmful sectors, tobacco, sugar, alcohol and gambling should pay much more for treating their damage, not the taxpayer. The NHS itself should fund more action on early detection and treatment of metabolic risks.

Conclusion

We all need to regain the confidence and ambition that it is possible to make our nation healthier by actions across society, as summarised in this report, other countries have done so. The public want this to happen and so we must reject fatalism and seize this moment as an opportunity for change. Doing so will be popular with the public and with a wide range of stakeholders who look ready to support a willing government. The tangible benefits are great, as summarised in Appendix 10.

Appendix 1 – Acknowledgements

We are grateful to the many organisations and individuals who offered evidence, insights and discussions. In a short document it is sadly not possible to reference all of them in the text.

Alcohol Change UK

Alcohol Health Alliance

ASH

Association of Directors of Public Health

Auditory Verbal UK

Barnardos

Lord Best

Breastfeeding Alliance

British Heart Foundation

Business for Health

Centre for Mental Health

Chartered Institute of Environmental Health

Chartered Institute of Public Finance and Accountancy

Children's Charities Coalition

Children's Society

Children and Young People's Health Policy Influencing Group

Professor John Deanfield

Faculty of Public Health

Professor Brian Ferguson, NIHR Public Health Research Programme

Elizabeth Filkin

First 1001 Days Movement

Food Foundation

Greater Manchester Active

Health Foundation

Lord Phillip Hunt

Impact Investing Institute

Institute of Population Health, Liverpool University

Professor Susan Jebb, Oxford University

Professor Michael P Kelly, Department of Public Health, University of Cambridge

Local Government Association

Mental Health Foundation

National Children's Bureau

Nesta

New Local

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NHS Confederation, Hashum Mahmood, Senior Policy Adviser, Population Health

Obesity Health Alliance

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Professor Sally Sheard, Liverpool University

Recipe for Change

Royal Society for Public Health

Dr Dolly van Tulleken, Policy Consultant, Food, Farming and Countryside Commission

Appendix 2 – About the Authors

Geoffrey, Lord Filkin led the team of seven experts below, with support from Sarah Woolnough, Chief Executive, The King's Fund and Dr Andrew Snell, World Health Organization.

Professor Kate Ardern is Honorary Professor of Public Health at Salford University and Visiting Professor of Public Health at Chester University. Kate currently co-chairs the expert advisory council for Reform think tank's Reimagining Health programme, is a member of the general advisory council of The King's Fund, is the public health expert on the Impact Investing Institute's Place Coalition and public expert adviser to Liverpool University's NIHR Health Protection Research Unit for Emerging Zoonoses and Infections. Kate was director of public health (DPH) and chief emergency planning officer for Wigan Council between 2008 and 2022, where she was responsible for developing the much-praised public health components of the internationally recognised Wigan Deal and was also lead DPH for the Greater Manchester Combined Authority for health protection and emergency planning. She had a key role in Greater Manchester's strategic response to the Covid-19 pandemic acting as senior public health adviser to the Mayor and as the expert media spokesperson.

James, Lord Bethell was Minister for Innovation in the Department for Health and Social Care during the Covid-19 pandemic. He is now a member of the House of Lords, a policy entrepreneur focused on preventative health and a business adviser to innovative companies. Before this, Lord Bethell was a journalist, consultant, entrepreneur and investor in a number of media businesses including the Ministry of Sound.

David Buck is Senior Fellow in public health and health inequalities at The King's Fund. He was Deputy Director of Health Inequalities at the Department of Health and Social Care, and previously held other economic and strategic roles. He also worked at Guy's and St Thomas' Hospital, King's College London, and the University of York on the economics of health and public health. Currently he is adviser to the House of Commons Health and Social Care Committee's inquiry into prevention.

Dr Paul Corrigan CBE has been a higher education lecturer in applied social science, a senior manager in local government and the NHS, and a special adviser to new Labour Secretary of State for Health then in No 10 to the Prime Minister Tony Blair. He was a non-executive Director of Care Quality Commission and now chairs Care City CiC.

Geoffrey, Lord Filkin CBE has held leadership roles in public, private and charitable sectors, as a chief executive, a government Minister, a strategy adviser and Chair. He founded the New Local Government Network, the Parliament Choir, the Public Services Reform Group, and the Centre for Ageing Better. He proposed and chaired the House of Lords Report, *Ready for Ageing*, and led two APPG Longevity reports: *The Health of the Nation; A Strategy for Healthier Longer Lives*, 2020 and *Levelling Up Health*, 2021. He led *A Covenant for Health*, 2023 and this report.

Professor Sian M Griffiths CBE is a past President of the UK Faculty of Public Health. Having co-chaired the Hong Kong government's Inquiry into the SARS epidemic of 2003 she was Director of the School of Public Health and Primary Care at the Chinese University of Hong Kong from 2005 to 2013, where she remains Emeritus Professor. After returning to the UK, she has had a portfolio career, being Associate Non-Executive Board member of PHE (2014–21), Chair of PHE Global Health Committee, Trustee of RSPH and specialist adviser to Healthcare UK in the UKTI. Currently, she is a non-executive member of the Board of Public Health Wales, Deputy Chair of GambleAware and Visiting Professor at Imperial College London.

Professor David Halpern CBE is the Chief Executive of the Behavioural Insights Team (BIT), one of the world's foremost practitioners of behavioural public policy and empirical social science for government. David has led BIT since its inception in 2010 and it is now a global social-purpose consultancy working for governments around the world. Before that, David was the first Research Director of the Institute for Government and from 2001 to 2007 the Chief Analyst at the Prime Minister's Strategy Unit in Tony Blair's government.

Sally Warren is Director of Policy at The King's Fund. Before joining The King's Fund, she had extensive experience in health, care and population health policy and delivery, in central and local government. She was Director for Social Care at the Department for Health and Social Care, Director of Programmes at Public Health England and Deputy Chief Inspector (for social care and registration) at the Care Quality Commission. She was also Director at the Cabinet Office, leading a project on social care funding for Budget 2017. Most recently, Sally worked at the Department for Environment Food and Rural Affairs as Director of the Agri-Food Chain, and latterly Director of EU Exit Preparedness and Response.

Appendix 3 – How to Encourage ICBs to Do More to Prevent Ill-health

Paul Corrigan

Whilst most health improvements will need much wider intervention than the NHS, the NHS does have a key role in preventing ill-health and in preventing minor illnesses from becoming major. The NHS structure to carry out this role is already in place. From July 2022 the Health and Social Care Act created 42 Integrated Care systems. Their four key aims are very much congruent with our overall argument.

1. Improving outcomes in population health and healthcare

2. Tackling inequalities in outcomes, experience, and access

3. Enhancing productivity and value for money

4. Helping the NHS to support broader social and economic development.

If ICBs were to carry out aims 1, 2 and 4 they would play a significant role in furthering the improved health of the nation, and an NHS that provided better value for money would have more to spend on prevention. These are good aims. But with some very few exceptions ICBs are not actually doing them. For the NHS to play its role we do not have a problem of structures but a problem of behaviours within those structures.

There are three recommendations to help change those behaviours to encourage more activity by ICBs in prevention.

1. **Changing financial flows** – The NHS finances, because they are organised through a series of fragmented mechanisms, make it almost impossible for one part of the system to invest in prevention and then realise the return on that investment. Hospitals are funded through one system, primary care separately from that and community care separately again. Social care finances are entirely different. Given this fragmentation if for example an ICB wanted to help keep more frail elderly people out of emergency hospital beds it may choose to increase the skills and capacity of the domiciliary care workers who are in their homes nearly every day. They could better monitor their health and after sending the results to a primary care hub this would enable the NHS to intervene before the health exacerbation leads to an emergency hospital bed. But at the moment there is no way in which the finance spent on the extra skills in social care can be recouped from the emergency hospital beds that are not filled. The money does not and cannot flow between investment in prevention and resource realised because of that investment. Given these financial flows this very rarely happened.

In March 2024 the NHS Confederation published *Unlocking Reform and Financial Sustainability*. This recommended that ICBs develop financial flows which amongst other outcomes would incentivise more work on prevention. From April 2025 ICBs hope to implement such new financial flows for services for the frail elderly and preventing some spells in emergency beds. The report outlines many other areas where new financial flows could incentivise better prevention.

2. **Regulating ICBs** to carry out more work on prevention – the role of the CQC. From April 2024 the Care Quality Commission has a legal duty to regulate ICBs and to publish inspection reports on the ICBs' capacity. Given the key aims of ICBs, above, and given that each ICB has published an integrated care strategy outlining their own specific aims for prevention, CQC could, through its regulation, publish a judgment on their work on prevention. They could make suggestions as to how this work could be extended and deepened.

3. **National leadership on prevention.** In order for Government to promote better building blocks of health this report recommends a much more powerful centre for Government that drives "health in all policies". These arrangements will provide leadership to public service endeavours to improve health and coordinate the way different departments play a role in prevention. It is important that the NHS plays a significant role in this work and therefore we recommend that as far as the NHS is involved in prevention this work should be nationally led and coordinated at the centre of Government, not just by DHSC.

Preventing ill-health and early symptoms becoming major illnesses requires actions by the whole of Government and the whole of society, but the NHS has a significant role to play in that work.

Paul Corrigan
March 2024

Appendix 4 – Health is Wealth – A Covenant

This mission can be framed as an attractive societal goal:

1. The great opportunity of a healthier society

- the Covenant, the benefits, the vision
- a partnership between the public, localities, NHS, business, and government.

2. Healthier environments

- cleaner, healthier air, water, rivers, and beaches
- healthier travel, healthier housing, healthier workplaces
- healthier food for all.

3. Healthier communities

- better health for all people, all places, support to realise this.

4. Healthier children

- an essential ambition and a societal plan to realise it.

5. NHS for Health

- early detection and early treatment; less risk of heart attacks, stroke, diabetes and cancer.

6. Healthier businesses

- healthy work, healthy workplaces
- prevent early loss of workers from ill-health
- healthy products and marketing, support the leaders, challenge the laggards
- polluters must pay for their harms, not just the taxpayer.

7. Healthier longer lives

- helping each of us to own our good health
- reducing our risks
- person-centred early detection
- make smoking history
- protect from excess alcohol
- re-shape our food environment.

8. A mission for government and society

- how we can achieve this together.

Appendix 5 – Analysis of the Priority Topics

The priorities proposed in this report were supported by most commentators; this is very positive as it shows agreement on what matters most.

The first five of them, if resolutely pursued, would help many people have significantly better health and benefit our economy and society. Three of these five address the highest risks identified by the Global Burden of Disease. Two other topics address critical population groups – children and people with the worst health. There are many possible interventions to address the latter two, not a single policy. But given the number of people in these groups and the impact on their lives and on our economy, there is a compelling case to prioritise them.

Four other topics also need to be actioned – they will reduce the risks of ill-health for many people: alcohol, physical activity, clean air and mental health. But for these it mostly requires focusing and accelerating existing programmes.

It is not possible to assess the true costs and benefits of each of these programmes without a research team, but we offer an impression. Politicians will decide on which goals and policies should be a priority. Ideally all of them should be resolutely addressed.

1. Early detection and treatment

- **Personal benefit** – high benefit to an individual, reducing risks of CVD and other illnesses.
- **Scale** – up to half a million people could benefit over ten years.
- **Health inequalities** – great benefit to places with worst health, risks are highest there.
- **Speed of impact** – fast impact for individuals well treated – priority to places with worst health.
- **Cost to Government** – moderate – more people in work, benefits to the economy.

2. Tobacco and Vaping Bill

- **Personal benefit** – great benefit for every child who avoids smoking.
- **Scale** – great benefit to a whole generation of children.
- **Health inequalities** – significant impact, smoking is highest in poorest places; reduces poverty too.
- **Speed of impact** – rapid to implement but benefits not apparent for 20 years.
- **Cost to Government** – low.

3. Helping everyone quit smoking

- **Personal benefit** – very high benefit to an individual's health.
- **Scale** – great benefit, help 3 million who want help to quit over ten years.
- **Health inequalities** – great impact; places with worst health have most smokers.
- **Speed of impact** – rapid, over five to ten years.
- **Cost to Government** – moderate – most costs could be borne by tobacco industry.

4. Arrest the growth of obesity

Range of interventions with differing benefits, risks, and costs. If these succeed, then:

- **Personal benefit** – very high benefit to an individual's health who avoids living with obesity.
- **Scale** – over ten years help up to 4 million people to avoid obesity.
- **Health inequalities** – great benefit – deprived places have high levels of obesity.
- **Speed of impact** – five years to implement the Nesta model, focus on places with worst health.
- **Cost to Government** – moderate – less costly than new obesity drugs.

5. Healthier food and diets

Key measures aim to make food healthier and cheaper.

- **Personal benefit** – good benefit for an individual's health.
- **Scale** – a population wide set of measures, a large aggregate impact.
- **Health inequalities** – great benefit – places with worst health have worst diets.
- **Speed of impact** – regulatory changes relatively rapid to introduce with rapid impact.
- **Cost to Government** – mostly regulation, financial cost to government relatively low.

6. Healthier children

Many interventions with differing benefits, risks and costs. If they impact, then:

- **Personal benefit** – great lifetime benefit to a child with a healthy lifestyle.
- **Scale** – aim for all children to benefit but focus on those most at risk of poor health.
- **Health inequalities** – great benefit – children have worst health in most deprived places.
- **Speed of impact** – ten years – focus first on places with worst health.
- **Cost to Government** – moderate.

7. Health equity – no one left behind

A wide range of interventions with differing benefits, risks and costs. If these succeed, then:

- **Personal benefit** – very high benefit to most deprived people and places.
- **Scale** – over a ten-year period aim for all places in bottom decile to benefit.
- **Health inequalities** – great benefit if successful.
- **Speed of impact** – ten years and more to build.
- **Cost to Government** – moderate/high depending on scale and focus.

Appendix 6 – Early Detection, Early Treatment – Specification for a Better System

Overall Strategy

The *Health in 2040* report stressed the need to focus on offsetting future demand, to delay the onset of illnesses and on the working age population, so people can remain in work [39].

First, clarify the role of the NHS in prevention – it should focus on much better secondary prevention of clinical risk factors; this is likely to have greatest impact faster, backed up by strong central government regulation on products and marketing of major risk generators – alcohol, tobacco.

Below is a suggested specification for a better system to detect and treat risk factors that would need to be developed and piloted in places where health is worst.

A Better Prevention Service

This needs a combination of:

i) A surveillance system for at-risk cohorts, to identify and manage early onset, and using a range of communications mechanisms to promote engagement.

ii) Develop Health Check system better to identify risk, targeted at people and places most at risk.

iii) Use of data – an analytical capability to run reports on GP data – e.g., lists of people not currently treated to target, access to blood tests and BP checks to stratify by risk.

iv) Increase access to lifestyle interventions, such as stop smoking, diabetes prevention and weight loss (particularly digital services). These do not need highly trained healthcare professionals and could be scaled through partnerships with other providers, and digital providers.

v) Behavioural incentives to engage people and to retain involvement.

vi) Invest in community engagement across ICSs with strong links into primary care.

vii) Shopfront and workplace service delivery – bring the services to where people are.

viii) Local pilots with some level of local ownership and involvement of local GPs to build confidence.

Wider Considerations

- **Liberalise workforce regulations** to bring a much wider range of healthcare professionals into place.
- **Agile regulation and validation** to speed up adoption.
- **Support the creation of systems outside the NHS** which can deliver these services at affordable prices and into communities overlooked by the NHS.
- **Do what works.** Be much clearer where to focus efforts and how to do so. Clarify who does what in local actions – responsibility for weight management, smoking and child health is currently split and confused between NHS and local government.

Appendix 7 – Targeting the Health of the Nation (Summary)

Nesta's industry targets for healthier food

Over the past thirty years obesity prevalence has doubled[40]. The British public is concerned about obesity, and supportive of stronger government[41] and industry[42] action. We urgently need more ambitious policies that will incentivise and support businesses to prioritise healthier food.

To achieve system wide impact, we need to design policies that target the retail, manufacturing and out-of-home sectors. **Our work to date has focussed on healthiness targets for large retailers.** We think these targets should **include all food sales across a business**, rather than focussing on ingredients or categories (e.g. sugar) as with the existing Government reformulation programmes[43]. These should be designed to deliver impacts on obesity that are proportionate to the scale of the challenge. To achieve this, the targets would **encourage *both* reformulation and a sales shift towards healthier options**.

Our work looked at a range of options for retailer targets, with a focus on assessing the best measures for healthiness and most effective implementation options. To do this, we have analysed a food purchasing dataset from a representative sample of ~30,000 GB households and carried out modelling of the potential impact of targets on calorie purchasing and population obesity rates. Alongside this, we engaged with experts across the system to assess the feasibility of different target options. We also commissioned an independent economic assessment[44] of the policy and developed a detailed implementation plan for the Government[45].

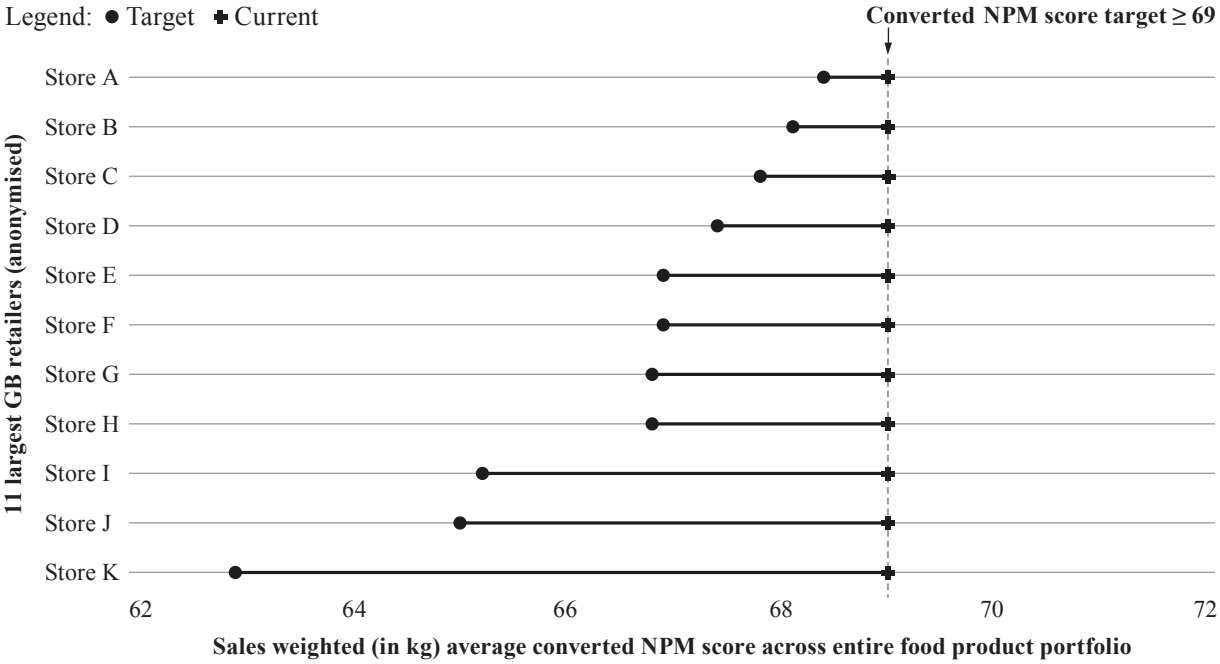
Policy Recommendation

We propose the introduction of **health targets that require large retailers to improve the healthiness of their offer** by increasing the average nutrient profile score across their entire food product portfolios (branded and own brand). **This offers an effective mechanism where the Government sets the ambition, while allowing businesses to retain flexibility in how they achieve this.** For the full details, see *Targeting the health of the nation: a policy brief*[46].

Our analysis estimates that **setting an average sales-weighted**[47] **nutrient profiling model (NPM)**[48] **target for the 11 largest UK retailers** at levels similar to the businesses with the healthiest product portfolios today **could reduce calorie purchases among the excess weight population by ~80 kcal per person per day, and obesity prevalence by 23%**. This would translate to around four million fewer people living with obesity in the UK and around £20 billion in annual cost savings to society[49].

To achieve this reduction, our modelling suggests that retailers must increase their sales-weighted average converted[50] NPM score to ≥ 69 NPM score (from the current average of 67) across their whole product portfolio by 2030. Below is a chart to demonstrate the targets and where retailers are currently performing.

Target and current sales weighted (in kg) average converted NPM score by retailer



Source: Nesta analysis of Kantar's Worldpanel Division Data (2021)

To ensure industry targets achieve their intended impact, targets should be mandatory, underpinned by mandatory data collection, and overseen by a central government body with the power to monitor progress and enforce penalties for non-compliance.

Penalties should be both proportionate but sufficiently sized to motivate compliance. To give industry and government time to prepare for implementation there should be a phased introduction with targets effective only after mandatory reporting has been in place for sufficient time. The implementation plan[51] includes further detail.

An economic assessment[52] of the policy proposal suggests it is unlikely to have a significant cost to businesses or consumers. This is due to the sufficient lead-in time between announcement and enforcement, and the flexibility it provides to retailers to find the most cost-effective methods to enhance the healthiness of their sales.

We urgently need to reshape our food system so that the healthier option is the easiest option for everyone. By implementing ambitious yet achievable mandatory health targets for retailers, we can make real progress towards these goals and start turning the tide on obesity once and for all.

Appendix 8 – Concentration of Risks that Drive Health Inequalities – Policy Actions

David Buck, The King's Fund

There is no single policy action that will make a population-wide difference to the concentration of risks that drive and sustain inequalities in health. This needs a more strategic policy approach across health policy; at national, regional, local and neighbourhood level, as set out in Table 1 on page 37.

These actions need to be cohered by a national health inequalities target and system support (such an approach has led to improvement in the past[53,54,55]). Whilst fine tuning this target is required[56], at a high level it should be based on narrowing gaps in healthy life expectancy (HLE) between areas and include a focus on MSK and mental health (big drivers of HLE gaps in people of working age[57]). This will support many of the 2.8m people out of the labour force with long-term illness[58] back to work, creating a virtuous circle between health and wealth and helping address our productivity problem.

Table 1: Policies required to tackle concentration of risks

	Wider determinants	Behaviours	Integrated care systems	Community
National	**All government departments analyse the concentration of health risks associated with their main policy goals** linked to parties' 'health missions' and implement cost-beneficial interventions to address.	**HMT design tax policy to recognise health behaviours cluster and concentrate** e.g., Tax policy on alcohol, smoking, and foods is focused on influencing clustering of behaviours and consumption.	**DHSC sets ICS goals and targets which are focused indirectly and directly on reducing the concentration of risks.** For example, as overall goals: reducing inequalities in avoidable mortality; and healthy life expectancy. And contributing goals.	**DLUHC and DHSC jointly roll out the model behind Local Trust's approach to Big Local and 'left-behind neighbourhoods'.** Giving every local authority £10m to spend over ten years.
	Accompanied by **a national health inequalities target**; **national learning support**; with **a focus on MSK and mental health** as core drivers of health inequalities in the working age population.			
Regional	Regional bodies (e.g., combined authorities, regional offices of government and the NHS) **review and be clear on how their activities are impacting on the concentration of health risks; allocating resources and actions in alignment**, e.g., coordinate and bring coherence to national funding streams; influence policies and implementation especially over the concentration of risks through the wider determinants (e.g., regulating housing quality; clean air zones) and coordinate behaviour support (for example regional tobacco control).			
Local	**Local government needs adequate and fair financing.** This requires more fiscal devolution to enable local areas to focus on places/ communities where concentration of risk are highest. Govt reverses £3bn cumulative deficit in public health grant (on trajectory back to 2015/15 level in real terms per capita).	**The NHS and local government develop integrated wellness services at scale and focus on concentration of clusters of health behaviours in key groups.** Supported by joint budgets, approaches and genuine integration between the NHS and local government.	**ICSs to prevent, delay and mitigate the impact of multiple long-term conditions.** Including: capitated budgets to incentivise prevention/control of people's health; using voluntary sector at scale; population health management (PHM) analysis and intervention.	**Local government, NHS (and partners) have specific goals to increase community participation in decision-making and resource allocation decisions**; actively introduce and systematise community budgets.
	Underpinned by **clear accountability and peer learning support**.			

Appendix 9 – Four Other Priority Topics

There are existing government programmes for three of the topics below. Ideally these should all be scaled up and also focused on the places where health is worst.

1. Alcohol Harms

Alcohol use accounts for 4% of all DALYs in England, the sixth biggest driver of illness. The most effective way to reduce alcohol harms is through price, followed by marketing changes. When alcohol is cheaper, harm increases. Alcohol-related hospital admissions and deaths are significantly higher in areas of greater economic deprivation. Scotland reduced harmful drinking by restricting advertising, increasing the price of cheap strong alcohol, and by using every opportunity to point problem drinkers to help. This resulted in significant falls in alcohol-related hospital admissions and deaths. Measures that increase costs for families in a cost-of-living crisis are difficult, so, we suggest an initial focus on laying the ground for stronger action in a year's time.

Key actions in the first 100 days:

- Consult on a national alcohol strategy, on MUP, and on the regulation of alcohol marketing
- Review access to treatment and support; 80% of adults in need of it do not receive it
- As the cost of living stabilises, reintroduce automatic uprating to alcohol duty
- Then introduce minimum unit pricing, maybe after a high-quality deliberative assembly.

2. Physical Inactivity

One of the most effective preventative measures against physical and mental illness is being physically active. Low physical activity only accounts directly for 1% of all DALYs in England but it is a major driver of other risk factors. Living a physically active life is one of the best ways to avoid CVD and mental illness. Yet 12 million adults are inactive and so at higher risk.

Successful policies to increase physical activity will have great benefits for mental and physical health, and for the environment, especially for those who are very inactive.

The best solution is to hardwire physical activity into everyday life. Active Travel is a particularly good way to do so. It helps keep people healthy, reduces congestion, air pollution and climate harms, but needs investment to make cycling and walking to work, school, shopping and leisure safe, attractive and preferable. These actions must be what local people and places demand, not imposed by central government. See how Scotland and GM Moving

have adopted such an approach and are good exemplars. Focus on people and places who are least active.

First 100 days:

- DCMS, DfT, DHLUC and DEFRA and local government to co-develop a national strategy to cut the numbers who are inactive by a third in five/ten years.

3. Mental Ill-health

Poor mental health is rampant and serious, it causes great distress. Depression and anxiety are the biggest cause of days of lost work, and mental health problems are the most common reason given for not finding a job by young people. Mental health and physical health are interactive and many of the steps to reduce inequity will benefit mental health. Schools are an essential focus.

The evidence on how to prevent mental illness is weak, so focus on doing what we know works.

Early detection and prevention of risks in childhood is critical. Good evidence exists for a range of public mental health interventions. Bullying is a well understood risk factor for poor mental health and so helping all schools to reduce this will work. Preventative mental health measures in schools have been effective. The right support for women in the perinatal period is important. Expanding MHSTs to all schools is needed too, as resources allow.

But fundamentally mental ill-health requires much better understanding of how to prevent, detect and treat it early. Early targets should be ending 'toxic' work environments and stressful employment terms, and as the LGA suggests, a focus on early intervention and building on the Prevention Concordat for Better Mental Health, to promote healthy communities. A new government could announce at the launch that it will develop a national mental health and wellbeing strategy.

4. Clean Air

Cleaner air is part of the climate change agenda, as actions for one are relevant to the other. Air pollution generates about 1.8% of all illnesses in England. Poor air quality has risks for us all and great harms for tens of thousands of people; very young children, those with prior poor health, the elderly and some highly polluted communities are particularly exposed.

Fine particle emissions are now of most concern. Excess deaths attributed to long-term exposure to them suggests many could be avoided if residential combustion and road-transport emissions are reduced. These sectors are also the focus of net zero strategies, so we must optimise air pollution and climate policies for maximum health benefits. Focus on places with high pollution and high population density. The coroner in the report on the Ella Kissi-Debrah death recommended bolder action to get closer to WHO particulate recommendations.

The Environment Act 2021 introduced a new target for PM2.5 of 10 μgm-3 by 2040. A new Government might commit to lowering levels of PM2.5 in England to this level by 2030.

Appendix 10 – Outcomes in Five to Ten Years

An illustration of the ambitions:

- Help 3 million to quit smoking over ten years and children never to start
- Help 3–4 million people, adults and children, avoid living with obesity to 2030
- Help 300,000 people to avoid heart attack, strokes and diabetes
- Ensure a healthier food environment for everyone
- Reduce alcohol harms – and so dementia, and cancers risks
- Help 3 million people to start to be physically active
- Cleaner air, especially where it is worst, and so fewer respiratory illnesses
- Help all our children to grow up in good health
- Help many people in our most deprived communities to have good health for longer.

Endnotes

[1] The same team agreed to work on this report, plus Sally Warren, Director of Policy, The King's Fund. See biographies in Appendix 2.

[2] This is a report for England. Many of its themes will be common to the other nations but there will be different levers/structures brought into play.

[3] Health Foundation evidence.

[4] As they did with the Soft Drinks Industry Levy

[5] ONS.

[6] Health Foundation. 2022. *"less than 20% think the government has done enough to improve diet, reduce alcohol harms, reduce obesity or improve physical activity"*.

[7] CMO 2023

[8] ADPH.

[9] Such as the Obesity Health Alliance.

[10] LGA.

[11] See Public First report. This gives a clear idea of what local communities want.

[12] Professor Michael P Kelly, Department of Public Health, Cambridge University.

[13] William Roberts, RSPH.

[14] Health Foundation.

[15] Holding Us Back. November 2023.

[16] ADPH support these nine priorities but add climate change as the biggest health threat to humanity.

[17] DALYs adds the years of life lost from the risk to the years lived with disability because of it.

[18] See the Khan review, the Dimbleby review, Green Future Plans, Uniting the Movement (Sport England).

[19] Cardiovascular disease is one of the biggest causes of premature death and alone accounts for about a fifth of the difference in life expectancy between the most and least deprived places in England. BHF.

[20] The Healthcheck is currently commissioned by local government.

[21] People who consume food high in sugar and fat and are physically inactive are at highest risk of obesity. Early detection and monitoring of BMI, dietary habits, and activity is essential. Adults with CVD who are also overweight or living with obesity are five times more likely to suffer a stroke, and four times more likely to have a heart attack, than adults living with obesity alone. LCP.

[22] Health checks are currently being delivered by councils but not at pace due to budget constraints.

[23] ASH: 30% of smoking households live in poverty, rising to 42% in the North East, where the cost of smoking is over 11% of Gross Disposable Household Income per head.

[24] In 2012, 487,000 people took part.

[25] Reinstate government funding to local authorities for stop smoking services to 2013 value.

[26] OHID.

[27] Nesta estimates it would cost £16.5 billion a year to halve adult obesity by 2030 using new weight loss drugs.

[28] Also review local authority planning rules to manage fast food outlets; the poorest areas have five times more.

[29] As identified in the Future of Food report.

[30] Government sets the ambition; businesses would have the flexibility to meet that goal most cost-effectively.

[31] Recipe for Change

[32] As called for by the LGA and major children's charities

[33] Well supported by the major charities

[34] It is difficult to reverse obesity; over 60% of children with obesity remain obese in adulthood.

[35] Women here become ill when they are 47 years old, on average, 19 years earlier than in the least disadvantaged places.

[36] Acting on the topics in this paper might not alone reduce health inequalities, for policies have more impact where there is strong agency and favourable environments.

[37] Second only to the USA.

[38] To help create a market for effective investments in preventative interventions, as with the value of a tonne of carbon defined by Lord Stern in "The Economics of Climate Change".

[39] Health in 2040: Projected patterns of illness in England. The Health Foundation, July 2023.

[40] **https://researchbriefings.files.parliament.uk/documents/SN03336/SN03336.pdf**

[41] **https://docs.cdn.yougov.com/fvmal14vk1/ObesityHealthAlliance_Results_230516_W.pdf**

[42] **https://www.health.org.uk/publications/public-perceptions-of-health-and-social-care-november-2022**

[43] **https://www.gov.uk/government/collections/sugar-reduction**

[44] **https://media.nesta.org.uk/documents/Targeting_the_health_of_the_nation_economic_assessment.pdf**

[45] **https://media.nesta.org.uk/documents/Targeting_the_health_of_the_nation_implementation_plan.pdf**

[46] **https://www.nesta.org.uk/report/targeting-the-health-of-a-nation/**

[47] The health metrics in our analysis were sales weighted by volume (measured in kilos). Sales weighting ensures that products that have a higher volume of sales contribute more to average scores than those that are less frequently purchased (see technical appendix for more detail, available at: **https://www.nesta.org.uk/report/targeting-the-health-of-a-nation/**).

[48] Nutrient profiling model (NPM) scores are a holistic measure of health that assigns an integer score to food products based on their nutritional content (energy; sugar; saturated fat; sodium; protein; fruit, vegetables and nuts; fibre). The UK NPM was originally developed to determine the suitability of products for advertising to children.

[49] Calculation based on Frontier Economics modelling of £97.8 billion annual cost of adult obesity to society. Available at: **https://assets.ctfassets.net/75ila1cntaeh/2GSXP7mDl3RrjP1xiIyxbH/a539a326c5654e9fa36ed03c585d2928/Frontier_Economics_-_Updated_estimates_of_the_cost_of_obesity_and_overweightness_2023.pdf**

[50] We have used a converted NPM score that runs on a scale of 0–100 with a higher number translating a healthier score for ease of interpretation. For more information on the NPM conversion, see the technical appendix, available at: **https://www.nesta.org.uk/report/targeting-the-health-of-a-nation/**.

[51] **https://www.nesta.org.uk/report/targeting-the-health-of-a-nation/**

[52] **https://www.nesta.org.uk/report/targeting-the-health-of-a-nation/**

[53] **https://www.kingsfund.org.uk/insight-and-analysis/long-reads/how-can-we-tackle-health-inequalities**

[54] **https://bmjopen.bmj.com/content/12/9/e063137**

[55] **https://www.bmj.com/content/358/bmj.j3310**

[56] **https://www.health.org.uk/publications/reports/targeting-health-inequalities-realising-the-potential-of-targets-in-addressing-health-inequalities**

[57] **https://www.gov.uk/government/publications/understanding-the-drivers-of-healthy-life-expectancy/understanding-the-drivers-of-healthy-life-expectancy-report**

[58] **https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/reweightedlabourforcesurveydatasummarytable**