A Covenant for Health

Appendices

This document accompanies the report *A Covenant for Health: Policies and partnerships to improve our national health in 5 to 10 years*. The report recommends a series of actions to be taken by government to help people lead longer, healthier lives, to reduce the growth in demand for health and care services, and to bring wider benefits for our economy, and society.

These appendices have each been written by the organisations shown as inputs to this project. We thank them all most warmly.

July 2023

Contents

1 Subjective wellbeing and mental and physical health 1

Nancy Hey, Executive Director, What Works Centre for Wellbeing

2 Why is prevention so hard and how can you change the narrative? 4

William Roberts, Chief Executive, RSPH

3 Helping smokers quit: a blueprint for success 8

Deborah Arnott, Chief Executive, Action on Smoking & Health

4 Shifting the system: tackling obesity through changes to the food environment 16

Nesta

5 Obesity: key facts and statistics 22

6 Food Foundation evidence 24

Isabel Hughes, The Food Foundation

7 Why a manifesto for health must address alcohol harm 29

Sir Ian Gilmore and Poppy Hull, Alcohol Health Alliance UK

8 Early nutrition and development 37

Zoe Birch

9 Early detection and treatment of chronic disease 41

Veena Raleigh, The King's Fund

10 Increase secondary prevention to develop a renewed NHS 46

Dr Paul Corrigan

11 Race and health 51

Runnymede Trust

12 Concentration of risks 58

David Buck, Senior Fellow in public health and health inequalities, The King's Fund

13 Putting prevention and population health at the heart of integrated care systems 63

David Buck, Senior fellow public health and health inequalities, The King's Fund and Dominique Allwood, Director of Population Health, Imperial College NHS Foundation Trust

14 The politics of population health 67

James Bethell

15 What does integrated leadership look like to drive health in a place? 73

Laura Charlesworth, Head of Health Research, New Local

Jessica Studdert, Deputy Chief Executive, New Local

16 Devolution, health and growth: North of Tyne and wider North East 77

Henry Kippin, Chief Executive, North of Tyne Combined Authority

17 Science, technology and data for better health 79

James Bethell

18 Social Finance submission 82

Social Finance

1 Subjective wellbeing and mental and physical health

Nancy Hey, Executive Director, What Works Centre for Wellbeing

What is wellbeing?

Wellbeing is how we're doing as individuals, communities and as a nation, and how sustainable that is for the future. It encompasses the environmental factors that affect us and how we function in society, and the subjective experiences we have throughout our lives. Wellbeing can be used to go 'Beyond GDP' to measure progress and the success of nations.[1] Personal wellbeing is whether we are feeling good and functioning well. National Wellbeing approaches use personal subjective wellbeing measures, especially life satisfaction, as an indicator of success.

What the evidence tells us about wellbeing and health

How you feel about your health is consistently one of the biggest correlations with subjective wellbeing as measured by life satisfaction.[2] What Works Wellbeing's 2018 review of longitudinal survey data from Australia, Britain, Germany and the US provides strong evidence that the top driver of individual wellbeing is health.[3]

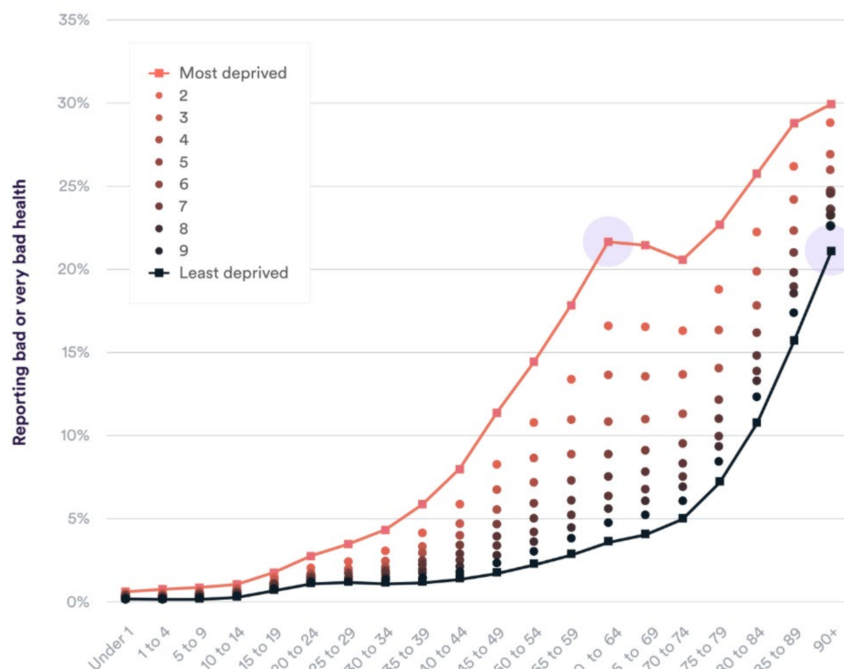
At a national level, healthy life expectancy is the third biggest indicator of high wellbeing nations after GDP and "Having someone to rely on in times of trouble".[4] We know that people are least happy when being ill in bed[5], and that time taken to manage ill health contributes to lower wellbeing. In contrast, physical and mental health can be improved over time through physical activity, supporting subjective wellbeing through experiential enjoyment and sense of purpose, as well as increased resilience.[6]

Analysis by the Office for National Statistics reveals that self-reported **very bad or bad health is the strongest factor associated with the poorest personal wellbeing**, and those self-reporting a disability are almost twice as likely to have the poorest personal wellbeing as those who said they were not disabled.[7]

[1] https://www.ons.gov.uk/news/news/thefutureofeconomicstatisticsaspeechbysiriandiamondnationalstatisticiantotheroyalsociety9march2023
[2] Life satisfaction is one of four personal wellbeing measures as used by the Office for National Statistics: "Overall how satisfied are you with your life, these days?", measured on a scale of 0 to 10 from "extremely dissatisfied" to "extremely satisfied"
[3] https://whatworkswellbeing.org/wp-content/uploads/2020/06/www-briefing-origins4.2.pdf
[4] World Happiness Report https://whatworkswellbeing.org/blog/levelling-up-life-in-the-uk/
[5] Are you happy while you work? Bryson & McKerron *The Economic Journal*, Volume 127, Issue 599, February 2017, Pages 106–125,
[6] https://whatworkswellbeing.org/wp-content/uploads/2018/06/sport-dance-sec-analy_0239640000.pdf
[7] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/understandingwellbeinginequalitieswhohasthepoorestpersonalwellbeing/2018-07-11

The picture is nuanced: people can have the same physical and mental health conditions and their quality of life can vary. The implication is that we can improve the quality of life for those with long term illnesses, chronic conditions, disability and at the end of life.[8]

Figure 1.1



Source: Nuffield Trust analysis of Census 2021 data[9]

We can use subjective wellbeing as a common currency across departmental priorities to understand and value the impact each sector and department has.[10] By making overall happiness the goal and shifting from "wealth creation" to "wellbeing creation", distinctions between sectors of government become fairly arbitrary, and cross-sector prioritisation is important for making the best use of resources.[11]

Health creation, promotion and prevention is at the core of a wellbeing approach. If we want to reduce misery and improve wellbeing, an area for policy, delivery and research prioritisation is mental health.[12] This requires accelerated scaling up of effective interventions and significant investment in research.[13] We are already seeing evidence-informed systematic change, for example the inclusion of wellbeing as a topic in the 'Mental

[8] https://whatworkswellbeing.org/projects/dying-well/

[9] Deprivation levels measured using Index of Multiple Deprivation (IMD) 2019, which is based on factors such as income, education, crime and access to housing within an area, available at: https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-when-being-64-for-the-most-deprived-feels-like-90-for-the-better-off

[10] The Levelling Up White paper introduced a broader definition of Human Capital that expanded it beyond the value of the qualifications our people in the UK have to include health too. The HMT Green Book supplementary guidance on wellbeing, used in the White Paper, provides a more consistent way of using this across departments and valuing it. Change is now possible; we can create a future we want and make Progress.

[11] Peasgood, Foster and Dolan, *Global Happiness and Wellbeing Policy Report 2019*. Available at https://s3.amazonaws.com/ghwbpr-2019/UAE/GH19_Ch3.pdf

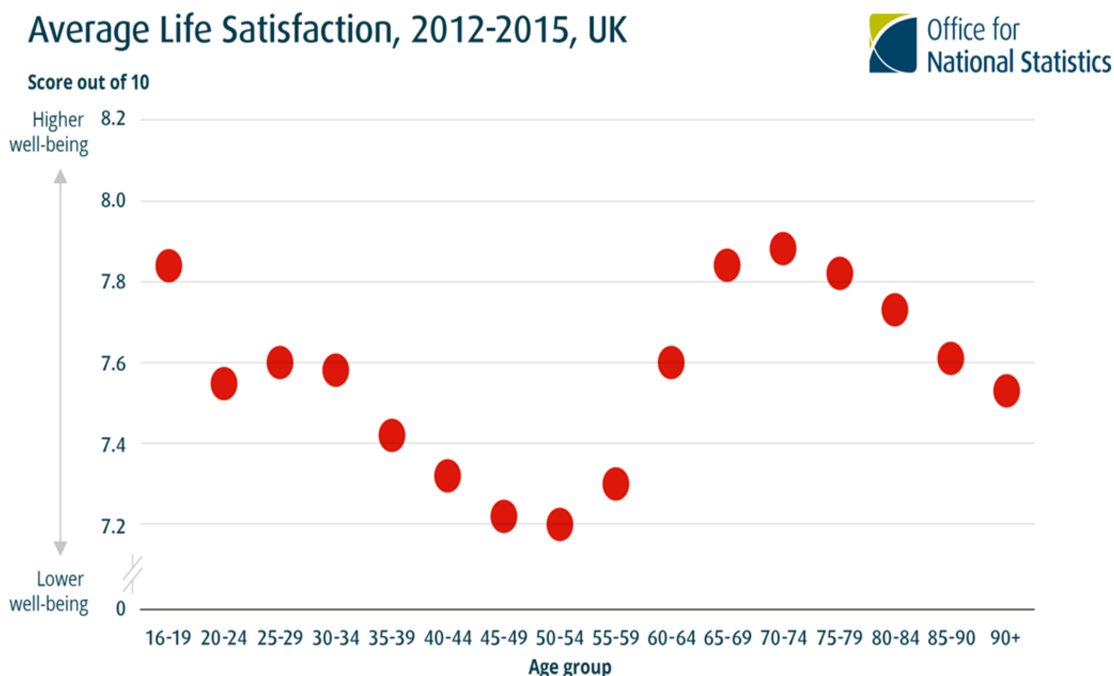
[12] https://whatworkswellbeing.org/wp-content/uploads/2020/06/www-briefing-origins4.2.pdf

[13]https://whatworkswellbeing.org/blog/lord-gus-odonnell-on-why-we-must-stop-spending-on-failure-with-mental-health/

Health & Wellbeing JSNA' OHID public health profile.[14] This shift in focus does not negate physical health, which remains important.

Change is now possible; we can create a future we want and make progress.

Figure 1.2



About What Works Centre for Wellbeing

What Works Centre for Wellbeing is an independent collaborating centre that believes improving people's wellbeing is the ultimate goal of effective policy and community action. By accelerating research and democratising access to wellbeing evidence, the Centre develops and shares robust evidence for governments, businesses, communities and people to improve wellbeing across the UK and reduce misery in the UK.

[14] https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna

2 Why is prevention so hard and how can you change the narrative?

William Roberts, Chief Executive, RSPH

How to reposition public health and prevention

At the heart of all public health is a belief that healthy, happy and fairer societies are stronger societies. For a number of years there has been a clear narrative that public health seeks to exert control over people and act as the nanny state. In reality that is a flip side of the idea that **equity of choice, growth, freedom and opportunity can only be achieved with some intervention and support**, Public Health has to offer a reframing that clearly shows its value whilst embracing the modern world and the technological and societal changes that have happened over the last century. There are new opportunities and levers presenting themselves and it's important that public health isn't left behind as the world changes around it.

In reframing the discourse, there are three audiences that need engaging: the public; the treasury and politicians.

Public- **the public broadly support public health interventions but also want to see the benefits to them and society**. At the moment the benefits are only presented through the lens of either personal responsibility or society responsibility. The reality is that this needs to be better explained in simple terms. When presented in an accessible way the public time and time again support fair and equitable approaches.

Treasury- **public health is rarely presented in a way that makes it comparable to the treasury**. The Public Health community (myself included) has to shift from a belief that the evidence alone (the strategic case) is sufficient when paired with the promise of long term savings from prevention are a good enough answer and start to make the case for change in a way that speaks to the treasury five case approach. The other issue that is often associated with the Public Health Community, is that we just cannot decide what it is we want, with every group having a different "ask". Both treasury and the public health community need to come together to better understand what case needs to be made, what will work and what should be prioritised. It is also true that the evidence for the efficacy short, medium and long term of successful public health approaches is overwhelmingly positive both in human and societal terms rather than accepting the myth that there isn't a fiscal case.

Politicians- Public health is often presented as a left-wing ideology. This is of course not true. Politicians are democratically elected and want to represent the electorate. This means that it often ends up feeling as if party political issues are being played out in public health discourse. The **best public health improvements combine both the benefit to the**

individual and the benefit to the state. Things which may now seem uncontroversial like road safety, HIV, teenage pregnancy or even smoking were at the time hugely controversial and far from being a left wing nanny state ideology, many progressive public health interventions were introduced by Conservative governments, the banning of CFCs being an notable example.

Aligning public health benefits to the things that matter to the electorate and thus politicians who are placed there by the electorate is essential if we are to make progress in this area. Politicians claim to be led by the evidence and the experts in their decision making, in reality we know that even when they are presented with all the evidence highlighting the problem, politics and the policies/interventions that will support better public health, we may not necessarily gain any traction as has been witnessed by many members of the public health community over the last 5 -8 years. Party politics, lobbying and vested interests play a role. Each year several opportunities for change present themselves, when the window of opportunity arises, where the politicians are willing to look at the public health response, the public health community must be ready with all the evidence, case for change and clear messaging on how implementation will work.

Making change happen

It's not like we don't know how to do this stuff- **there is undeniably a public health way to achieve impact**- we used this for smoking, we used this for HIV, we used this for teenage pregnancy, and we used this for road safety. All of these were areas that were deemed to be controversial, unpopular to tackle and expensive. They all also follow a tried and tested set of approaches. That isn't to say that it's just one set of interventions replayed for each area but a set of approaches and ideas that can be shifted and nuanced to the individual area. What specific interventions work in smoking or teenage pregnancy may not work around the obesogenic environment or communicable disease, but the principles can be applied, and a range of interventions need to be considered to be truly successful.

If we were to consistently apply these principles to other public health issues, we could start to replicate the successes we have seen elsewhere.

- **At the heart of the public health approach is an aim to prevent disease, prolong life and promote health through the efforts of society**. Therefore, any public health response will need interventions that do different things.
- **Public health problems are nuanced and complex so there will be differing views amongst public health experts, but they will all broadly be in the same direction rather than radically different.** There are differing views on the extent to evidence can be applied, but crucially, the evidence points in the same direction, its often intensity and depth that matters.
- **Complex issues require a range of interventions rather than a single solution**. Using road safety as an example, the combination of speed limits, seatbelt design, seatbelt legislation, drive driving rules and car safety testing has reduced fatalities due to road traffic accidents. It is the combination of these things rather than any one particular

change that has made the difference. However, we cannot ask for everything at once and it is important that we have the data (modelling etc) that shows how an intervention will save health and societal costs and for the community to agree the top 3 asks at any one time and have a strategy that outlines the full set of interventions that if implemented would lead to a success story. Some interventions will yield quick results, some over a longer period but all will need to be systematically applied, not in piecemeal or part.

- **Debunking disinformation, myths and false economic arguments is central to making progress.** Harm industries do need to change, they don't want to and its not in their short term financial interest to do so.
- **It takes a long time, so results take a while and it requires patience**. You need to stick to it as the changes become embedded and normalised. Using HIV as an example, the benefits we are seeing now in reductions in UK transmission are as a result of interventions that were first introduced over 20 years ago. By consistently sticking to the interventions the UK has become the first country to achieve 90:90:90.
- **Focus on interventions that support the whole population not just the high risk**. Using teenage pregnancy as an example, the introduction of SRE in schools helped to educate and empower all children to make better choices even though many were seen as low risk for teenage pregnancy. It also had the value of targeting boys as well as girls and to get them to understand their responsibility.
- **Legislative and regulatory change is needed alongside societal and personal change not either or**. We know advertising bans work, they do not stop people from doing something but make it far less likely, we know that many industries are regulated (including schools, the NHS and charities) and it doesn't stunt growth or development. Its odd that we heavily regulate markets that seek to do good (but may cause harm) but lightly or allow self-regulation for markets that do cause harm.
- **We cannot just change legislation and expect individuals to change their behaviour**, these need to be done in parallel and support of one another rather than seen as competing ideologies.
- **Independence of expertise is critical**. If you aren't independent, you have a conflict and that will either knowingly or unknowingly compromise your viewpoint.
- **Understanding not all industries are the same**. There are many harm industries but not all organisations set out to seek harm, those that do should be treated as such, but those that don't need to be worked with and respected.
- All public health approaches need to be seen in the context of a wider set of issues as healthcare is only a small driver of health.

Using market forces for good. If we also thought about the opportunity of using the market as a way to define this, we could see more sophisticated consumer choice emerging, after all without consumers there's not a market and helping the public to shape the products they want is a hugely powerful approach and political argument, at the moment the market shapes this product not the other way around. All of this is a very different framing from the nanny state and public health overreach.

In summary

- At its heart, public health is pro-growth, pro-improvement and pro-equity. All three of these need to be in place to have a strong and prosperous nation.
- Public health must get better at shaping the narrative in a way that makes the public, treasury and political case for change rather than just the evidence case and needs to use the opportunities of modern approaches to do this.
- The treasury and politicians have a significant role to play in helping make their country prosperous.
- There is a clear public health playbook for undertaking complex public health improvements. It works and can be replicated but is nuanced and not linear.
- There are several very good examples of effective systemic public health improvements, they all were successful and delivered benefits, both societal and financial but they took time and needed investment.

3 Helping smokers quit: a blueprint for success

Deborah Arnott, Chief Executive, Action on Smoking & Health

Introduction

There is good evidence that a comprehensive strategy can reduce the number of people starting to smoke and increase the number of smokers who quit. The set of tobacco control measures set out in the table overleaf were developed by ASH and the SPECTRUM public health research consortium, based on work originally carried out for the APPG on Smoking and Health.[15]

The detailed modelling of policy impact was carried out by UCL Tobacco and Alcohol Research Group[16] based on a substantial body of research and evaluation evidence, which also provided the basis for costing each intervention.

Summary

Spending from the public health grant on smoking cessation and tobacco control declined by 47% in real terms between 2013 when public health was handed over to local government, and 2022. The settlement announced for the next two years represents another real term cut in funding. The funding we recommend is needed to reinstate capacity to provide specialist support to all smokers with the addition of targeted measures to reduce health inequalities and needs to be coupled with a ratcheting up of regulation.

Our recommendations, set out in Table 1 below, go further than the government commissioned Khan review and would cost around twice as much, £250 million a year rather than £125 million recommended by Khan. UCL modelling of the interventions show that together they could reduce smoking to 5% within 8 years (although formal aggregation would require additional modelling). The direct benefit to public finances would be a return on investment of 3 times. The wider economic benefit to society, including value of life, would be an 86 times return on investment.

Targeting

Stronger regulation is proven to reduce youth uptake, and is highly cost-effective. Raising the age of sale to 21 would reduce smoking rates by 30% among 18-20 year olds amounting to 95,000 fewer smokers in year one, and 8,500 a year thereafter.

[15] Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021. London: APPG on Smoking and Health. 2021.

[16] UCL Tobacco and Alcohol Research Group. Modelling of recommendations for the Tobacco Control Plan. Open Science Framework

Supporting smokers to quit is more expensive, but still highly cost-effective and could be made more effective by better targeting of communities with high rates of smoking:

- around a third of people aged 16+ living in social housing smoke amounting to four in ten smokers (41% of smokers aged 16+)
- around a third of smokers 16+ have common mental illnesses (anxiety disorders and/or depression) amounting to 30% of people who smoke
- around one in four people in routine and manual occupations (C2DE) smoke, compared to fewer than one in ten in managerial and professional occupations, and the gap has widened since 2012[17]
- one in sixty people visit their GP a day, and GP records identify smokers.[15]

Motivating smokers to quit

Seven out of ten adult smokers want to stop smoking, and three quarters regret ever having started.[18] However, smoking is highly addictive and smokers need to be motivated to move from wanting to trying to quit.

The most cost-effective means of motivating smokers is mass media behaviour change campaigns. After real terms funding was cut by over 90% between 2008 and 2018 the numbers of smokers trying to quit each year fell by a quarter from 40% to 30%.[15] Funding of £28 million could deliver a targeted campaign which would deliver 255,000 additional quit attempts in year one, two thirds of whom would be C2DE smokers, at £110 per quit attempt.

Maximising successful quitting

Smokers are most likely to quit successfully if they use e-cigarettes, or licensed medications, plus behavioural support. Opt-out referral when smokers are offered support rather than just advised to quit is most effective, this can increase quitting fourfold and is highly cost-effective.

E-cigarettes nearly double successful quit rates compared to traditional nicotine patches and gums, so ensuring smokers have access to e-cigarettes will increase successful quitting.

Providing opt out referral throughout the NHS, in acute and mental health care, in secondary, primary and community settings, backed up by reinstating funding for stop smoking services would deliver 145,300 additional long-term quits in year one broken down by:

- opt out referral to Stop Smoking Services = 54,000
- E-cig offer in social housing = 37,000
- targeted Lung Health Checks including cessation to all 55+ smokers = 36,000
- support to quit in IAPT = 16,000
- support to quit to smokers with SMI = 1,200

[17] ONS. Adult smoking habits in the UK: 2019. July 2020.
[18] National sample of 3,717 adult smokers in England (18+ years) who participated in a web-conducted survey undertaken between March and June 2018. International Tobacco Control (ITC) Project: 29 countries.

- financial incentives to pregnant smokers = 1,100.

The GP Quality Outcomes Framework (QOF) needs revision to mandate opt-out rather than opt-in referral as is currently the case (this should be cost neutral or marginal cost) and the capacity of the specialist stop smoking services would have to be increased (this would cost £80-90 million). Although there have been commitments to tobacco dependence treatment for long-term users of specialist mental health. as part of the Long Term Plan, funding cuts are threatening to undermine successful rollout. Mandating tobacco dependence treatment in the rollout of the Targeted Lung Health Check would cost around £11 million per year based on 15% of eligible population invited for checks. Rollout of Tobacco Dependence Treatment in outpatients has still to be costed. An estimated total of £250 million a year allows a reasonable margin for uncosted or undercosted interventions.

Review and revision

The strategy would need close, rapid monitoring and evaluation, and pivoting to new approaches if insufficient progress made within 2-3 years.

Table 1: A blueprint to end smoking

Recommendation	Rationale and evidence	Outcome
Secure funding		
Yr 1 windfall tax Yr 2 onwards 'Polluter pays' levy	Capping tobacco manufacturers profits to 10%, (average for UK manufacturing) to fund tobacco control and other public health programmes	£74 million windfall tax yr 1 Up to £700 million pa levy thereafter
Set course		
Interim target 5% on route to making smoking history by 2040. Research & evaluation = **£2 m pa**	Setting targets and benchmarking progress using rapid reviews of the evidence enables timely adjustments to the route map to stay on target	Publish strategy to deliver targets in yr 1 and review every 3 years to stay on track.
Target investment – public health interventions		
Mass media campaigns to motivate smokers to quit targeting C2DE smokers £19m national + £9m uplift for most disadvantaged regions = **£28m pa**	**5.4 m 18+ smokers in England** Multi-media behaviour change campaigns highly cost-effective tool to motivate smokers to quit and also help discourage youth uptake	255,000 additional quit attempts in yr 1 (164,000 = C2DE smokers) at £110 per quit attempt
Specialist Stop Smoking Services (SSS) Reinstate government funding to local authorities for stop smoking services to 2013 value to boost capacity to deliver = **£80 m pa**	**Boost Specialist Stop Smoking Services attendance from 178k** (2021 NHS digital number setting a quit date) **to 486k pa** (rate per smoking population achieved in 2012) by proactively contacting smokers with opt out referrals, swap to stop and mass media campaigns to motivate quitting behaviour.	54,000 additional long-term quits in yr 1 at £1,500 per additional quitter

Social housing "swap to stop" offering e-cigarettes as adjunct to stop smoking services to all smokers in social housing. Government commitment April 2023 for 2 year programme delivering 1 million vapes **circa £11 m pa**	2.6 m smokers in social housing Pilot programme in Salford quadrupled uptake of services and improved quit success, with biggest effect on deprived quintile, halving the cost per successful quit.	37,000 additional long-term quits in yr 1 from social housing at £240 per additional quitter
Regional tobacco control Programmes should be mandated to provide essential bridge from national to local across NHS and local government delivery. Funding from increases identified above for mass media, SSS, and "swap to stop" Plus additional **£10 m pa** to reinstate local authority tobacco control budgets to 2013 levels some of which can be used for regional activity	Regional Make Smoking History programmes in the NE (Fresh) and GM are proof of concept that regional behaviour change campaigns, illicit tobacco partnerships and promoting best practice are cost-effective and can help address widening inequalities. Current funding for Fresh and GM programmes at around 50 pence per head funded jointly by local authorities and NHS, equivalent to £22 million nationally earmarked for regional activity.	Inequalities have widened nationally: GM and NE programmes have been able to narrow the gap.
Target investment – NHS interventions for people who smoke		
Acute inpatients Ensure adequate funding for NHS LTP commitments to provide tobacco dependence treatment for all acute inpatients who smoke who and mainstream as part of business as usual post LTP.	Around 20% of people coming for hospital treatment are current smokers equals 3.4 million inpatient admissions of people who smoke a year. Evaluation of GM Health and Social Care Partnership implementation of Ottawa model tobacco dependence treatment for inpatients delivered 22% quit rate for smokers at 12 weeks post discharge costing £475 per quit. The gross	Ottawa model inpatient programme evaluation showed hospital readmission rates nearly halved at 30 days and down by 30% at 1 year; all cause A&E visits within 30 days reduced by 20%

Funding already in place but needs to be sustained at optimum levels.	financial ROI ratio was £2.12 return per £1 invested with a payback period of 4 years.	
Severe Mental Illness Ensure adequate funding for NHS LTP commitments to provide tobacco dependence treatment patients with long term mental health conditions who smoke and mainstream as part of business as usual post LTP. Implement LTP commitment to funding tobacco dependence treatment in community mental health settings and ensure sustained as part of business as usual post LTP. **Funding in place for secondary care yet to be secured for community mental health settings cost TBC**	**220k patients who smoke a year with SMI in secondary care** There is a causal association between smoking and SMI. Quitting improves mental as well as physical health. Smoking contributes up to two-thirds of the reduced life expectancy in people with severe mental illness.	1,200 additional long-term quits among smokers with SMI in yr 1 from tobacco dependence treatment in inpatient settings. Impact of treatment in community mental health settings TBC
Anxiety disorders and/or depression Embed smoking cessation in Improving Access to Psychological Therapies (IAPT) **Funding TBC** but small marginal additional cost to £140 per IAPT appointment plus training and medication.	1.69 m referrals to IAPT a year for anxiety disorders and/or depression = around 500k smokers a year who could be given support to quit through IAPT. 1 in 5 people who smoke are currently in treatment for a mental health condition – the majority of these are people with depression and anxiety. Stopping smoking improves mental as well as physical health, with benefits as significant as from anti-depressants. Furthermore there is a causal link between smoking and development of anxiety disorders/depression.	16,000 additional long-term quits among smokers with anxiety disorders and/or depression in yr 1. .

Pregnancy Ensure adequate funding for NHS LTP commitments to provide tobacco dependence treatment for all pregnant smokers and mainstream as part of business as usual post LTP with addition of financial incentives. April 2023 government commitment to incentives for all pregnant women circa £10m pa	**50 k women smoking at time of delivery pa -** single largest modifiable risk factor in pregnancy. Incentives plus support double quit success and are highly cost-effective given harm caused by smoking. Based on successful Glasgow pilot with shopping voucher £400 generating uptake of 50%	1100 fewer women smoking at time of delivery in yr 1. Long-term cost per QALY £482 - ROI of £4 per £1 invested
Targeted lung health checks Embed tobacco dependence treatment in national Lung Health Check programme = **£11m pa (based on 15% throughput)**	The National Screening Committee has recommended that the Targeted Lung Health Check (TLHC) become a national screening programme for 55+ smoking population (high risk group for lung cancer and COPD).	36,000 additional long-term quits a year if all of the eligible (55+ smoking) population were offered a TLHC. Average cost per quit between £1,600 and £1,900
Outpatients and primary care services Require all smokers to be given brief advice to quit, medication and opt out referral to specialist support. **Cost TBC**	2.4 million outpatient appointments and 7 million GP visits take place weekly. At average adult smoking rate of 13% (could be higher) = over 300,000 opportunities a week in outpatients and over 900,000 in general practice to give smokers advice to quit.	Impact of intervention in outpatients and primary care TBC
Shape the environment		
Raising age of sale for tobacco Consult on options to include raising age from 18 to 21 (T21) and alternatives such as NZ recommendation of 1 year every year.	Reduced smoking rates in 18-20 yr old by 30% US raising age of sale Insufficient evidence to model New Zealand recommendation to raise age one year every year.	T21 delivers 95,000 fewer smokers under 21 in yr 1, and 8,500 pa thereafter

Toughen tobacco regulation including licensing retailers; updated pack warnings and new warnings on cigarettes; and quit messaging on pack inserts	Evidence comprehensive strategy increases rate of decline. UK led Europe in policy 2000 to 2019 and smoking prevalence went from average for Europe in 2006 to half the European average in 2020.	incremental gains towards a smokefree 2030 in reduced uptake and increased quit attempts
Strengthen regulation of vaping and novel nicotine products	Reduce affordability and appeal of packaging and labelling, and further restrict advertising and promotion.	Reduce youth vaping while encouraging adult use of e-cigarettes as a quit aid

4 Shifting the system: tackling obesity through changes to the food environment

Nesta

Summary

Over the past thirty years, there have been almost 700 government-proposed obesity policies[19], yet the prevalence of obesity has doubled.[20] In the UK, 3 out of 5 people are overweight and a third are obese.[21] Obesity is now the second biggest cause of ill health and premature death after smoking and **costs society £54bn.**[22]

According to a recent Nesta analysis, to halve obesity within the UK, the average person with excess weight must cut their daily calorie intake by a far smaller amount than is commonly realised: just 8.5% or 216 calories - equivalent to a 500ml coke bottle.[19] Weight loss with this small change occurs gradually and must be sustained over years.

The route to achieving this is not through individual willpower and dieting. Nor is it through exercise. The solution lies in obesity prevention policy that shifts the obesogenic food environment to one where making healthier choices is the easy, accessible and convenient option. Importantly, changes should be made by the food industry that will not even be noticed by consumers - 'designing out' obesity, as we do with crime.

This approach can deliver major improvements to the health of the nation and take the strain off the NHS with little or no increased funding. If the prevalence of obesity in the UK were halved, the economic benefits would be significant creating a **cost saving to the NHS of around £3.25 billion per year.**[19] A better estimate of **the total cost of obesity to the country is placed at £54 billion,[21]** roughly equivalent to 2-3% of GDP or the total annual funding allocated to schools in England.[23]

There is no 'silver bullet' to halving obesity, but through a combination of initiatives, it is possible to achieve the calorie reductions required. At Nesta, we believe that action in three

[19] Theis, D. R. z. & White, M. Is Obesity Policy in England Fit for Purpose? Analysis of Government Strategies and Policies, 1992–2020. Milbank Q. 99, 126–170 (2021)
[20] Obesity levels have increased from 14% in 1991-2 to 28% in 2019, according to the Health Survey for England (data for 1991 and 1992 is not separated). According to the Health Survey for England 2019, 28% of adults are obese and 36% are overweight. See our report on modelling obesity reductions: https://www.nesta.org.uk/report/modelling-ways-to-improve-our-health/
[21] 'Health Survey for England'. 2022. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england (June 14, 2022).
[22] https://www.frontier-economics.com/media/5094/the-full-cost-of-obesity-in-the-uk.pdf
[23] https://explore-education-statistics.service.gov.uk/find-statistics/school-funding-statistics

areas of focus are needed, these are: 1) reducing the energy content of food and drink (e.g. exploring how we encourage a reduction in an individual's unhealthy consumption and

how we advocate for industry reformulation); 2) reducing unhealthy food and drink promotion and marketing; 3) improving access to healthy food and drink.

We know that the food sector is not making sufficient progress towards improving the healthiness of its offer to consumers[24] and will need stronger incentives to make the changes we need to see to halve obesity. The food industry needs to recognise that these changes will demonstrate their responsibility to support the health of the nation, thereby supporting the NHS.

In order to see the change required, we need policies in place that shift the system. We think these are:

1. regulating industry with mandatory targets, backed by penalties
2. mandate data collection and reporting for the food and drink industry
3. giving statutory powers to an organisation to set future ambition

Full note

Since 1992, there have been almost 700 government-proposed obesity policies[1], yet obesity rates have doubled[2]. In the UK, 3 out of 5 people are overweight and a third are obese[3]. The UK has the highest rates of obesity in western Europe, and for some groups, obesity now accounts for more deaths than smoking.[25] Obesity contributes to the poorest in society dying around nine years before their more affluent peers, and experiencing ill health almost two decades earlier[26].

The true cost of obesity-associated diseases is extraordinary. For example, obesity is believed to account for 80-85% of the risk of developing type 2 diabetes,[27] which currently costs the NHS £10 billion.[28] Without action, the prevalence of diabetes will increase by 30% to approximately 5 million people by 2035,[29] costing the NHS an estimated £17bn.[30] This is more than the combined treatment cost of all cancers.[31]

Current public government analysis dramatically underestimates the cost of obesity, as it only includes some of the associated health conditions,[32] A better estimate of **the total cost of obesity to the country is placed at £54 billion,[21]** roughly equivalent to 2-3% of GDP or the

[24] https://www.foodfoundation.org.uk/sites/default/files/2022-10/FF_SofNFI_Report%202022_0_3.pdf
[25] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10167-3
[26] https://www.health.org.uk/publications/public-perceptions-of-health-and-social-care-november-2022
[27] https://cks.nice.org.uk/topics/diabetes-type-2/background-information/risk-factors/
[28] https://www.diabetes.org.uk/about_us/news_landing_page/nhs-spending-on-diabetes-to-reach-169-billion-by-2035
[29] PHE. Diabetes Prevalence Model. (2016).
[30] Hex, N., Bartlett, C., Wright, D., Taylor, M. & Varley, D. Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. Diabet. Med. J. Br. Diabet. Assoc. 29, 855–862 (2012).
[31] Hilhorst, S. Cancer Costs. A 'ripple effect' analysis of cancer's wider impact. (2019).
[32] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736417/dhsc-calorie-model-technical-document.pdf

total annual funding allocated to schools in England.[33] The impacts of poor diet and nutrition, including issues associated with high sugar, and high salt intake, are likely to be far higher.[34]

The costs of obesity are not just experienced by individuals. The NHS spends around £6.5 billion a year (close to 4% of its 22/23 budget[35]) on treating its consequences which are forecasted to increase to £10 billion a year by 2050.[36] High rates of obesity also result in significant indirect costs to the economy beyond the health sector. Reductions in workforce productivity and increased use of social care are estimated to cost around £7.5 billion a year.[37]

Shifting the focus from individual responsibility to the food environment

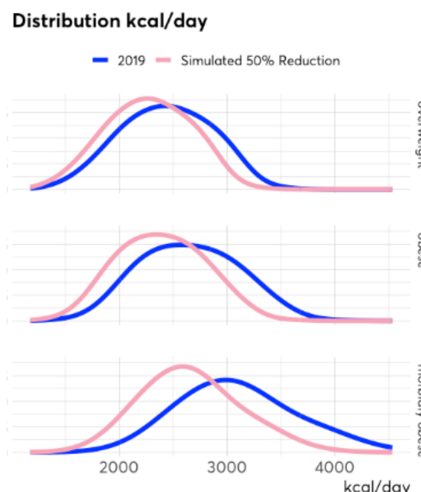
Over the last 30 years, obesity strategy has been misfocused, placing responsibility on the individual rather than tackling the wider environment. Unsurprisingly, this approach has not had its desired effect when implemented in an environment where healthy options are rarely the easy option. Nesta believes it is possible to halve obesity in the next decade in a way that is acceptable to the public, but only if we adopt an entirely different approach to the issue.

Our recent modelling suggests that halving obesity prevalence would only require a small reduction - 216 kcal daily on average (8.5% of a person's daily intake) - in daily intake among people living with excess weight (excess weight is defined as having a Body Mass Index of 25 or higher)[2]. This is equivalent to a 500ml bottle of coke. Realising this change would produce cost savings to the NHS of around £3.25 billion per year.[19] However, the change has to be sustained. Weight loss will occur gradually but over time, so we can't rely on transient, individual motivation.

[33] https://explore-education-statistics.service.gov.uk/find-statistics/school-funding-statistics
[34] GBD https://vizhub.healthdata.org/gbd-compare/
[35] https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget#:~:text=Current%20funding&text=Planned%20spending%20for%20the%20Department,for%20spending%20on%20health%20services
[36] https://www.kingsfund.org.uk/sites/default/files/2021-07/Tackling%20obesity.pdf
[37] https://www.nesta.org.uk/blog/the-economics-of-obesity/

Our goal to halve obesity by 2030

Achievable by a reduction **216 kcal** daily on average



Additionally, in the same way that we design out crime through changes to the layout of streets and town centres, it is possible to 'design out' calories from our foods and food environments. This places the responsibility for addressing the issue firmly at the source - industry - rather than at the end consumer meaning that the NHS will not have to pick up all the costs associated with diet related disease. There's no single initiative that will get us all the way there but we can posit the necessary mechanisms of change. We can look at **marginal reductions in portion sizes** of ready meals and fast foods, and shift the choice architecture within fast food outlets. We can **increase access to, and promotion of, healthier foods** - whether through physical store layouts, promoting healthy swaps in online stores, and reducing or removing junk food adverts.

A particularly interesting route is reformulation - which means changing the recipes and preparation methods of foods to remove small proportions of calories or improve satiety without noticeably affecting taste, price or quality. Our recent research, analysed data from 29,000 households' food purchases and worked with food producers to identify the top 10 food categories where change would be feasible and impactful.[38] A 10% reduction in the calorie content of these 10 categories would mean 38 kcal fewer per

To identify a top 10:

- 'Ambient' cakes and pastries
- Chocolate confectionery
- 'Everyday' biscuits
- Savoury pastries
- 'Morning' goods
- Treats
- Salad condiments
- Chilled ready meals
- Chilled cakes
- Crisps

Source: Nesta analysis

nesta

38 https://media.nesta.org.uk/documents/The_future_of_food_1.pdf

day, getting us 1/5th of the way to halving obesity. Importantly, much of this can be achieved with barely perceivable differences in taste.

Policy proposals: creating a new system for action

At Nesta, we have a strong sense of the food environment changes that are needed to tackle obesity. That is structural measures that disrupt and shift the existing food system in a way that is good for both health and the economy. If implemented correctly this will lead to effortless calorie reduction, through consumers being presented with healthier food, facing fewer prompts to eat, and leading to improved weight outcomes across society.

We have outlined below our approach and the policy levers we would recommend.

Regulate industry with mandatory targets, backed by penalties:

Voluntary targets for the food industry without enforcement will be unlikely to achieve the scale of change necessary to shift the dial on obesity. Businesses will not make significant changes to meet voluntary targets of their own volition, as it will always feel risky or at tension with their commercial incentives. We therefore need mandatory, organisation-level targets across the food and drink sector that mandate a clear goal of calorie reduction but give the industry the freedom to decide their path for achieving that goal. Specifically:

- for retailers, this could be a percentage reduction in the sales-weighted average calories sold from higher calorie-dense products - ultimately a shift in sales from unhealthy to healthy products
- for producers, the goal could be a reduction in the average calories of their products. Either through energy density (kcal/100g) or portion size reductions.

This measure must be mandatory with non-compliance penalised with fines. This would incentivise businesses to take positive action that would improve the nation’s health. This is positive for the consumer as it means their food environments shift without needing them to actively change their behaviour. In practice, manufacturers would reformulate products to avert financial repercussions whilst supermarkets and delivery platforms would promote the most healthy products and portion sizes. Meanwhile, consumers would experience a shift in what is advertised to them, what is on special offer, and what is on the menu in the first place. So without the consumer having to make a specific behaviour change, they would experience modest and sustained reductions to their calorie intake.

Nesta is currently conducting a project to explore specific and implementable mandatory targets for calorie reduction applied to the in-home food sector. It will expand on our aforementioned reformulation work and propose formats for organisational wide targets that function via levers additional to reformulation. Modelled impacts of targets on purchasing, calorie consumption and obesity will also be produced.

Mandate data collection and reporting for the food and drink industry:

A key step to achieving the mandate of targets is to understand the current practices of the sector which is currently opaque. In addition, data collection and reporting should be embedded and legislated. Businesses have data on what is produced and understand their sales performance. This information will be necessary for setting and monitoring targets.

The Food Data Transparency Partnership (FDTP), announced in the recent government food strategy, will be pivotal in achieving this proposal. It should create a system of mandatory reporting against health metrics that will apply to the entire food and drink industry thus generating the necessary data for monitoring against targets. The government has made no further announcements on the FDTP, hence, it is vital that they are pushed to make progress. Until this data is available to support public policy, we will not be able to hold businesses accountable for their actions. This is especially true for the out-of-home sector where data is less accessible, eg, restaurants and takeaways.

Through this mechanism, good and poor business practices can be highlighted. Progressive businesses could use this to publicise their successes and delineate themselves from competitors as health champions.

Give statutory powers to a body to set the future ambition:

To make significant progress on obesity **we need to embolden an organisation - akin to the Climate Change Committee - with the power to set ambitious calorie reduction targets across the sector**. This organisation would be charged with:

a. establishing a bold direction for the UK to achieve its target of halving obesity
b. setting and recommending calorie reduction targets mandated with financial penalties for non-compliance
c. collecting data on food production and sales to inform targets and track progress
d. identifying good and poor performers to shed light on the businesses that are not prioritising the health of the nation

5 Obesity: key facts and statistics[39]

- Today over 3 in 5 (64%) adults and around 2 in 5 (37.8%) children aged 10 to 11 years old are overweight or living with obesity and younger generations are becoming obese at earlier ages. (HSE 2021 & NCMP 2021-22).
- 22.3% of children in Reception (aged 4-5 years) are overweight or living with obesity, of these 10.1% are living with obesity. (NCMP 2021-22).
- 37.8% of children in Year 6 (aged 10-11 years) are overweight or living with obesity, of these 23.4% are living with obesity. (NCMP 2021-22).
- Obesity is a concern across all groups independent of level of deprivation, but children living in the most deprived areas were more than twice as likely to be living with obesity, than those living in the least deprived areas with 13.6% of Reception children living in the most deprived areas were living with obesity compared to 6.2% of those living in the least deprived areas. 31.3% of Year 6 children living in the most deprived areas were living with obesity compared to 13.5% of those living in the least deprived areas. [NCMP 2021-22].
- Obesity is a complex problem and the causes, notably dietary, are affected by factors including our environment, behaviour, biology, physiology and our society and culture – and importantly, the interaction of these determinants. These factors can impact upon and make it difficult for people to maintain energy balance and a healthy weight. (**Reducing obesity: future choices - GOV.UK (www.gov.uk)**)
- Obesity doesn't develop overnight. It builds over time through frequent excessive calorie consumption. On average adults living with overweight or obesity consume 250 to 425 excess calories per day, for children living with overweight or obesity this excess daily calorie intake is estimated to be 140 to 500 each day – varying considerably across age and gender. (**Calorie reduction: The scope and ambition for action (publishing.service.gov.uk)**)
- We have seen some important successes in making food and drink healthier through reformulation. For example, the ---average sugar content of drinks subject to the Soft Drinks Industry Levy decreased by 46% between 2015 and 2020. This equates to a reduction of 46,372 tonnes of sugar purchased over this time period. (**Sugar reduction and reformulation progress report 2015 to 2020 (publishing.service.gov.uk)**)
- One study has suggested this has led to 5,000 fewer girls in year 6 living with obesity: Associations between trajectories of obesity prevalence in English primary school children and the UK soft drinks industry levy: An interrupted time series analysis of surveillance data | PLOS Medicine. (**Associations between trajectories of obesity prevalence in English primary school children and the UK soft drink industry levy: an interrupted time series analysis of surveillance data - Abstract - Europe PMC**)

[39] Source: OHID

- There has also been success in some categories of the sugar reduction programme including a 14.9% reduction in average sugar levels in retailer and manufacturer branded breakfast cereals and 13.5% reduction in yogurts and fromage frais. **Sugar reduction and reformulation progress report 2015 to 2020 (publishing.service.gov.uk)**

6 Food Foundation evidence

Isabel Hughes, The Food Foundation

Introduction

The diets of both adults and children in the UK are not currently optimal for health. Overall, less than 0.1% of the population eat a diet which meets all of the Eatwell Guide recommendations.[40] 75% of the population eat too few fruit and vegetables and 72% eat too much sugar.[41]

The resulting rates of diet-related disease are putting an unsustainable burden on the NHS, reducing productivity, and contributing to ill-health related workforce inactivity. Four of the top five risk factors for ill health in England are related to diet[42], making diet the leading cause of avoidable harm to our health.

The National Food Strategy – an independent review of food policy in England – concluded that as a population we need to make the following four dietary shifts by 2032:[43]

There are currently significant dietary inequalities in the healthfulness of our diets between households of higher and lower incomes. The impact of these dietary inequalities is seen in both higher rates of food insecurity and higher rates of obesity amongst lower-income groups, as well as decreasing life expectancy in some of the most deprived areas in England.[44] 17.7% of households reported food insecurity in January 2023.[45] Children in poorer areas of England are already twice as likely to have obesity than those in wealthier areas.[46]

Focussing on the food environment

The ease with which we can access healthy and sustainable foods are important factors in determining what we eat. The most effective means of shifting our diets requires making changes to our food environment to make healthier food options more **available, affordable**

[40] National Food Strategy analysis of National Diet and Nutrition Survey**:** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772434/NDNS_UK_Y1-9_report.pdf
[41] https://www.nationalfoodstrategy.org/the-report/
[42] Global Burden of Disease, 2019 data: https://vizhub.healthdata.org/gbd-results/
[43] https://www.nationalfoodstrategy.org/
[44] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[45] Food Foundation Food Insecurity Tracker
[46] National Child Measurement Programme

and appealing than unhealthy options. Unlike educational approaches, this type of intervention makes healthier choices easier for everyone. An analysis of 14 government obesity strategies published from 1992 to 2020 (which contained 689 policies) found that the majority of these past interventions encouraged individual behavioural change, relied on voluntary measures to shift industry activity, and did not include sufficient monitoring and evaluation.47 During this period obesity rates amongst men, women and children increased significantly.48

In the next 10 years, policy-making needs to pivot to focus on shifting the food environment rather than on influencing our individual choices. In 10 years' time, success would be a customer being able to walk into a supermarket or down the high-street and find that the cheapest, most convenient, most attractive options are healthy. In such a world, eating a healthy diet would become the default.

Making healthier food more readily ***available***

Less healthy food has crept into all of the settings where people spend time eating or buying food: on high streets, in restaurants, in takeaway outlets, in school canteens, and in supermarkets. We are understandably more likely to eat food which is convenient and readily available. Many products that we routinely see on supermarket shelves and menus are too high in fat, salt and/ or sugar, and lacking in fruit and vegetables. Measures like calorie and nutrition labelling can be helpful in some cases, but they put the responsibility on the individual to decipher whether something is healthy or not, and often the minority of available options are actually healthy. If instead manufacturers reformulated their products and businesses offered more healthy options, it would make these foods more readily available and therefore, easier for people to eat.

Local food environments vary across the country, significantly affecting people's level of access to healthy food. Healthy food is less readily available in low-income communities. Around 1 in 3 places to buy food in the most deprived local authorities are fast-food outlets, compared to 1 in 5 in the least deprived local authorities.49 Convenience stores (on which many low-income households depend) often stock little to no fresh produce.

Key evidence-based policy interventions to make healthier food more readily available include:

- empowering local authorities to improve the food environment in their local areas by strengthening planning rules
- investing in innovation across the food industry by supporting the development of healthy new products, funding research into alternative ingredients and formulations which will enable businesses to make new and existing products healthier, and helping businesses to take these innovations to scale

[47] https://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12498
[48] https://www.nationalfoodstrategy.org/
[49] The Food Foundation, The Broken Plate 2022

- using the power of public procurement to create viable new markets for healthy, sustainable food, introducing mandatory standards and a robust enforcement regime - ensuring at a minimum that two portions of vegetables are included as standard in every main meal in all venues where the state provides food – including hospitals, schools and prisons
- increasing the volume of fruit and vegetables served at snack times and mealtimes in schools and expanding the School Fruit and Vegetable Scheme to all primary school children.

*Making healthier food more **affordable***

Price and affordability are major determinants of the food people choose to purchase, particularly for people on low incomes. For many households, buying healthy food is not currently a sensible economic choice, with healthier options costing nearly three times as much per calorie as less healthy options.[50]

The ability to afford food is not only affected by food prices, but also by the amount of income families have and the costs of other essentials. The poorest fifth of UK households would need to spend 43% of their disposable income on food to meet the cost of the Government recommended healthy diet (the Eatwell Guide).[51] Given rapid rates of food price inflation during the course of the cost-of-living crisis, the financial challenge of affording healthy food is only getting more acute (food prices rose by 18% in the 12 months to February 2023 according to the CPI,[52] and by 20-25% since April 2022 according to tracking of a Basic Basket of food undertaken by The Food Foundation).[53]

The balance of prices needs to shift so that healthy, sustainable foods are the most affordable and within everyone's means.

Key evidence-based policy interventions to make healthier food more affordable include:

- fully implementing existing commitments to restrict multi-buy promotions on less healthy foods. Polling conducted by The Food Foundation in 2022 suggested that 81% of households would find it most helpful for supermarkets to put essential products like fruit, veg, meat and pasta on promotion, compared to just 2% of households that said they would find it most helpful for less healthy products like sweets and savoury snacks to be promoted.[54]
- building on the success of the Soft Drinks Industry Levy by developing new fiscal policies that encourage businesses to reformulate other food and drink categories and rebalance the cost of more healthy and less healthy foods; and investing the revenue

[50] The Food Foundation, The Broken Plate 2022
[51] The Food Foundation, The Broken Plate 2022
[52] Food Foundation Food Price Indices Tracker
[53] Food Foundation Basic Basket Tracker
[54] https://www.foodfoundation.org.uk/news/our-reaction-policies-protect-childrens-health-are-delayed-government

raised into policies which target low-income households and help make healthy foods more affordable and accessible
- requiring that the cost of healthy and sustainable diets be taken into account when setting benefits levels and the minimum wage.

Making healthier food more ***appealing***

Advertising affects our perceptions of foods and food brands and has a direct impact on how much less healthy food we eat. Advertising for less healthy foods is everywhere – online, on the radio, on TV and cinema, on transport, on high streets and at events. Companies would not spend millions of pounds a year on advertising campaigns in the UK if they did not work.

Key evidence-based policy interventions to make healthier food more appealing include:

- fully implementing existing commitments to restrict the prevalence of junk food advertising on TV and online
- reducing the prevalence of unhealthy food and drink advertising in outdoor areas
- investing in advertising for healthy options like fruit and vegetables and pulses to drive aspiration and to normalise consumption, building on the work of hugely successful initiatives like Veg Power.

Providing effective nutritional safety nets

Alongside making improvements to the food environment we also urgently need to provide effective nutritional safety nets to ensure that those on the lowest incomes are able to access good food. There has not been a strong focus on dietary inequalities in any of the government's recent strategies on food and health – including the 2020 Obesity Strategy, the 2022 Levelling-Up White Paper, and the 2022 Food Strategy.

Key evidence-based policy interventions to provide effective nutritional safety nets include:

- expanding eligibility for Healthy Start (in England, NI and Wales) and Best Start Foods (in Scotland) to all children in households on Universal Credit, and making the extension of Healthy Start to children with no recourse to public funds permanent
- extending eligibility for Free School Meals (initially to all children in households on Universal Credit, and longer term on a universal basis for all children), putting all children on an equal footing and eliminating stigma from our school canteens.

Improving food system governance

Successful change will also require shifts in the way that policy in the food system is governed. There is an urgent need for government to use the levers at its disposal to set a clear direction of travel for transformative change in the food system. Without a clear sense of where policy is heading, the food industry lacks the confidence and incentives that would allow it to invest and innovate at the pace that is necessary. In addition, the data that would allow progress to be transparently monitored is not currently reported or collected consistently.

Key evidence-based policy interventions to improve food system governance include:

- demonstrating serious political commitment to dietary shifts by committing to a new food bill for England to provide the means of delivering action, ensuring that England keeps pace with the Good Food Nation bill in Scotland and the Food Bill which is being consulted on in Wales
- setting a series of targets which articulate the long-term outcomes we expect of the food system for our health, environment and economy, and establishing a process for monitoring progress and ensuring accountability
- improving transparency by introducing mandatory public reporting by food businesses against a range of health and sustainability metrics (delivering the promises of the Food Data Transparency Partnership)
- supporting food partnerships to be established in every local area.

About The Food Foundation

We are a young, dynamic, and impactful charity with a mission to change food policy and business practice to ensure everyone, across the UK, can afford and access a healthy diet supplied by a sustainable food system. We are independent of all political parties and businesses. We work with others who believe there is a problem with the system and want to change it.

7 Why a manifesto for health must address alcohol harm

Sir Ian Gilmore and Poppy Hull, Alcohol Health Alliance UK

- Alcohol is the leading risk factor for death, ill-health, and disability amongst 15-49-year-olds in the UK.[55] It is linked to seven types of cancer, suicide, and obesity, and causes more working years of life lost than the ten most common cancers combined.[56]
- 1 in 20 hospitalisations are primarily or secondarily linked to alcohol,[57] and alcohol-specific deaths are at record-high levels, having increased by 27.4% since 2019.[58]
- 17.5% of people now drink at increasing-risk and higher-risk levels, compared to 12.4% in February 2020.[59] Modelling suggests that unless alcohol use returns to pre-pandemic levels, an estimated extra 99,500 cases of hypertension and 20,000 cases of stroke by 2035 will cost the NHS up to £1.2 billion.[60]
- Alcohol harm is both a determinant and outcome of socioeconomic inequality: in England, the death rate from alcohol in the most deprived decile is double that in the least deprived.[61]
- Alcohol can fuel crime and disorder, lead to family breakdown, domestic violence, and puts significant pressure on our public services. [62]
- The overall societal costs from alcohol are estimated to be at least £27 billion every year, including £8.3bn in healthcare costs.[63]

How to make progress tackling alcohol harm

An independent review of alcohol harm looking at prevention, treatment and recovery would help us understand the scale of the problem and identify policies to inform a comprehensive, long-term alcohol strategy with national targets. The below interventions are cost-effective and recommended by the World Health Organization for reducing alcohol-related harm.[64]

[55] VizHub - GBD Results. (2019). Global Health Data Exchange, Institute for Health Metrics and Evaluation, University of Washington.
[56] Schütze M. et al. (2011). Alcohol attributable burden of incidence of cancer in eight European countries based on results from prospective cohort study. *British Medical Journal*. Public Health England (2016). The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies.
[57] NHS Digital (2022). Statistics on Alcohol, England 2021
[58] Office of National Statistics (2022). Alcohol-specific deaths in the UK: registered in 2021.
[59] Alcohol in England (2023). Monthly tracking KPI.
[60] IAS and Health Lumen (2022). The COVID hangover: Addressing long-term health impacts of changes in alcohol consumption during the pandemic.
[61] OHID (2021). Local Alcohol Profiles for England: short statistical commentary, December 2021

[63] Burton, R. et al. (2016). A rapid evidence review of the effectiveness and cost-effectiveness of alcohol control policies: an English perspective. *The Lancet*.
[64] World Health Organization. (2018). SAFER – alcohol control initiative.

Pricing policies

The affordability of alcohol is directly linked to alcohol harm, with heavier drinkers tending to consume products that are both cheaper and stronger on average.[65] Alcohol taxation and pricing policies are some of the most cost-effective alcohol control measures.[66]

- **Alcohol duty:** Increased excise taxes on alcoholic beverages reduce harmful use of alcohol while raising revenue for vital public services. We support the strength-based duty system that will come into effect on 1 Aug 2023, with alcohol duty to increase in line with RPI, after cuts and freezes cost the Treasury £8.6bn since 2012.[67] To be most effective, cider exceptionalism should be ended, and duty rates should automatically increase annually with inflation.[68] The alcohol duty escalator (automatically uprating duty by 2% above inflation every year) helped curb the rising trend in alcohol-related deaths from 2008 until its repeal in 2013.[69] Modelling indicated that returning to this duty escalator in England for 12 years would save over 4,700 lives, prevent more than 160,000 hospitalisations, save NHS England £794 million, prevent 260,000 crimes, and save the economy £156 million by reducing workplace absences.[70]
- **Minimum unit pricing (MUP):** England should introduce a minimum unit price of at least 50p, along with a mechanism to regularly review and revise this in line with inflation.[71] In Scotland, MUP has been effective in reducing overall alcohol consumption by 3-3.5%,[72] with the proportion of drinkers consuming at hazardous levels also decreasing by 3.5%.[73] Household purchases have decreased in Scotland by 7.7% and in Wales by 8.6%, with changes predominantly seen in the heaviest-drinking households.[74] In Scotland, MUP has been associated with a 13.4% decline in alcohol-specific deaths.[75] The largest reductions were found for those living in the 40% most deprived areas, groups re known to experience disproportionally high levels of alcohol health harms in Scotland.[76]

Alcohol marketing

Alcohol marketing normalises alcohol consumption and exposes children and vulnerable people to alcohol products, leading people to drink more and at an earlier age.77 The current self-regulatory system governing alcohol marketing does not work: despite existing codes prohibiting the targeting of alcohol adverts to children, more than 80% see alcohol marketing

---

[65] Griffith, R. et al. (2017). Tax design in the alcohol market. *Institute for Fiscal Studies.*
[66] World Health Organization. (2018). SAFER: Raise prices on alcohol through excise taxes and pricing policies.
[67] The Institute of Alcohol Studies (2021) October Budget Analysis
[68] Alcohol Health Alliance UK. (2022). Alcohol duty reform.
[69] Analysis by IAS
[70] Angus, C. and Henney, M. (2019). Modelling the impact of alcohol duty policies since 2012 in England and Scotland.
[71] Alcohol Health Alliance UK. (2022). Minimum unit pricing.
[72] Giles, L. et al. (2022). Evaluating the impact of Minimum Unit Pricing (MUP) on sales-based alcohol consumption in Scotland at three years post-implementation. Public Health Scotland.
[73] Holmes, J. et al. (2022). Evaluating the impact of minimum unit pricing in Scotland on people who are drinking at harmful levels.
[74] Anderson, P. et al. (2021). Impact of minimum unit pricing on alcohol purchases in Scotland and Wales: controlled interrupted time series analyses. *The Lancet*.
[75] Wyper, G. A. (2023). Evaluating the impact of alcohol minimum unit pricing on deaths and hospitalisations in Scotland: A controlled interrupted time series study. *The Lancet.*
[76] Gregory, A. (2023). Scotland's minimum pricing linked to 13% drop in alcohol-related deaths, study finds. *The Guardian.*
[77] Jernigan et al. (2016). Alcohol marketing and youth alcohol consumption. *Addiction*.

monthly, most are aware of various alcohol brands, and children as young as nine can accurately describe alcohol brands' logos and colours.78The WHO recommends comprehensive marketing restrictions as most effective to reduce alcohol harm and protect children and vulnerable people. Until a full comprehensive ban is introduced, the following policies can help reduce children's exposure to alcohol marketing:

- **Ending alcohol sports sponsorship.** Sports sponsorship enables alcohol companies to reach and influence millions of young people every year: broadcasts of the fifteen 2019 Guinness Six Nations Rugby Championship matches delivered an estimated 758 million Guinness-related branded impressions to children aged under 16 in the UK.[79] Alcohol sports sponsorship has been found to increase levels of consumption and risky drinking amongst schoolchildren and sportspeople.[80] It is inappropriate to use sports to promote an addictive and health-harming product, which misleads consumers that alcohol is compatible with a healthy lifestyle.
- **TV watersheds.** Time restrictions for alcohol advertising on TV can reduce children's overall exposure to alcohol advertising, although can increase exposure for older children:[81] following a watershed restriction in the Netherlands, alcohol ads more than tripled after 9pm.[82] Nonetheless, as this is already expected to come into place for high in fat, salt and sugar products as per the obesity strategy,[83] there is no reason why an age-restricted product such as alcohol should not face the same regulations.
- **Online bans.** Children and young people are regularly exposed to alcohol marketing online: around 2 in 5 11-17-year-olds in the UK report having seen adverts on social media, and 19% had interacted with alcohol marketing online in the previous month.[84] Participation and engagement with digital alcohol marketing is positively associated with alcohol use for adolescents and young adults.[85] Data-driven advertising also disproportionately targets people with (or at risk of) an alcohol use disorder at times when they are most susceptible,[86] underlining the need to restrict digital alcohol marketing.
- **Restricting advertising in public spaces**: These have been successful in reducing consumption of other unhealthy products: banning advertising of foods high in fat, sugar and salt on the London transport network was associated with significant reductions in purchases of such products.[87]
- **Restricting the visibility of alcohol in the retail environment**: Removing confectionary, chocolate, and crisps from checkouts in England saw a 17% reduction in

[78] Alcohol Health Alliance UK (2021). No escape: how alcohol advertising preys on children and vulnerable people.
[79] Barker, A. B. et al (2021). A content analysis and population exposure estimate of Guinness branded alcohol marketing during the 2019 Guinness Six Nations. *Alcohol and Alcoholism*
[80] Brown, K. (2016). Association between alcohol sports sponsorship and consumption: A systematic review. *Alcohol and alcoholism.*
[81] Ross, C. S., et al. (2013). Do time restrictions on alcohol advertising reduce youth exposure? *Journal of Public Affairs*.
[82] van den Wildenberg, A. et al. (2011). *Report on youth exposure to alcohol commercials on television in Europe: Volume of youth exposure in the Netherlands*. European Centre for Monitoring Alcohol Marketing (EUCAM).
[83] DCMS and DHSC. (2021). Introducing further advertising restrictions on TV and online products high in fat, salt and sugar
[84] Alcohol Health Alliance UK (2021). *No escape: How alcohol advertising preys on children and vulnerable people*.
[85] Noel, J. K. et al. (2020). Exposure to digital alcohol marketing and alcohol use: A systematic review. *Journal of Studies on Alcohol and Drugs, Supplement*.
[86] Carah, N. et al. (2021). Alcohol marketing in the era of digital media platforms. *Journal of Studies on Alcohol and Drugs*.
[87] Yau, A. et al (2022). Changes in household food and drink purchases following restrictions on the advertisement of high fat, salt, and sugar products across the Transport for London network: A controlled interrupted time series analysis. *PLoS Medicine*.

purchase of these items within four weeks of implementation, and a 15% reduction still present after a year.[88]

- **No and Low alcohol products**. These policies should apply to no and low alcohol products that share a brand name, or identifiable brand markings, of alcoholic drinks. This advertising encourages brand allegiance, including amongst underage consumers, and serves to circumvent restrictions and undermine the objectives of legislation to reduce alcohol advertisement.[89]

Alcohol labelling

To raise public awareness about alcohol harm so consumers can make informed choices about what and how much they drink, all alcohol labels should display relevant information. This should include: the Chief Medical Officers' low-risk drinking guidelines; a prominent health warning; a pregnancy warning; a drink-driving warning; an age warning; the units provided in the whole container and a typical serving; a list of ingredients and full nutritional information including calorie and sugar content.[90] Mass media campaigns are also an effective means of raising awareness. Evaluation of the TV-led "Alcohol Causes Cancer" campaign in the North East found that 68% of those who recalled the campaign said it made them stop and think. 17% of drinkers said they cut down how often they drank, and 13% cut down how much.[91]

Availability

The availability of alcohol directly correlates with levels of harm: in Scotland, alcohol-related hospital admissions, deaths, and crime rates are closely associated with the density of licensed premises.[92] Limits on alcohol availability in nightlife in Queensland, Australia resulted in a 49% drop in assaults between 3am and 6am on Friday and Saturday nights.[93] Local Authorities need to be able to better control the availability of alcohol in their areas. Making public health a licensing objective can support public health bodies' position as a responsible authority in reducing health harms.[94]

As alcohol outlet density tends to rise with increasing neighbourhood deprivation (and both being linked to higher rates of alcohol-related hospitalisations and deaths), limiting availability could have benefits for reducing inequalities of alcohol harm.[95]

Drink driving

The UK Government must reduce the drink drive limit in England and Wales to 50mg/100ml in line with Scotland and the rest of Europe.[96] The current, 80mg/100ml, limit

[88] Ejlerskov, K. T. et al. (2018). Supermarket policies on less-healthy food at checkouts: Natural experimental evaluation using interrupted time series analyses of purchases. *PLoS Medicine.*
[89] Nicholls, E. (2022). "You can be a hybrid when it comes to drinking." The Marketing and Consumption of No and Low Alcohol Drinks in the UK. Institute of Alcohol Studies.
[90] Alcohol Health Alliance UK (2022). Alcohol labelling.
[91] Balance, Evaluation (2022).
[92] Alcohol Focus Scotland (2018). Alcohol outlet availability and harm in Scotland.
[93] Movendi (2022). Common Sense Limit to Alcohol Availability in Nightlife Leads to Reduction in Assaults in Queensland, Australia.
[94] Public Health England (2017). Findings from the pilot of the analytical support package for alcohol licensing.
[95] Angus, C. et al (2017). Mapping patterns and trends in the spatial availability of alcohol using low-level geographic data: a case study in England 2003-2013. AFS a (2018). Alcohol Outlet Availability and Harm in Scotland
[96] Alcohol Harm Commission. (2020). 'It's everywhere' – alcohol's public face and private harm.

was set in 1967 and has never been amended. This should be enforced by random roadside breath-testing of drivers and the introduction of Mobile Evidential Breath Testing Equipment to avoid delays in testing samples once drivers are pulled over. Mass media public education campaigns would also improve understanding of the dangers and penalties of drink-driving.

Treatment

Investment in and improvement of alcohol treatment (including prioritising the long-awaited updated Alcohol Treatment Guidelines[97]) is necessary to reduce the large level of unmet need and improve outcomes. Alcohol treatment provides very good value for money: in England, every £1 invested in alcohol treatment is predicted to yield £3 of social return, increasing to £26 over 10 years.[98] However, only 18% of dependent drinkers in need of specialist treatment can currently access it.[99] The manifesto should incorporate a call for better alcohol treatment including:

- **Alcohol-specific funding.** Reductions in funding available to commission alcohol services have led local authorities to combine alcohol and other drug treatment services, resulting in the deprioritisation of alcohol treatment compared to drugs, a reduction in alcohol specialisation, and increased barriers to alcohol users approaching services.[100] There is also considerable regional variation in public health budgets.[101]
- **Workforce strategy:** There are fewer specialist addictions psychiatrists, clinical psychologists, and nurses, with a greater reliance on doctors without specialist training and volunteers with limited training. Training places for addiction psychiatrists have gone from around 60 to around 5.[102] The Royal College of Psychiatrists have recommended an allocation of £90 million of capital funding for drug and alcohol use disorder services by 2024/25, which will hopefully prepare local authorities and NHS services for a likely increase in demand following the COVID-19 pandemic.[103]
- **The scaling up of cost-effective treatments including:**
    - Alcohol Care Teams (ACTs): ACTs are teams of specialist proven to reduce acute hospital admissions, readmissions and mortality, and improve the quality and efficiency of alcohol care. They are cost-effective across crime and social disorder, families and family networks, the workplace, and health.[104] The optimal seven-day service is estimated to save £179,000 per annum per 100,000 population.[105] Implementation of an alcohol specialist nurse service in Nottingham improved the health outcomes and quality of care for detoxification and alcohol-related cirrhosis patients, resulting in a saving of 36.4 bed days per month in detoxification patients and

[97] PHE (2019). UK alcohol clinical guideline development begins.
[98] PHE (2018). Alcohol and drug prevention, treatment and recovery: why invest?.
[99] PHE (accessed September 2021). Public health dashboard.
[100] PHE (2018). PHE inquiry into the fall in numbers of people in alcohol treatment: findings.
[101] Dame Carol Black (2020) Review of Drugs: Executive Summary.
[102] Ibid.
[103] Royal College of Psychiatrists. (2021). The Royal College of Psychiatrists' Spending Review Representation Autumn 2021.
[104] Moriarty, K. (2019). Alcohol care teams: where are we now? *Frontline Gastroenterology*.
[105] NICE (2016) Quality and Productivity Case Study: Alcohol Care Teams: reducing acute hospital admissions and improving quality of care.

a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month.[106] The NHS Long Term Plan set aside £27 million to support the implementation of specialist ACTs in 25% of hospitals with the highest rates of alcohol-dependence related admissions, estimated to prevent 50,000 admissions over five years.[107] There should now be a national roll-out of ACTs.

- Assertive outreach: Assertive outreach delivers effective results for high-need, high-cost repeat attenders at hospital.[108] In 2015/16, just 9% of people with alcohol dependence accounted for 59% of inpatient alcohol-related hospitalisations. These 54,369 patients accounted for 365,000 admissions and over 1.4 million bed days, at an estimated cost of £858 million.[109] Interventions targeting this group can offer considerable cost savings, improved health and quality of life. One evaluation showed an increase in abstinent days from 14% to 68%, and inpatient bed days reduced from 26.8 to 1.2 - a return on investment of £3.42 for every £1 spent.[110]
- Intervention and brief advice (IBA): IBA is a cost-effective intervention that can reduce consumption before the point that treatment for dependence is needed.[111] IBA has a return of £1.23[112] (rising to £12 over 7 years)[113] for every £1 spent. It is often delivered in primary care but has been rolled it out in innovative settings e.g. dentists, hairdressers, driving lessons.[114]

- **Engaging with community groups:** A Cochrane Review showed that AA and other 12 step programmes are at least as effective as other established treatments and "produces substantial healthcare cost savings."[115] Experts by experience also highlight the benefits of peer support and mutual aid for their recovery. For those who undertake formal treatment, the recovery community can help to provide support and prevent relapse after treatment.[116] There should be better integration between formal and informal treatment, with staff in treatment services better aware of the range of support available so they can signpost people.
- **Better coordination between alcohol treatment and other services such as mental health, domestic abuse, and housing support services.**
  - Alcohol dependence often co-occurs with other mental and physical health conditions. Two-thirds of new starters into alcohol treatment between 2021 and 2022 also required mental health treatment.[117] Of all alcohol-related hospital admissions, 23% are for mental and behavioural disorders due to the use of alcohol.[118] Individuals with

[106] Ryder, S. D. et al (2010). Effectiveness of a nurse-led alcohol liaison service in a secondary care medical unit. *Clinical Medicine*.

[107] Hansard (2020). Response to Written Question, UIN 91927.
[108] DHSC (2021). Independent report: Review of drugs part two: prevention, treatment, and recovery
[109] Drummond, C. et al. (2019). Assertive outreach for high-need, high-cost alcohol-related frequent NHS hospital attenders: The value-based case for investment. NIHR.
[110] Moriarty, K. (2019). Alcohol care teams: where are we now? *Frontline Gastroenterology*
[111] PHE (2018). PHE inquiry into the fall in numbers of people in alcohol treatment: findings.
[112] Drummond, C. et al. (2019). Assertive outreach for high-need, high-cost alcohol-related frequent NHS hospital attenders: The value-based case for investment. NIHR.
[113] Department of Health (2011) Mental health promotion and mental illness prevention: the economic case
[114] Alcohol Harm Commission (2020) It's everywhere – alcohol's public face and private harm
[115] Cochrane Library (2020) Alcoholics Anonymous and other 12-step programs for alcohol use disorder
[116] Alcohol Harm Commission (2020) It's everywhere – alcohol's public face and private harm
[117] OHID (2023). Adult substance misuse treatment statistics 2021 to 2022: report.
[118] NHS Digital (2022). Statistics on alcohol, England 2021

a mental health condition concurrent with problematic alcohol use also experience a greater burden of physical illness.[119] Despite the prominence of dual diagnosis, treatment for each condition is often dependent on a patient recovering from one condition first.[120]More alcohol training for non-alcohol specialists is needed to prevent stigmatisation across different services, as well as anti-stigma campaigns for both public and practitioner audiences to reduce the normalisation of alcohol as a form of self-medication for dealing with stress and distress.[121]

- Around 10% of those accessing domestic violence support services had an alcohol use need.[122] Yet women-only provision of substance use treatment is available in fewer than half of local authorities in England and Wales.[123] Alcohol harm should be incorporated into the Domestic Abuse Commissioner's remit to ensure the link between alcohol and domestic abuse is considered in safeguarding schemes.
- Employment opportunities and housing status are also important for improving recovery outcomes. 1 in 10 of those starting treatment between 2020-2021 for alcohol problems said they had a housing problem.[124] Housing First is an effective model for people with complex needs who sleep rough, which should be rolled out more widely.[125] Individual placement and support (IPS) has an established evidence-base in the mental health sector, and is also successful in getting people in drug and alcohol treatment back into work.[126]
- Two NICE principles are crucial to take forward: 'everyone's job' indicates that both commissioners and service providers are responsible for providing services for people with a dual diagnosis or complex needs. Secondly, 'no wrong door' underlines that service providers should not turn away people with co-occurring conditions and that treatment for any of the conditions should be available at every point of contact (Making Every Contact Count).[127]

Industry involvement

The Manifesto for Health should recognise wider issues regarding the commercial determinants of health: private sector activities that impact public health. The alcohol industry relies enormously on high-risk drinking, with the heaviest 4% of the population contributing 23% of all industry revenue.[128] Due to the harmful nature of alcohol, it is inappropriate for the industry to be involved in policy-making when there is an inherent conflict of interest. Any industry involvement should require a careful risk assessment process to identify and mitigate risks, and ensure there are net public

[119] Gomez, K. U. et al. (2023). The clustering of physical health conditions and associations with co-occurring mental health problems and problematic alcohol use: a cross-sectional study.
[120] Care Quality Commission (2015) Right here, right now: People's experiences of help, care and support during a mental health crisis.
[121] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.
[122] Office for National Statistics (2018) Table 63: Personal characteristics of clients accessing Independent Domestic Violence Advisor (IDVA) services that use SafeLives' Insights tool.
[123] Agenda and AVA (2017) Mapping the Maze: services for women experiencing multiple disadvantage in England and Wales Executive Summary
[124] OHID (2021). Adult substance misuse treatment statistics 2020 to 2021: report
[125] DHSC (2023) Independent report: Review of drugs part two: prevention, treatment, and recovery
[126] Ibid.
[127] NICE. (2019). Coexisting severe mental illness and substance misuse.
[128] Bhattacharya, A. et al. (2018). How dependent is the alcohol industry on heavy drinking in England? *Addiction*

benefits from any partnerships. We would recommend the statutory use of guidelines such as Public Health England's 'Principles for engaging with industry stakeholders.'[129]

[129] Public Health England. (2019). Principles for engaging with industry stakeholders.

8 Early nutrition and development

Zoe Birch

How can we avoid setting our children up for obesity and addiction?

The challenge

In 2019, over a million children were in private and voluntary nurseries, and about 240,000 were with childminders (Department for Education, 2019). A survey of nutrition practices in 851 nurseries in England reported that about 7% of children in these settings were under one year (Neelon *et al*, 2015). England has no mandatory food and nutrition standards for early years settings. Lack of compulsory standards means childcare settings often offer inappropriate food high in sugar, fat and salt and lack diversity of the key nutrients needed for healthy brain development.

Nutrition and brain development

Nutrition plays a critical role in brain development during the first five years of a child's life. Proper nutrition provides the essential nutrients and energy for the brain to grow, develop, and form neural connections. Providing adequate nutrition to children during the first five years of life is essential for healthy brain development, which is critical for their long-term cognitive, emotional, and behavioural wellbeing.

Excessive sugar consumption has been linked to changes in the brain's reward system, which can lead to a preference for sweet foods and a reduced ability to regulate food intake. This can contribute to an increased risk of being overweight and obesity, which negatively impacts cognitive development and academic performance.

Sugar is a genuine addiction. One of the reasons why sugary foods have such a strong pull (and a reason not to introduce them too early) is that sugar activates the *pleasure and reward* centre of our brains. Sugar has the same effect on the brain as hard drugs. Dopamine is a neurotransmitter associated with pleasure and reward. Sugar activates this also. After consuming foods high in sugar, salt and fats, the brain is flooded with endorphins, but a drop quickly follows this in both blood sugar and mood. The brain then trains us to look for the same substance that gave us the dopamine hit. i.e. Foods high in sugar.

Baby food

Commercial baby foods are frequently high in sugar, and their packaging may encourage overeating. Limited regulation relating to the composition, labelling and marketing of baby foods means that families using commercial products are likely to offer soft, sweet foods, often with limited nutritional content, as these dominate the market (Crawley and Westland

2017; Westland and Crawley 2018; Sparks and Crawley 2018; Public Health England 2019b). The widespread use of commercial baby foods matters because while they are marketed as healthy, many are not (García *et al* 2019). Many are high in sugar or salt, including processed fruit ingredients such as purées, powders and pastes which are included in the definition of free sugars (Public Health England 2019b).

By feeding 0-5 years olds food high in sugar, fat and salt (often referred to as UPF's Ultra-processed foods, we are literally training our children's brains by setting up the neuropathways to become addicted, first to sugar and then later in life to anything that will activate these same pathways.

Non-communicable diseases (NCD) in children

Excess sugar intake is a known risk factor for several non-communicable diseases (NCDs) affecting children under five in the UK, including Obesity linked to excess sugar intake. In addition, children who consume large amounts of sugary foods and drinks are more likely to become overweight or obese, increasing their risk of developing other NCDs such as diabetes and heart disease.

27.7% of children started primary school overweight or obese in 2020/2021, and that number is increasing year on year. Our Early Years food environment is broken, and we have recommendations to fix it, but the government are choosing to ignore it.

The cost

See end for list of referenced reports

- Two in five children in England are now above a healthy weight (including one quarter living with Obesity) when they leave primary school.
- Children with Obesity are five times more likely to become adults with Obesity, increasing their risk of developing severe health issues.
- It is estimated that the NHS spends £6.5 billion annually on treating obesity-related ill health, with Government analysis in 2017 projecting this to reach £9.7bn by 2050. IPPR predict that excess weight amongst the current cohort of children will cost the NHS £74 billion over their lifespan.
- Almost 10% of the total NHS budget is spent on diabetes care.
- Nearly 60% of all new diabetes cases (and 70% of diabetes expenditure) are due to weight, as well as 18% of cardiovascular disease, 11% of dementia and 8% of cancers.
- Children from deprived areas are more than twice as likely (20.3% of children at reception age, 33.8% at year 6 age) to be living with Obesity than their more affluent counterparts (7.8% at reception age, 14.3% at year 6 age), with similar patterns across Scotland and Wales.

Unless we put meaningful interventions in place, everything will stay the same. You can't fix or reverse these issues. There are hundreds of reports showing that intervening at primary school or later will <u>not</u> turn the tide on Obesity. <u>Early Action is essential</u>.

The prescription

Many recommendations have already been made (First Steps Nutrition Trust), and some of those have already been accepted by the government only to be shelved instead of implemented:

Most impactful 3 changes that can be made now!

- A mandatory Food and Drinks strategy for Early Years Settings:
  An early year's food strategy should be drawn up, which includes menus dense with the foods needed for healthy brain development and limiting the amount of free sugars that contribute to Obesity and other NCDs. Meeting the standards should be part of the Ofsted inspection framework.
- Nutrition training for health professionals:
  Include nutrition training in core curricula for all healthcare professionals. Ensure all those healthcare professionals who have meaningful contact with our children are given appropriate information and skills to support healthy nutrition and understand why it is so important. No, training on nutrition is provided in the current framework. People will only make meaningful changes if they understand why.
- Reformulation Tax (modelled on the success of the soft drinks Levy. *See* end):
  Taxing processed baby foods, snacks and drinks designed and marketed for 0-5-year-olds that are manufactured and targeted at young children that are high in sugar. The money raised could then be spent on educating health professionals and increasing the amount provided to Early year setting per child to feed them. It is currently approximately £1.50 per day per child.

This report was written by Zoe Birch (birchz@parliament.uk) with reference to research provided by Obesity Health Alliance, Diabetes UK, The Health Kick, First Steps Nutrition Trust.

List of referenced reports

- NHS Digital (2021) National Child Measurement Programme, England 2020/21 School Year https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2020-21-school-year
- Simmonds M, Llewellyn A, Owen CG, Woolacott N. Predicting adult obesity from childhood obesity: a systematic review and meta-analysis. Obes Rev. 2016 Feb;17(2):95-107.
- Frontier Economics (2022) Estimating the Full Cost of Obesity https://www.frontier-economics.com/media/5094/the-full-cost-of-obesity-in-the-uk.pdf
- PHE (2017) Health matters: obesity and the food environment https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2
- IPPR (2020) The Whole Society Approach https://www.ippr.org/files/2020-08/a-whole-society-approach-aug-2020.pdf

- OECD (2019) The Heavy Burden of Obesity : The Economics of Prevention https://www.oecd-ilibrary.org/sites/6cc2aacc-en/index.html?itemId=/content/component/6cc2aacc-en
- The King's Fund (2021) New analysis reveals stark inequalities in obesity rates across England https://www.kingsfund.org.uk/press/press-releases/new-analysis-stark-inequalities-obesity-england
- PHE (2019) Overweight children: Facts & Figures https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-children/latest
- PHE (2019) Overweight Adults: Facts & Figures https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest
- Public Health England 2020 'National child measurement programme (NCMP): trends in child BMI between 2006 to 2007 and 2018 to 2019' https://www.gov.uk/government/statistics/national-child-measurement-programme-ncmp-trends-in-child-bmi-between-2006-to-2007-and-2018-to-2019

What success the soft drinks Industry Levy played in reformulation of drinks and reduction of sugar intake.

The World Health Organization has recommended that taxes are used to limit their consumption. In April 2018, the UK Government introduced the **Soft Drinks Industry Levy (SDIL)**, also known as the 'Sugary Drinks Tax', to help tackle childhood obesity. This applied a two-tiered tax to all soft drinks containing 5 grams or more of added sugar. Drinks with more than 8 grams sugar/100 mL (high tier) are taxed at £0.24/L and drinks with more than 5 grams but less than 8 g sugar/100 mL (low tier) are taxed at £0.18/L. Drinks with less than 5 grams of sugar/100 mL are not taxed.

Previous research led by NDPH found that **the soft drink industry had responded to the tax by reformulating their products**, with eight out of the top ten companies reducing the sugar content of their products by 15% or more and a **fall in the percentage of drinks with sugar levels over the tax threshold from 49% to 15%**. It was unknown whether this had changed household purchases of soft drinks.

This was investigated using data from a commercial household purchasing panel, which recorded all food and drink purchases brought into the home for approximately 22,000 UK households each week – a total of around 31 million purchases.

The results showed that there was a weekly reduction of 30 grams per household in sugar purchased from soft drinks that were taken home, compared with the expected amounts had the SDIL not been introduced.

9 Early detection and treatment of chronic disease

Veena Raleigh, The King's Fund

The burden of chronic disease

Relative to comparable European countries, the UK has a higher prevalence of largely preventable chronic conditions. An estimated one in four patients in primary care have multiple chronic conditions, and multimorbidity is becoming increasingly prevalent at younger ages. There are marked socio-economic inequalities in risk factors, disease prevalence and mortality. Chronic diseases with amenable risk factors form a large proportion of the morbidity burden, providing opportunities throughout the life-course for prevention strategies.

CVD and diabetes are among the leading causes of morbidity, disability and health inequalities in the UK.

- 6.8 million people in England are living with CVD and even more with comorbidities or common, treatable risk factors that significantly increase the risk of developing CVDs eg high blood pressure affects 1 in 3 adults, about 14 million adults, of whom 4 million are undiagnosed.
- CVD is among the largest contributors to health inequalities, accounting for one-fifth of the life expectancy gap between most and least deprived communities; people from South Asian and Black groups are at the highest risk of CVD.
- Modifiable risk factors explain 90 per cent of CVD incidence and up to 80 per cent of premature deaths from CVD are preventable.
- The risk factors for CVD are risk factors also for other leading causes of morbidity and mortality eg diabetes, cancer, dementia and Alzheimer's disease, Covid-19.
- An estimated 5 million people in the UK have diabetes, another 1 million are undiagnosed, and 14 million are at risk of developing it. Obesity and high blood pressure, major risk factors for Type 2 diabetes and its secondary complications like (CVD, amputations), are preventable.
- Less than half (47%) of people living with diabetes in England received all eight of their required checks in 2021-22, meaning 1.9 million people did not receive the care they need.
- Rising obesity and diabetes are offsetting declines in CVD mortality.

A strong focus on the prevention, early detection and management of common chronic diseases such as CVD and diabetes, and the risk factors for them, can improve population health, reduce health inequalities and mitigate against escalating demand for health and social

care, thereby avoiding unsustainable workload and cost pressures on the health and care system (including hospital and emergency care).

The drivers of chronic disease

Data for England from Global Burden of Disease 2019 shows the risk factors that make the biggest contribution to morbidity, disability and mortality, and which we should focus on:

- behavioural risk factors: tobacco (by far), diet, alcohol
- metabolic risk factors: high blood pressure, high blood glucose, high BMI, high LDL cholesterol

Individuals often have more than one risk factor. Prevalence of single and multiple risk factors is higher in men, the White ethnic group, lowest income households, most deprived areas, and people with long-term health conditions.

A pathway approach to reducing the burden of chronic disease

There are several stages to this.

1. Primary prevention of behavioural risk factors: strategies to address eg obesity, smoking, excess alcohol consumption, inadequate physical activity are vital for reducing the prevalence of chronic diseases such as CVD, diabetes, cancer and dementia. The reduction in population level behavioural risks eg obesity, smoking, will also benefit people at risk of or who have chronic disease, as it will reduce and/or delay the risks of disease progression.
2. Early detection and management of behavioural and metabolic risk factors to reduce the risk of developing a chronic disease: the NHS has a key role to play in addressing behavioural risk factors, and also early detection, management and treatment of metabolic risk factors, leading among which are high blood pressure, blood glucose, cholesterol and BMI. This is key for reducing the prevalence of serious chronic diseases and delaying the ages at which they occur; it is also key to reducing multimorbidity since the onset of a chronic disease often progresses to multimorbidity eg CVD is a risk factor for developing dementia. Management can involve lifestyle changes and/or treatment for risk factors. Primary care has a key role to play in early detection and management of risk factors as it is the gateway to health care and offers early opportunities for detection and management of behavioural and metabolic risk factors. But all points of contact with patients eg secondary and social care should be availed of.
3. Management of chronic disease: even after onset, most chronic diseases have a long pathway that offers many opportunities through early and effective risk factor management for delaying or slowing disease progression and averting or mitigating its sequelae eg reducing the risk of a heart attack or stroke or a recurrence, secondary complications of diabetes such as CVD, kidney failure or amputation. Because people with chronic diseases like CVD and diabetes are likely to interact with several parts of the system over the course of their lifetime, everyone in a local public health, health and care

system has a role to play in early intervention to manage risk factors and reduce the risk of disease progression.

Strategies for reducing the burden of chronic disease

Early intervention to detect and manage behavioural and metabolic risk factors can reduce the risk of developing chronic diseases like CVD and diabetes, and delay their onset and progression. Strategies for strengthening such interventions are needed at all levels and need not require significant resources:

- national: policy-makers need to adopt bolder, evidence-based public health / primary prevention policies and measures to support secondary prevention
- local: ICSs need to prioritise (a) prevention, with the NHS, public health services and local authorities (LAs) working jointly to make prevention everyone's business, and (b) early detection and treatment of the risk factors for CVD and diabetes, and management after onset.

Examples of what ICSs and the NHS can do in terms of secondary prevention of CVD and diabetes without significantly adding to costs are listed below.

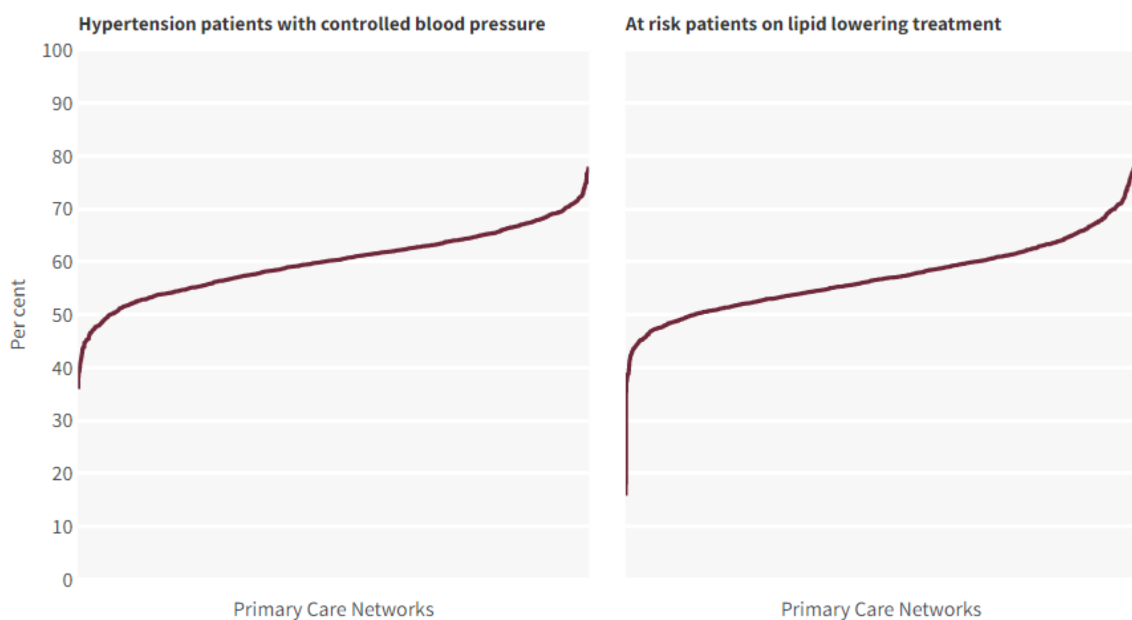
- Primary care (general practice) has near-universal coverage and is the gateway to care for most of the population. It already plays the lead role in the detection and management of behavioural and metabolic risk factors, but more can be done, in particular by reducing clinical variation in the quality of care. For example, there is wide local variation in care for CVD and late diagnosis and under-treatment are common; CVDPREVENT audit data show there is significant potential for reducing the wide variations across general practice in clinical process and outcome measures (see Figure 9.1). Similarly, the diabetes audit shows wide local variations in the quality of diabetes care. The Quality and Outcomes Framework (QOF) includes evidence-based indicators developed by NICE and designed to reduce risk factors for or manage leading chronic diseases such as hypertension, heart disease, stroke and diabetes eg the proportion of patients with heart disease whose BP is within target range. But there is significant scope for reducing practice-level variations by supporting quality improvement in under-performing practices: as is being done in some areas, data-driven quality improvement using the rich CVD and diabetes data available for benchmarking is promoting learning. Cardiac networks also have a role to play in reducing clinical variation. Reducing such variation will raise overall achievements.
  NB: The scope for using QOF or QOF-type incentives further can be explored with NICE and other national stakeholders eg DHSC, NHSE, RCGP.
- Another strategy for raising the mean by reducing variation is to identify local high-risk communities through comprehensive health needs assessment. People in deprived communities have the highest prevalence of chronic diseases and much of this disease burden is preventable. For example, high-risk groups for CVD and diabetes are women, deprived, South Asian and Black groups and those with serious mental illness. Policies and interventions can be targeted at high-risk communities, including through local community and voluntary organisations, places of worship etc to reduce risk factors such

as obesity and high blood pressure, and ensuring access to and uptake of care along CVD pathways is commensurate with need.

- Supporting and empowering patients to manage their condition by greater use of digital tools and technologies. The use of digital approaches was transformed during the pandemic, demonstrating that technology can be deployed at pace and scale to improve the delivery of health care and with more care delivered virtually. These solutions are particularly useful for non-communicable, progressive diseases like CVD, diabetes and enable monitoring and treatment outside clinical settings. Enabling people to self-care, for example, through the use of smart phones and other digital devices and apps, can support people to take a more active role in managing their health and improve access. This is already being done in some places eg for people with diabetes but there is scope for much more.
- Raise public awareness about risk factors for high prevalence conditions such as CVD and diabetes, and the need for timely health care, especially in high-risk communities eg Know Your Numbers campaign to raise public awareness of the need to get blood pressures measured. Public awareness of some symptom-less CVD and diabetes risk factors eg hypertension may be poor, especially among high-risk deprived and ethnic minority communities.
- Resources and capacities are over-stretched, so maximise community resources eg use of pharmacies, local leaders and communities, vol orgs etc. Community organisations and leaders also reach into high-risk populations and know best, for example, how to raise awareness of CVD risk factors, communicate with and reach those with undiagnosed or uncontrolled risk factors, and encourage follow-up with GPs and compliance with medication or lifestyle changes. Community engagement is especially vital for engaging high-risk and socially excluded groups.
- Making every contact count - especially in the wake of undiagnosed risk factors following the pandemic.
- NHS Health Check (to be revamped as recommended in Deanfield review) – the NHSHC is especially important in the wake of increased undiagnosed risk factors such as hypertension, excess alcohol consumption etc following the pandemic.
- The extensive and rich data from multiple sources on CVD and diabetes risk factors, prevalence, mortality, clinical management, outcomes and inequalities available at geographical (eg ICS, LA), provider (eg practice and trust) and patient level (see appendix) surpasses data available for most other conditions. There are many examples of such data being used to target and improve the quality of care and outcomes, and for many the capability already exists across different teams eg within clinical networks, PCNs, LAs and AHSNs. “Sweating these assets” should be a core element in local plans for reducing the impact of, and improving clinical management of, CVD and diabetes. These datasets and tools can be used by many agencies and professionals, at different levels and for multiple purposes in assessing CVD health needs and delivering care, for example:

- at population level for health needs assessments, identifying inequalities and high-risk populations, setting goals and monitoring progress
- at provider level for measuring access, quality improvement, benchmarking against peers, clinical variation, inequalities
- at patient level for risk stratification of patients and targeting clinical interventions
- integrated, inter-operable records and record linkage across eg primary, inpatient, outpatient, A&E services and mortality in some areas is enabling clinicians to have a better understanding of patient needs and the quality of care along CVD pathways.

Figure 9.1



10 Increase secondary prevention to develop a renewed NHS

Dr Paul Corrigan

Across nearly every aspect of English Society, this manifesto argues for the use of a wide variety of fiscal and regulatory mechanisms that place a much greater emphasis on the prevention of more illness. Most of the manifesto will outline these *primary* preventions (those that will act on issues that can improve health through activities beyond the NHS and before people get ill) that are aimed helping people not get ill in the first place.

Here we will concentrate on the issues of secondary prevention. This takes place where people have been diagnosed with an illness and secondary prevention is the work of the NHS – assisted by others- to help the person from getting worse.

17 million people in Britain live with a long-term disease. Whilst it is economically and morally better for them not to get that disease in the first place, once they have it, economically and morally we should help them live as full a life as possible whilst having that disease. This can have a very big impact both on individuals lives and our societies wider economic and social relationships.

Primary prevention can also improve their lives If for example, we were to succeed in cutting salt intake of 50-60 years old, people who already have CVD would have a much better chance of their CVD not getting any worse.

The role of secondary interventions

Everyday thousands of people are diagnosed with one of several long-term conditions and at the moment, as we grow older, many people have two three of more long-term conditions. How the NHS, patients, carers and family work with those long-term conditions has an enormous impact not only upon the nation's health, but also on the capacity of our labour market and the work of the NHS. Failure to take them seriously, to monitor them, to reduce harmful behaviour and to improve good behaviours has a major impact on the nation's health and economy.

Ensuring people are diagnosed

In every long-term condition, earlier diagnosis is better than a later diagnosis. Earlier diagnosis allows, where appropriate, for earlier medication and earlier behaviour change. One of the roles of the NHS is to ensure that there are sufficient channels for individuals to work with the NHS to obtain a diagnosis. Some of this happens through routine primary care contact for example- patients have their blood pressure taken routinely and it is discovered to be high.

Others will have a special health check to discover symptoms but for others they will though their lives without knowing their symptoms. For example, there are14 million people (32% of the population) with hypertension and 4 million of these (3 in 10) are undiagnosed (4m). [130]

To diagnose more people earlier we need to incentivise the NHS to behave differently and to reach out to these people.

The moment of diagnosis – the teachable moment for secondary prevention

But diagnosis on its own does not necessarily lead to a change in behaviour. For some a diagnosis of an illness acts as a motivation to radically change behaviour and improve health and life chances. For others it can increase depression and reduce the necessary agency necessary to improve health. The first reaction is one that the NHS and wider society needs to increase as it leads to continued independence, but the other leads to greater illness and dependency.

If diagnosis is to change behaviour, we not only need to diagnose illness earlier, but we need patient behaviour to change in line with what the diagnosis suggests. At the moment health checks are paid for if the patient has their health checked. If we are to incentivise the NHS to change behaviours, then the financial scheme needs to incentivise that behaviour change.

We need to construct incentives to expand these initiatives throughout more of the NHS. One way of achieving this would be to pay 25% of an initial health check a further 25% for a second check and 50% of the fee or the necessary change of behaviour identified in the first check.

Why is this important to the NHS?

In the UK, an estimated one in four patients attending primary care have multiple chronic conditions. This multimorbidity is becoming increasingly prevalent at younger ages. At present much of the discussion has been around reducing the risk in older patients of adverse events such as unplanned admissions. As we shall see this is important because the NHS is being overwhelmed by unplanned admissions into emergency beds. However alongside reducing the impacts of multimorbidity amongst older people, a slowdown in all forms of incidence is needed in order to substantially decrease its overall health burden, reduce the pressure on health and social care systems and allow patients to remain in better health for longer. That is why the remainder of this Manifesto for health argues for more powerful primary prevention aimed at preventing or postponing the onset of multimorbidity. [131]

[130] For info - I've had confidential feedback from ONS about their analysis of undiagnosed hypertension using Health Survey for England data (due to be published 27 April).

[131] Head, A., Fleming, K., Kypridemos, C., Pearson-Stuttard, J., & O'Flaherty, M. (2021). Multimorbidity: the case for prevention. JOURNAL OF EPIDEMIOLOGY AND COMMUNITY HEALTH, 75(3), 242-244. doi:10.1136/jech-2020-214301. An opinion piece on how prevention needs to be leveraged to impact on multimorbidity.

The biggest crisis for the NHS is the extent of unplanned emergency care that it has to deal with. This is largely caused by its failure to work with patients to enable them to better manage their long-term conditions.

Over 60% of emergency patients admitted to hospital have one or more long term conditions and it is the exacerbations of those long-term conditions that leads many of them to become admitted to hospital to take up emergency beds. Reduce the number of these exacerbations and you remove much of the pressure on emergency beds in hospital.

To achieve this, we all need to increase the capacity and capability of patents, their carers and families in managing their long-term conditions in such a way as to better maintain their health. It is important to locate this better self-management securely with the patients and their carers. Patients with long term conditions spend 1% of their time in contact with health professionals. Their care monitoring and treatment in between that time is undertaken by themselves and their paid and unpaid carers.

If this capacity is increased the better outcomes for the NHS are considerable. For example, patients who are most able to manage their health conditions had 38% fewer emergency admissions than the patients who were least able to.[132]

To achieve this, we need to incentivise the NHS to expand those elements of its work NHS that can achieve this increase in self-management.

Over the last few years, there have been significant extensions to the way in which the primary care team can motivate patients to improve health promoting behaviour. Many primary care teams now employ health trainers whose job it is to help patients increase their healthier behaviour. Specifically, the use of motivational interviewing by health trainers enhances the capacity of the primary care team to help patients change behaviour.

Secondly the development of social prescribing has enhanced many primary care teams to work with voluntary sector groups to improve the activities of patients. As with health trainers, the social prescribing coordinators rarely have clinical backgrounds but bring additional experiences to the patients who are managing long term conditions. Crucially they can spend more time than clinicians with patients motivating them and helping them to change their behaviour.

Given the shortage of clinically trained staff, the primary care teams across the country have great difficulty filling GP and nurse practitioner posts. There is no such difficulty in filling these posts and developing better and better contacts with the wider voluntary sector.

[132] Health Foundation Briefing 2018 Reducing emergency admissions unlocking the potential of people to better manage their long-term conditions.

Organising wider financial incentives to secure a return on investment in secondary prevention

In nearly all arguments for increased prevention work by the wider society and the NHS, there are strong argument about how increased expenditure on prevention provides a return on that investment which makes the original investment good economic sense.

But those who argue for the current distribution of expenditure with annual increases in secondary care are sceptical about whether the returns of the increased investment in prevention will be met. Those of us arguing for investing in prevention need to demonstrate that that investment does save.

The largest burden of ill health suffered by the public is the 17 million people who have long term conditions This consumes over two thirds of the NHS resources and given an ageing population gets worse every few years. As their conditions worsen and multiply their lives become less fulfilling, they need much more primary and community care, and on increasing occasions the exacerbations of bad episodes of the conditions means they have to spend a couple of weeks in an emergency bed in hospital with all the attendant reduction in their independence that is caused by long stays in hospital for older people.

For over 98% of the time, the patient is looking after themselves. If they and their carers in partnership with the NHS do that well then, they only rarely suffer exacerbations and maintain their health often for decades. If they don't their health worsens and -often for decades- they live a life which involves emergency bed stays in hospital and declining quality of life.

If we want out manifesto for health to be put into practice, we need to understand why the good intentions from the NHS of a greater emphasis on prevention have not taken place.

First the NHS has not been economically set up to develop and implement a model of care where increased investment in one part of the NHS say primary care can really save money in another. The four payments systems for primary care, community care, hospital care and social care are entirely different. All of these systems are silo 'd and worry about balancing the budget in their own silo and not across the board.

Second the NHS as a set of clinicians does not see that 'saving money' in another part of the system is a part of their job. The fragmentation of these different parts of the NHS is the normal way in which the system works. The fragmented financial system incentivises fragmented care.

For secondary prevention reducing emergency provision to work the NHS and social care needs to create a single financial flow between all these currently fragmented budgets This could work with for example an agreement that for people with diabetes, if an increase in primary care work to improve self-management would decrease the emergency bed days in a hospital 50% of that saving goes to the primary care team that invested in the improved secondary prevention. The 40 integrated Care Systems across the country could develop this

for the long-term conditions that cause the most emergency bed days in their hospitals. This is a gain for the hospital since, if those beds are not used for emergency care, they can be used to cut into the long waits for elective care.

Second, the NHS is not culturally set up to work in such a way as to implement such a scheme in a way that would actually reduce emergency care. NHS staff and systems do not have ethe experience of really saving resources in response to investment in another part of the system. For so much of the NHS money comes from the Treasury to provide care and the economic possibility of that care in some way reducing expenditure elsewhere, is not a part of the culture of the NHS. This means for this argument for secondary prevention to actually work we need to change that culture to one that will work to reduce emergency bed expenditure. In other parts of our society the notion of invest to save gains traction because unless the savings are made, the money for the investment stops. The savings have to be made to pay for the investment.

That has not been the case in the NHS.

To make secondary prevention at scale work in the NHS we will need to develop a mechanism of financial flows that incentivises that way of working. In the summer of 2023 work is being developed with the NHS Confederation to make this happen. This development will only have the impact it needs if there is strong political and managerial leadership.

11 Race and health

Runnymede Trust

Experiences of racism and racial discrimination are linked with poorer mental and physical health outcomes for people from BME communities. Multiple studies have revealed that BME people in the UK are 'more likely to have underlying health concerns because of their disadvantaged backgrounds, but they are also more likely to have shorter life expectancies as a result of their socio- economic status.

The following trends have been identified among BME communities, which illustrate the stark extent of health inequality in England and the UK.

- There is a consistently higher rate of heart disease among Bangladeshi, Pakistani and other South Asian groups than their white counterparts.
- BME people with learning disabilities die younger than their white counterparts. There is a 26 year difference in life expectancy between white and BME people with profound and multiple learning disabilities.
- Black Caribbean and Black African people have higher rates of admission to psychiatric hospitals with a diagnosis of severe mental distress.
- Black women are four times and Asian women twice as likely to die in pregnancy or childbirth as white women. The new Women and Equalities report lays bare the longstanding inaction in tackling these stark disparities.
- The health of white British women in their 80s is equivalent to that of Black Caribbean and Indian women in their 70s and Pakistani and Bangladeshi women in their 50s.

Although a longstanding body of evidence has documented ethnic inequalities in health and healthcare, a concerted exercise is needed to critically synthesise and appraise that evidence, provide high level conclusions on where gaps exist in the evidence, and produce a clear set of recommendations (Race and Health Observatory 2022).

Mental illness

Mental health 'conditions' such as psychosis, schizophrenia and personality disorder are highly over diagnosed within ethnic minority groups, yet these communities are also least likely to gain access to sufficient care or therapeutic treatment. In 2017, data showed that Black men (3.2%) were more likely to have had experience of a psychotic disorder than White men (0.3%).

The shelved white paper to reform the Mental Health Act (2021) advocated for more patient independence and dignity - particularly those from a minority ethnic background and those with specific learning disability. However, research carried out by MIND and further

qualitative study identified that further reforms pertaining to BME communities must be made.

Below are some key areas where racialised disparities exist and should be tackled over the next 5 to 10 years.

Common mental health disorders

According to the Adult Psychiatric Morbidity Survey (2014), a higher rate of Black/Black British women (29%) experienced a common mental disorder (CMD) in the week leading up to the survey in comparison to White British women (16%). Depression was experienced at a greater rate for Black women, whilst panic disorders were more prevalent among women in Black, Asian and mixed or other ethnic groups.

CMDs are understood to be the following:

- generalised anxiety disorder
- mild, moderate and severe depression
- phobias
- obsessive compulsive disorder (OCD)
- panic disorder.

Significant data gaps

Whilst data does provide insight into CMDs and mental health disorders, it disregards those:

- living in prisons: as of 2020, Black offenders make up 32% of the under-18 prison population despite only making up 13% of the total population. Black and Mixed ethnicity prisoners were disproportionately represented across all younger ages groups, making up 21% and 8% of all prisoners aged under 25
    - According to MIND, “Black people are 40% more likely to access treatment through a police or criminal justice route” implicating a clear correlation between incarceration and poor mental health outcomes.
- staying in hospitals and in temporary accommodation
- people experiencing homelessness.

The inclusion of these socio-economic drivers in datasets would be integral to our research at Runnymede. The overrepresentation of black and minority ethnic households facing homelessness, in temporary accommodation, and in carceral institutions underpins the sheer amount of data missing on mental health outcomes for BME communities. The index of deprivation that BME communities are exposed to, but the lack of data these communities are represented in regarding mental health statistics, is indicative of the need to complete further research into these outcomes.

Access to mental health care

As Black and minoritised people generally hold lower socioeconomic positions in the UK, mental health care is less accessible compared to those in higher socioeconomic position. Even prior to the pandemic, many households (44%) across each disaggregated ethnic group felt they would not be able to make ends meet if they lost their main source of income.

The prevalence of income and savings insecurity amongst these communities has resulted in significant disparities in access to mental health care.

- Black people (6.5%) were found to be much less likely to receive treatment for mental and emotional problems than White British people (14.5%)
- Qualitative research has demonstrated how therapists have been unable to recognise the relationship between religious and spiritual practice when administering care.
- Language barriers and lack of interpreters are another contributing factor to lack of access to mental health services.

Disproportionate policing

Under Section 136 of the Mental Health Act (1983) the police have powers to detain anyone they believe to be in a mental health crisis in public. The use of coercive treatment and over policing during mental health crises rose during the height of the pandemic. Moreover, according to Governmental data:

- from October 2019 until October 2020, detentions under Section 136 per month rose from 35 to 43
- Black people were 4 times more likely to be detained under the Mental Health Act in comparison to White people at the height of the pandemic (March 2020)
- the highest detentions by ethnicity in 2021 per 100,000 were Black, 344 (0.34%) with Asians, 105 (0.102%). The lowest detention rates per 100,000 were that of White British, 75 (0.075%).
- the likelihood of police presence at the moment of detention, use of physical restraint and extended detention time was much higher amongst England's Black population.

According to the Race and Health Observatory Rapid Rapid (2021), the new reforms proposed to the Mental Health Act 'gave only cursory attention to race inequalities, thereby neglecting a real opportunity to address the institutional racism evident in the psychiatric care system." Failing to acknowledge racism as a key driver of healthcare inequalities faced by ethnic minority people is a "dangerous omission, and without which, inequalities cannot be adequately addressed.'

Racism as a determinant of health

BME communities are more likely to be negatively impacted by their wider determinants of health and so a serious plan to address them is also likely to offer greater benefit to our communities. However, we are also mindful that doing this kind of preventative policy work

in a universalised way, without insight from a race equality and wider intersectional perspective, will miss some of the structural and institutional processes that have designed that unequal landscape in the first place and will therefore fail to deliver the changes that are needed.

Racism leads to poor health for minoritised ethnic groups, both directly (for example, through increasing stress, or worsening mental health), and indirectly (for example, increased exposure to toxins in the environment, and targeted marketing of harmful substances like tobacco and alcohol). A key mechanism underlying the poor health of minoritised ethnic groups is the way racism leads to socioeconomic opportunities and outcomes, which have been strongly linked to poor health (Nazroo, 2022).

Although there is a growing awareness that BME communities are over-exposed to wider determinants of health that make them more likely to suffer poorer health outcomes, there remains a shyness about naming that over-exposure as being one that is due to racism - it is often talked about as though it is coincidental. But it is a series of structural, institutional and interpersonal processes and practices that are rooted in racism that are the problem and it is that that causes BME communities to have disproportionate exposure to bad housing and bad work.

Examples of how this has played out:

Disproportionate deaths during Covid

Our report '*Overexposed and underprotected*', highlighted that in almost every analysis of COVID-19, from hospitalised cases, to deaths and severe illness, Black and minority ethnic people were over-represented in those figures. Our most recent analysis shows that a Bangladeshi man was 3.1 times more likely to die than a white British man.

Despite early unhelpful and misleading explanations which centralised genetic and physiological differences and talked about Vitamin D deficiencies, we know that it was in fact the disproportionate exposure to wider determinants of health like poor housing conditions, insecure and front-line facing employment and low levels of financial resilience that contributed to the deaths of working-class BME communities.

Some key issues and learnings we identified are listed below.

- There is much evidence on the disproportionately high mortality and morbidity rates amongst Black and minority ethnic healthcare professionals, indeed the first ten doctors to die were from BME backgrounds. Greater proportions of BME key workers (32%) reported that they were not given appropriate PPE compared with their white peers (20%). Among those in this position, 50% of Bangladeshi, 42% of Pakistani and 41% of Black African respondents reported that they had not been given adequate PPE.
- BME staff faced greater difficulty in accessing PPE that fitted correctly, with types of mask that did not fit particular faces. Doctors from ethnic minority backgrounds were also less likely to speak out against safety concerns in fear of how this might impact their

careers. As recommended by the Health and Social Care Select Committee in its 'Coronavirus: lessons learned to date' "the Government must learn from the initial shortage of appropriate PPE for these staff and set out a strategy to secure a supply chain of PPE that works for all staff in the NHS and care sectors."

- A lack of meaningful and intersectional data impeded the ability of the government and authorities to enact the appropriate public health interventions early enough. Researchers from the Universities of Nottingham and Leicester explain this aptly: "One of the key lessons that we should learn from the response to this pandemic is the importance of setting up a robust system for data collection, aggregation, and analysis as a pandemic-preparedness measure rather than a response. This action will not only help to ensure future responses are quicker and more effective than was the initial response to COVID-19 but also that the government is better prepared to identify and address the multiple and intersecting factors driving health inequities."
- Many minority ethnic individuals found it harder to self-isolate because of the conditions in which they live and work. Nearly one third of Bangladeshi households and 15% of Black African households are classified as overcrowded, compared to only 2% of white households.
- Inclusivity in relation to COVID-19 public health messaging was not appropriately planned for or considered, as the majority of the messaging was delivered in English.
- The UK Government's pre-existing Hostile Environment policies — such as No Recourse to Public Funds (NRPF), right to rent and work checks, and NHS charging and data-sharing — worsened the effects of COVID-19 across all areas of life for undocumented migrants. These policies have a disproportionate impact on people of colour, and they exacerbated financial insecurity, precarious employment, insecure housing and barriers to healthcare for undocumented people, at a time when access to safety and support had never been more critical.

Maternal and neonatal healthcare

In its new report, the Women and Equalities Committee tells us more of what we already know about disparities in health outcomes for Black and Asian women. The Committee finds glaring and persistent disparities in outcomes for women depending on their ethnicity. These ethnic disparities have been reported now for over 20 years, but targeted action by the government and health service has lagged well behind.

The Committee notes that multiple and complex driving factors are causing these disparities, but explicitly acknowledges the role of ethnicity and racism in driving poor health outcomes for women of colour. Previous reports have failed to meaningfully acknowledge the role of structural racism, instead claiming that the reasons for the disparities are unclear, or driven by socio-economic or physiological factors.

This report lays bare the disparities long faced specifically by Black women: 'Too many Black women have experienced treatment that falls short of acceptable standards, and we are

concerned that the Government and NHS leadership have underestimated the extent to which racism plays a role.'

Moreover, the Maternity Disparities Taskforce established by the government in February 2022 'to make real progress in understanding the reasons for poor outcomes in maternity care' after data showed that black women are 40% more likely to experience a miscarriage than white women. But it hasn't met since July 2022, despite the pledge for meetings to be held every 2 months, to maintain and track progress. The government has provided no reason for the lack of meetings during this time.

We believe the government should accept all of the recommendations of the Women and Equalities Committee. The question of structural racism in healthcare needs to be explicitly acknowledged and addressed, especially when the facts are right in front of us.

In particular, the government should take heed of the below recommendations.

- The Government should publish measures for gauging the success of the Maternity Disparities Taskforce. It should commit to publishing the dates of meetings in advance, and the minutes of the meetings soon after. The Taskforce should update this Committee on a six-monthly basis on the progress the Taskforce has made to tackling maternal health disparities. (Paragraph 37)
- There should be a cross-government target and strategy, led by the Department of Health and Social Care, for eliminating maternal health disparities. The Maternity Disparities Taskforce should be charged with consulting on this strategy within its membership and more widely, and for proposing and developing metrics by which this target can be achieved and measured. (Paragraph 50)
- NHS England and NHS Improvement (NHSEI) and NHS Digital must prioritise the accurate and complete capture of ethnicity data and ensure their new system for ethnicity data captures granular level data on ethnicity.

Major conditions strategy

We are concerned that the Health Disparities White Paper, Obesity Strategy and mental health reform has been shelved in favour of the new major conditions strategy. It is unclear if this will adequately address the issue of health inequalities. The NHS RHO explains these concerns with the new proposals from the government, as 'geography will be the primary lens through which the strategy understands health disparities' and this may lead to glaring omissions in understanding what causes inequalities.

Q12. Which products and practices should be priority? How to stimulate change - by regulation, price penalties? Can media, shareholder and other systemic pressures promote this?

We affirm the plans of the Health Foundation and Health Equals to increase research activity around the social determinants of health. Indeed, in the wake of Covid's disproportionate impact on minority ethnic communities, researchers have renewed their interest in how racial

inequalities within these social determinants in turn drive further racial inequalities in health outcomes. Yet as Covid made clear, there is more work to be done in exploring both how these social determinants operate and how we conceptualise and talk about the determinants themselves.

Historically, ideas about the social determinants of health (see WHO, n.d.; Wilkinson and Marmot, eds. 1998) have neglected to include race and racism as explicit factors, instead foregrounding more general social and economic factors.

Q13. How can the voluntary sector have even more impact on population health? Can approaches such as 'community power' or 'health creation' make a difference at scale?

By their very nature, voluntary sector organisations tend to be embedded in, and run by members of, the communities in which they operate. As a result, while trust in charities has fallen over time, they are still more trusted than private companies, the government, and the media. This is especially true in areas with higher ethnic and cultural diversity.

Exemplifying the deep trust that minority ethnic groups place in voluntary sector organisations compared to, for instance, the government, is the impact that these organisations had in boosting vaccine take up during Covid-19. At the time of the vaccine rollout, civil society organisations played a vital role in helping minority ethnic communities overcome historic mistrust of certain institutions, including health services.

Following the introduction of civil society funding schemes and partnerships aimed at countering misinformation and meeting local need during Covid, the gap in the vaccine uptake between white and non-white residents in England fell significantly, while overall vaccine uptake among minority ethnic residents in England tripled.

About the Runnymede Trust

The Runnymede Trust is the UK's leading race equality think tank. We were founded in 1968, to provide evidence on racial inequalities, to inform policymakers and public opinion about the reality of those inequalities, and to work with local communities and policymakers to tackle them. We hold the secretariat for the APPG on Race and Community, chaired by Clive Lewis MP, and publish reports, briefings and research on race equality issues.

Our work is rooted in challenging structural racism and its impact on our communities. Our authoritative research-based interventions equip decision makers, practitioners and citizens with the knowledge and tools to deliver genuine progress towards racial equality in Britain.

12 Concentration of risks

David Buck, Senior Fellow in public health and health inequalities, The King's Fund

Our society is not equal. This reflects itself in health outcomes, experience and access to the health and care system. In particular, there are places, communities and people in our country who face unequal risks, and these concentrate in avoidable and unfair ways. These apply to all of the behaviours and policy issues that we have raised as key areas for bold change.

Any government serious about improving health and tackling health inequalities has to understand and act on the concentration of risks to health across the four pillars of population health[133]: the wider determinants, behaviours, integrated health and care, and communities involved in their own health.

Concentration of risks in what drives population health, drives health inequalities

We know that the most important factors that influence health at population level are the wider determinants, followed by health behaviours (or 'lifestyles', often portrayed as 'choices' but in reality very constrained for many people), the efforts of the health and care system and wider services, and finally pre-disposition and genetic factors. These drivers interact and combine, concentrating in certain populations and places *within* each driver and concentrate *across* them. Any policy approach needs to take this fully into account.

Concentration in the wider determinants of health

For example, in terms of wider determinants, air pollution kills 29,000-36,000 people per year. But it doesn't kill equally – for example in urban areas living along arterial roads, which the poorest communities often do compared to the wealthiest increases exposure and risk. Similarly, the health risks of poor housing are not experienced equally, poorer people live in poorer quality housing in less well designed areas where active travel is harder and less safe to access. Hence air pollution and poor housing conspire to concentrate health risks for some groups compared to others.

Concentration in health behaviours

The same concentration happens for 'unhealthy' behaviours. Each behaviour we have focussed on (and associated outcomes, such as obesity) are highly socially patterned, often

[133] https://www.kingsfund.org.uk/publications/vision-population-health

concentrating in poorer groups and communities – this is true for alcohol, tobacco, obesity, diet and physical activity. Well meaning, and necessary policy can therefore concentrate risks further, unless policy is more nuanced and multi-faced. This is also complex, some cultural ties and norms can disrupt these general relationships, for example cultural attitudes to tobacco and alcohol mean some communities who are poor, are much less likely to have harmful risks than some other groups.

Health behaviours also cluster in populations (e.g. most adults don't experience health behaviour risks in isolation from each other). We know this is critical for three reasons: first clustering of health behaviours in mid-life is strongly related to premature mortality; second clustering of health behaviours often precedes multiple long-term conditions which in turn are associated with poor experience of health and morbidity, high demands for care and labour market exclusion; and third, clustering is far more common in some groups than others, driving health inequalities.[134]

This is a major problem and is as much about *how* policies and practices are implemented, and the *incentives and goals* around them, as *what* policies and practices are implemented.

Concentration in long-term conditions, and experience of multiple long-term conditions

Multi-morbidity does not affect all population groups equally, it is concentrated: people living in deprived areas are more likely to have multiple long-term conditions than people in the least-deprived areas, and the onset of multi-morbidity is around 10 to 15 years earlier.[135] Those with multi-morbidity are in contact with multiple health professionals, and are more likely than those with a single condition to report care co-ordination problems and suffer problems in transitions of care due to poor communication and data flows. This disrupts their wider lives and compounds the impact on their wellbeing.

> *The worst year I had for appointments – 52 weeks in a year and I had 68 appointments. Different departments, different check-ups. That was doctors, GP, hospital, diabetes check, eye checks and everything else. I had to give up work because of it.*
> Lynda, 61, Brixton[136]

How this concentrates risk in places and communities and is manifested in inequalities in health

All these concentrations in the drivers of health combine and compound in places, communities and particular groups of the population and lead to health inequalities. Lower socio-economic groups tend to have a higher prevalence of higher-risk health behaviours, worse access to care and less opportunity to lead healthy lives than higher socio-economic groups. This is often reinforced by other drivers, unemployment as well as being associated

[134] https://www.kingsfund.org.uk/publications/clustering-unhealthy-behaviours-over-time
[135] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/fulltext
[136] https://urbanhealth.org.uk/insights/reports/from-one-to-many

with a direct negative impact on health, harms future earning, affecting other determinants of health such as income and poverty – which in turn impact on health behaviours and people's decision-making.[137] This vicious concentrated circle of disadvantage leads to long-term sustained inequalities in health which are a stain on our society.

Inequalities in life expectancy, healthy life expectancy and many other outcomes are systematically related to this concentration and interaction of risks. In 2017–19, women living in the least-deprived 10 per cent of areas could, at birth, expect to live to 86.4 years old, whereas women in the most-deprived 10 per cent of areas could expect to live to 78.7 years – a gap in life expectancy of almost 8 years. For men, this gap was even wider. In 2015-17, males in the most deprived areas are expected on average to spend around 30% of their lives in poor health, twice the proportion spent by those in the least deprived areas. Females in deprived areas are expected to spend an even higher proportion – a third – of their shorter lives in poorer health. We know that many forms of mortality are preventable and amenable to healthcare. If the right policies and practice get to the right places with highly concentrated risks, it can make a difference. We are simply not doing this well enough - some local authority areas have avoidable mortality rates three times as high as others – our policies on prevention and action through the NHS are not reaching or being effective enough for places and populations with concentration of risks.

Finally, these concentrations of risk and the inequalities these result in are not only dreadful in themselves but weaken the ability of communities to deal with new risks and threats. This is all too starkly demonstrated by the toll of covid-19 and where and who it fell upon. Up to March 2022, the Covid-19 mortality rate was 2.6 times higher for the most deprived decile in England than for the least deprived decile. We know from other major disasters that communities who are compromised and subject to multiple concentrations of risks do worse when disasters strike and are less able to recover from them. This happened in covid-19, it should be no surprise but it should shock and we need to change our approach to policy and practice to address the prevention, reduction and mitigation of the concentration of health risks.

The positive in all of this, if there is any is that the knowledge of this concentration of risks can lead to better policy and practice, and ultimately the health of the population and especially the narrowing of health inequalities. *If* those policies and practice are designed to address them.

The policy and practice response needed

This requires the coordination and coherence of policy across the four pillars of population health:[138] the wider determinants, health behaviours, integrated care systems, and communities. We set out below some key ideas in each of these spaces. However, coherence and a commitment to implementation over time are as important as any single policy area. A

[137] https://www.lse.ac.uk/PBS/Research/Research-Articles/How-poverty-affects-peoples-decision-making-processes#:~:text=Key%20points%20from%20the%20findings,the%20expense%20of%20future%20goals.
[138] https://www.kingsfund.org.uk/publications/vision-population-health

summary of some key areas to focus on to do this are summarised in Table 1 below, with reasoning provided in the text that follows.

Table 1: Policy ideas to tackle concentration or risks – summary

	Wider dets	Behaviours	Integrated care systems	Community
National	**All govt depts analyses the concentration of health risks associated with their main policy goals linked to the health mission of the levelling up white paper (e.g. housing, air pollution), undertake HIAs, and implements cost-beneficial interventions to address**. The is coordinated by OHID and reported on publicly annually.	**HMT design tax policy to recognise health behaviours cluster and concentrate** e.g. taking into how you tax cigarettes, effects consumption of alcohol. Tax policy on alcohol, smoking, and foods is not seen as discrete but focussed on influencing clustering of behaviours and consumption, thus reducing the concentration of risks and the inequalities in health this drives	**DHSC sets ICS goals and targets which are focussed indirectly and directly on reducing the concentration of risks.** For example, as overall goals: reducing inequalities in life expectancy; avoidable mortality; and healthy life expectancy. And as contributing goals measuring and then setting reduction targets for how the clustering of health behaviours concentration in place and communities	**DLUHC and DHSC jointly roll out the model behind Local Trust's approach to Big Local and 'left-behind neighbourhoods'.** Giving every local authority £10mn to spend over 10 years to invest in community development and community budgets (at least £10mn p.a.) targeted towards areas with high deprivation and low level of social infrastructure and community networks using the Left Behind Neighbourhoods methodology. This is accompanied by national learning support.
Regional	Regional bodies (e.g. combined authorities, regional offices of govt and the NHS) can coordinate and bring coherence to national funding streams from different departments; influence policies and implementation especially over the concentration of risks through the wider determinants (e.g, regulating housing quality; clean air zones)) and coordinating behaviour support (for example regional tobacco control). **As a partnership these bodies need to review and be clear on how their activities are impacting on the concentration of health risks; allocating resources and actions in alignment**			

Local	**Local government needs adequate and fair financing**, moving beyond levelling up bidding contests. This requires more fiscal devolution to enable local areas to focus in places/ communities where concentration of risk are highest. The public health grant is 3-4x as cost-effective in producing health as NHS spending. It needs talking back to it's 2015/16 level in real terms as a minimum, reversing the £3bn cumulative deficit since then in what it can purchase	**The NHS and local govt are charged with developing joint integrated wellness services at scale with a focus on reducing the concentration of clusters of health behaviours in key groups.** This can follow good practice that already exists, but requires joint budgets, approaches and genuine integration between the NHS and local government	**ICSs need to prevent, delay and mitigate the impact of multiple long-term conditions**. They can do this in many ways inc: changing payment systems such as capitated budgets to incentivise prevention and overall control of people's health, moving away from payment for results; working more cohesively with the VCS; use the power of data and analysis to identify concentration of risk and analyse impact of interventions through population health management.	**Local government and its' partners (including the NHS) have specific goals to increase community participation in decision-making and resource allocation decisions**; actively introduce and systematise community budgets

13 Putting prevention and population health at the heart of integrated care systems

David Buck, Senior fellow public health and health inequalities, The King’s Fund

Dominique Allwood, Director of Population Health, Imperial College Healthcare NHS Trust

Introduction

Integrated care systems are the culmination of a long-term goal of creating structures that are more likely to integrate care across the complex organisations within the NHS, and between wider partners. They also have a much bigger potential, to make a significant difference through prevention and focussing on population health, not just the delivery of healthcare. This lies in the relationship, power and priorities of the integrated care board, and the integrated care partnership which make up an ICS. In their establishment it is made clear that the focus is on outcomes, and wider connections and outcomes beyond the NHS alone:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

However, there is a clear danger that ICSs could ‘revert to type’, focusing only on the connections with the NHS, or worse become an additional layer of performance management from the centre. To avoid that, and fulfil their potential ICS’ need to be incentivised and supported to focus more clearly on prevention and population health.

This appendix summarises proposals – representing the authors own views (not necessarily those of their institutions) – that fed into thinking that informed work supporting the NHS Confederation, which in turn fed into the Hewitt Review and its recommendations on prevention and population health.

The policy and practice response needed

ICSs have a real opportunity to be the body that brings coordination and coherence of local policy and practice across the four pillars of population health;[139] the wider determinants, health behaviours, integrated care systems, and communities; and to do so in a way that is

[139] https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems

preventive, not purely responding to illness once it has developed. Some of them are on this journey, but it needs to be more systematic, swifter and sustained over time. We know that momentum is easily lost, and institutional memory and capability too (for example on health inequalities policy[140]), so efforts on prevention and population heath need to be hard-wired.

There are many central and locally own levers for population health. Alignment across these is key, every lever has to support every other; they must not be designed in isolation. However, levers are not enough. What will drive change is the leadership for improving population health and inequalities that is evident, sustained and visible across ICSs; and the explicit principles and behaviours that underpin partnerships over time.

Building and sustaining adaptive capability within ICSs for prevention and population health is vital, and requires both short term and longer term interventions. Institutional memory with the NHS and other sectors is often short. Building the long-term adaptive capability (and institutional memory) to keep the focus on population health, prevention and health inequalities is therefore key. Capability takes many forms. Shared systematic approaches to change alongside leadership and culture change is also important.

Community is where health generation happens. We know that strong communities have better health and have a stronger ability to recover from and adapt to health challenges. Understanding needs and context is vital for this work but it's not the only part of jigsaw. ICS' need to work with and support communities in a more consistent and coherent way if they are to fulfil their potential including an emphasis on communities in influencing care pathways and decisions; and more radically in supporting communities and their health directly.

Alignment of actions as more important than any single action itself. Prevention, population health, health inequalities and community involvement need to be 'the natural' thing for systems to do, the levers, capability and accountabilities lined up to make that natural for any change to be sustained over time.

Our ideas and recommendations that follow are therefore a set and intended to be mutually supportive. Each needs resting/amending or rejecting – but it is how any of these connect together that is most important. We set out recommendations in areas of: levers that will incentives and reward ICSs for prevention and population health; actions that will build and sustain their capability over time; and how they need to focus more on communities and in specific areas of long-term conditions and behaviour change.

[140] https://www.kingsfund.org.uk/publications/how-can-we-tackle-health-inequalities

Table 1: Pulling the right levers to incentivise and reward ICSs for prevention and population health

Levers	Recommendations
Framework	• Each ICS needs to adopt a cohering framework to direct its efforts, to avoid scattergun approaches
Funding	• DHSC commissions and publishes work on the optimal level of prevention funding
	• DHSC recommits to measuring prevention spending, publishing it and monitoring it
Level playing field for prevention	• NHSE/CIPFA/OHID HFMA standardise definition of RoI as investment not revenue, and it is not implemented as 'pay for itself in X months)
	• Implement recommendations of CIPFA/PHE report
Allocation of resources – national	• Explore case for resource allocation to be non-neutral: How could it be used to support investment in drivers of population health (e.g. tied to shared outcomes framework); localism (e.g. health and OGD formula together); a blended public health formula (bottom up for priority service levels plus top-up formula)
Allocation of resources – within ICSs	• A review of approaches to allocations and how they fund prevention and population health – muddling through will lead to marginal change at best. Some examples e.g. LLR for primary care
	• Clear policy on funding small community organisation – away from short-term, discretionary funding to l-term contracts (with outcomes measures) as per 5YFV recommendations
Accountability and support	• Outcomes frameworks must a) include a balance of metrics around the four pillars of population health (wider dets/behaviours/integrated care/community) and b) be mapped to a cohering framework that is clear on where accountability is org/sector specific and where it is jointly held
	• A significant ramp-up of system support (at centre/region/local) for prevention and population health. The Health Inequalities National Support Team model is a good one. Need greater clarity on how
ALIGNMENT	• Answers on the above need to align, not grind against each other, since each either support or undermines the others

Table 2: Investing in ICS capability on prevention and population health to ensure effort is sustained over time

System principles/ behaviours	Recommendations
Agreeing and codifying principles and behaviours	• ICSs need to develop explicit principles and behaviour agreements with key sectors – examples in pack re public health. This then needs to be codified – for example through MoUs etc clarifying on what, who will: Lead, collaborate, advise, inform, advocate
Investment in adaptive capability	**Recommendations**
Health inequalities funding	• An audit, and public sharing of how ICSs are using their recurrent health inequalities funding (£200mn)
Population Health Management	• PHM (and wider analysis) needs to go beyond a focus on care pathways – into other drivers of population health – example given of poverty but needs focus on a range of determinants of health
Academies and other models	• Some ICSs (examples given) are developing population health and/or health inequalities academies to invest in knowledge/leadership and other capability across their systems. All ICSs should do so.
Making the most of joint capability	• Every area will have a plethora of capability and assets for prevention and population health (e.g. CSUs and equivalent, AHSNs, collaboratives, academic units, networks, types of specific expertise, regional teams) these need to be mapped and better used and seen as joint assets than they are
Workforce support	• Every staff member has a role in improving population and health inequalities – through either/or awareness raising, action and advocacy. The allied health professionals community has a framework to make sense of this with case studies. Other staff groups should learn from this, and develop their own
Public health and ICB constitutions	• Access to public health expertise will be critical to long-term success for ICBs – yet many do noy have this hard-wired into key governance and decision-making posts, this need to be addressed
OD and leadership training	• Every ICS should offer a leadership and OD programme for population health and inequalities, through academies and/or with external support as appropriate – there may be a case for networked models

Table 3: ICSs and their roles in communities and focus on multiple long-term conditions and behaviour change

Community/anchors	Recommendations
A strategic approach	ICSs need strategies that bring together: i) communities in care pathway design (not just consulted); ii) communities given commissioning power over what supports their health inc beyond healthcare services; iii) how they fund and support direct community development – investing in community strength not simply supporting access and health management
A step change	• If ICSs are serious about the role of community emerging paradigms – such as that of community power – need to be tested in practice
Anchor networks	• Every ICS should be a member of an anchor network and play a convening role with local anchors
Clinical conditions	**Recommendations**
Children and young people	• Integrated approaches to this getting care 'beyond clinical walls' is critical and there are examples of how this is happening re holistic care and a focus on wider determinants of health (inc through integrated training, joint placements and workforce redesign). This needs to be supported
Multiple long-term conditions prevention and delay	• ICSs need to focus more upstream on prevention/delay of onset of multiple long-term conditions – this will make a significant difference to health inequalities. This should include more integrated wellness offers alongside local authorities (examples exist)
Multiple health behaviours	• ICSs need to systematically support Making Every Contact Count (MECC) approaches

14 The politics of population health

James Bethell

Introduction

To dream of a public health revolution without thinking about politics is an exercise in futility. The opportunity exists to use modern, proven public health strategies to address the great economic, social, and clinical challenges of our time. Most of the laws, strategic documentation, and targets are already in place. New technologies cutting prices and achieving wonderful miracles of detection and prevention. But we waste our time noodling with frustration on how this opportunity is running through our fingers because there is no political will to execute the plan.

The origins of the public health craft are the managerial delivery of sensible long-term programmes; the guiding principles are based on evidence-led research; the values are born of scientific endeavour; and the priorities are clinical goals like morbidity and disability, rather than social or economic aims. This dry, empirical culture regarded politics as a distracting or dangerous "third rail".[141] This frustrating lack of agency expresses itself in the form of displacement therapy, and discussions about the need for "leadership" by some sort of senior national figure like the Prime Minister.[142]

But if we are to make progress, we need to face up to the reality that no Nitchzean Superman is riding to the rescue. That might happen in autocratic countries like Saudi Arabia where the King has the resources and authority to impose "2030" public health programmes. But in cash-strapped liberal democracies, Prime Ministers do not lead opinion and no single Government has the political heft or longevity to deliver such a programme in the face of public opinion or civic consensus. Prime Minister Johnson might commit to an obesity strategy one day, but if you have not brought over the rest of his parliamentary party, then it will be a short-lived victory. Therefore, we must be realistic, not romantic, and recognise that there are vested interests to be tackled, unfair economics to be challenged, damaging social policies to be overturned and nasty politics to be navigated, and this can only be done with a solid political strategy.

The traditional playbook is broken

The traditional playbook for building political support for public health, as expressed by the WHO materials, does not achieve this. It recommends a series of sleight of hands to disguise intentions from the public and legislative tricks to bind Governments to uncomfortable

[141] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4974059/
[142] Report by Health Foundation.

targets. It presents politics as a "three-cup trick" and the wise public health official as someone who somehow jollies along the politicians without ever showing them the ball.[143]

This approach can work at a time when the goals are limited in terms of the resources involved to projects worth a tiny fraction of the health budget and the scope of the activity limited to incremental changes, geographically local or narrow sectoral projects – for funding education programmes or mass vaccination programmes, and so forth. Whilst politics can indeed be a game of smoke and mirrors, and there is a role for legislatively-mandated targets, Parliamentary commissions, and the suchlike, the sheer scale of the commitment necessary to conduct meaningful change – for instance, costing significant fractions of the total national budgets, huge political capital to enact new legislation and challenging major partners in the industry - cannot be done through artifice and disguise.

Whilst recognising the challenges of bridging long-term public health measures with fickle political priorities, we should reject this doctrine because it will not achieve our goals. Instead, we must commit to a more thoughtful doctrine that involves overt political marketing of a long-term vision, tying in a broad range of supporters and creating a resilient political architecture.

Designing a resilient political architecture

The test of a resilient political architecture comes when a Government, for whatever reason, thinks of cancelling a programme. Today, the UK public health infrastructure is virtually friendless. The public health grant is slashed with impunity. The post-Covid public health diagnostic and data infrastructure is dismantled without a complaint. White papers on disparities, smoking, gambling, and obesity are shelved with only a ripple of dissent.

Social justice

One of the strengths of the public health message is the emotional resonance around social justice. Sir Michael Marmot put it powerfully when he said in the WHO report Commission on public health, 'Social injustice is killing people on a grand scale.' [144] There is a powerful agenda here that links a human sense of fairness with the practical observations that wasted human lives are costing societies and economies a fortune. This resonates powerfully in the UK and reverberates around the sector.

But the architecture of a resilient political strategy cannot rely on a one-legged stool. Whilst social justice is a cause that motivates many, particularly those in the public health profession, the case for a major investment in public health should have other considerations that tie key stakeholders to the cause.

[143] WHO paper
[144] https://www.who.int/news/item/28-08-2009-inequities-are-killing-people-on-grand-scale-reports-who-s-commission

The economic case

It needs a strong economic case around the productivity and longevity of the workforce, and the resilience of the nation in an "age of pandemics", as termed by Peter Piot, EU special scientific advisor on pandemics.[145] This is critical for making the return-on-investment arguments for further investment in public health, arguments currently hint at massive returns but are not conclusively endorsed by Her Majesty's Treasury.[146]

At present, we are held back by weak, incomplete data linking workforce health with the costs of welfare, healthcare costs, the quality of the workforce output, and the opportunity for more years of economic activity. So, this needs a huge investment in analysis. The economic case naturally attracts the interest of political supporters of the market economy who are looking to optimise the wealth of the nation and can connect with the public health agenda to reduce healthcare costs, increase productivity, and mitigate the economic shock of future pandemics. These include important national stakeholders in business, finance, and economics who would be instinctively sceptical of the legal interventions, red tape, and market distortions created by public health, and who can blackball sensible but ideologically-uncomfortable measures by their resistance, but who might be won over by arguments around national economic productivity and resilience. Winning over these sceptics is essential. The role of Business for Health, the group founded by John Godfrey and supported by the CBI is a critically important development in this area.

Supporting the NHS

A resilient public health architecture needs to overcome the snobbery and scepticism from higher-prestige clinical hierarchy to gain support from the broader healthcare community. At present, public health is easily passed over, financially to pay for doctors and shiny new hospitals, institutionally within Government when it seeks to deprioritise public health over other policy objectives (protecting pubs, clubs, and Frosties, for instance), within the health system to prioritise outcome targets like waiting lists, and in the competition for the best people.

We cannot secure national commitment to a public health programme without full-throated support from all parts of the medical hierarchy, from the CMO and RCGPS down to the nurses and health visitors who deliver the services. We need them to understand why successful public health interventions will reduce demand for healthcare services, we need them to have the confidence that public health measures will deliver the desired results and we need them to remain committed when long-term projects are threatened by tight resources. British Generals and Special Forces operatives, once sceptical of soft power and civilian presence on the ground, learned in theatres like Afghanistan to massively value health visitors and community liaison because they stopped the attacks on their bases. So, we need NHS Trust CEOs and brain surgeons to value screening programmes and gambling

145 http://www.oecd-forum.org/posts/entering-the-age-of-pandemics-we-need-to-invest-in-pandemic-preparedness-even-while-covid-19-continues

146 York paper

regulations because they reduce demand for healthcare services and assist effective rehabilitation. This week there was not a flicker of resistance from the Royal Colleges when the public health minister did not fulfill Government commitments on countering the harms of Tobacco – this is a reputational disaster for the cause of public health.

Personal health

We need to move away from the idea of a finger-wagging Nanny State that attributes health challenges to personal responsibility and never-ending exhortations to eat better, exercise more, drink less, and generally lead a colourless life because they do not work, and these alienate the mid-market media and the membership of the Conservative Party.

At the same time, we must recognise that there is a massive disconnect between mainstream public health doctrine and the rest of the world about the role of individual responsibility. Modern public health doctrine dismisses the role of individual agency in health outcomes (20%) and emphasises the importance of the environment. The public believes personal responsibility in health care is that if we follow healthy lifestyles (exercising, keeping a healthy weight, and not smoking) and are good patients (keeping our appointments, heeding our physicians' advice, and using a hospital emergency department only for emergencies), we will be rewarded. GPs, civic leaders, and ministers broadly agree with them, and the values of our liberal democracy, judicial processes, and market-based economy are founded on the principles of individual responsibility. Framing your message thoughtfully is helpful. But it is very difficult to have a winning political proposition that uncompromisingly flies directly in the face of the 21st-century human experience, your leaders, your public, your stakeholders, your constitution, and your economic system. That is not going to work. Public health rightly emphasises the community nature of its work, the shared risks, and outcomes, but a 21st-century solution needs to put the individual at the centre of things.

We need a post-Nanny-State approach to individual responsibility that is supported by science and engages those who celebrate individual endeavour and aspiration. The forces of history are already moving in this direction – because GPs no longer deliver meaningful public health and patients are more self-reliant, using walk-in care, the NHS app, NHS 11, and the internet to a much greater extent. Recent experience gives hope - when patients were given the tools (the tracing app, access to testing, opportunities to vaccinate) they stepped up in huge numbers and made a big difference.

That is why a modern public health programme should be celebrating the role of the engaged citizen-patient in promoting their health (not talking down the power of individual responsibility, demonising the “worried well” and relying solely on communitarian systems of intervention).

The new covenants for health

This deliberately broad four-legged architecture offers a smorgasbord of opportunities for elected politicians who can pick-and-chose items from the menu depending on their geography, political beliefs, the electorate, and personal tastes.

It is resilient to political and economic turmoil. It engages the voters, rather than patronising or demonising them. To get to this point, we would to recast three important relationships.

A new social contract on health with the voter-patient-taxpayer

There needs to be a new social contract on health with the voter-patient-taxpayer. One that's not just based on access, though that is still an intrinsic element. It has a sense of responsibility. This, by the way, is well recognised by voters. Policy First, the thoughtful researchers, talked to the public in 20 of the unhealthiest places in Britain it was clear that they do understand the wider determinants of health – with a strong emphasis on crime, green spaces, and affordability of things like food, leisure, and access to health services. But they feel strongly that individual handles their own health. I wonder if it is fair to ask people to do much more when we are doing so little to curate environments to promote health, but the political question is, how can we earn a licence to put more responsibility on individuals and what are the right government interventions and in what sequence to redefine this relationship.

A new contract with clinicians

Secondly, we need a new contract with clinicians. We should feel frustrated that GPs are not fully engaged in prevention, that hospitals soak up so much of the resources and that the clinical colleges are not effectively campaigning for a pivot to prevention. Maybe this is because they can tell the government isn't serious about its public commitment to longevity, inequality, and pivots, so quite understandably do not lean-in? We need a political strategy that builds confidence amongst the broad clinical classes – doctors, nurses and all the others – that prevention will be delivered, it will work, it will reduce the demand for services, it should be resourced accordingly and it's worth fighting for.

Clinicians understandably feel that ministers spend too much time on operational interference with their war-rooms and dashboards, and what in Yiddish is called Kibbitzing on clinical issues, and not enough time focused on their role which is building political support for mandatory population-wide measures to protect us from contagious and non-contagious epidemics. They've got a point. The political challenge is to figure out which interventions make the greatest impact and to bring clinicians on board for the Big Pivot.

Driving decisions to the local level

Lastly, we need a new way of doing health that pushes many more decisions down to a local level, so that services can be tailored to communities and innovation, that delicate flower, can

bloom. Here, the prevention project needs to change its whole mindset. Too often it is looking to grab powers to the centre to command-and-control behaviours. Sometimes, like with sin-taxes and national watersheds, that's necessary. But what Scotland has done with minimum pricing and Sadiq has done with TfL junk food advertising and ULEZ show how much should be done locally.

Conclusion

We need an architecture whereby the Government's commitment to public health budgets and targets is supported by businesses, the Chancellor, trade unionists, nurses, Mums and Dads, Marcus Rashford, and Andy Burnham. If we can achieve that political alliance, the pivot to prevention will look after itself.

15 What does integrated leadership look like to drive health in a place?

Laura Charlesworth, Head of Health Research, New Local

Jessica Studdert, Deputy Chief Executive, New Local

System collaboration

To ensure that health in a place is improved, national bodies need to enable ICSs to define place-specific objectives, and meaningfully engage communities in that process. This will help to refocus on the needs of populations and avoid a top-down culture that can impede effective integrated leadership across systems and places.

It is essential that systems, places and neighbourhoods should avoid functioning as separate organisations and move to collaborate for communities. The voice and representation of communities is integral to this. Traditional leadership styles must be replaced with system leadership behaviours as we propose in our community powered NHS report:

Traditional leadership styles	System leadership styles
Seeks change using procedure	Seeks change through influence
Manages complexity with answers	Navigates complexity with openness
Focusses on the "what": tells the workforce	Focusses on the "how": asks the workforce
Emphasises upwards accountability	Drives frontline autonomy
Reinforces accountability to organisation	Builds shared accountability across a place
Pushes organisational priorities down the hierarchy	Creates space within the system for shared priorities to develop
Focusses on the risks of innovation	Focusses on the risks of status quo
Prime focus is governance	Prime focus is culture
Colleagues would say they are risk averse	Colleagues would say they are courageous
Values only formal experience within the system	Values also lived experience from outside the system

Integrated care systems present the great opportunity to enable an equal relationship between health partners and local government. This includes a role for the NHS to support broader social and economic development to reduce health inequalities by addressing the wider determinants of health outcomes. This should recognise the role of councils as essential for effective population health given their role in relation to social determinants of health and public health. Primary care networks should also be considered as catalysts to shift to a culture where communities are central to health system design. The ambitions set out for Integrated Care Systems are at risk of being overwhelmed by the ongoing short-term priorities associated with acute care. To avoid acute providers dominating ICSs, integrated care leadership must ensure a greater focus on prevention and population health.

A greater focus on population health and a shift to prevention is required if we are to address the demand pressures facing the health and care system, and the increase in demand coming with an ageing population with greater multimorbidity and complexity of health and care needs. To enable this shift, Integrated Care Boards should commit to shifting a proportion of budgets from acute care to community-led population health at system and place level.

Wider health and care reform

Learning from the COVID-19 pandemic demonstrated how community-led responses can increase trust and connectivity across populations. The experience of the pandemic, in the early days and during the successful vaccine rollout, is a great demonstration of the role community mobilisation can play in delivering effective prevention and health protection.

To understand the expertise and value of communities, health and care systems should actively build in the voice and representation of communities to decision-making. Integrated care systems should also ensure parity to the value of community expertise and recognise the value of meaningful engagement and empowerment.

To improve population health, this requires a shift to a community powered health service in which there is parity between prevention and treatment.

What does community-led population health look like?

The idea of involving communities and people’s participation in their own health has long been identified as essential to the long-term viability of the NHS. The Wanless Review outlined the ‘fully engaged’ scenario as essential, with the public being highly engaged in their own health. This model had the best health outcomes and was the least expensive. This has not been realised. Similar principles have been in the background of NHS reform plans. In 2014, The NHS Five Year Forward View identified the ‘renewable energy represented by patients and communities’ that the NHS needed to draw upon.

But since its foundation, the NHS has reinforced the acute response rather than an upstream approach. A shift to prevention requires a shift to a new community paradigm. To shift towards community powered prevention, we make the following recommendations:

For national bodies

National bodies should reduce their over-reliance on single-service performance targets as ICSs define place specific population health outcome objectives, with regulation evolving to support this.

The Government should set out a clear cross-Whitehall plan to shift the centre of gravity of our health system towards prevention and address the wider determinants of health outcomes across all policy areas.

For systems, places and neighbourhoods

Build in the voice and representation of communities to decision-making.

Give parity to the value of community expertise alongside clinical and professional expertise in strategic planning and service design.

Ensure that equity, diversity and inclusion strategies, embody the lived experience of communities.

ICSs should ensure an equal relationship between health partners and local government, with the role and assets of councils recognised as essential for effective prevention.

Recognise culture as a key enabler that can shift institutional behaviour, and ensure it is a strategic priority for leaders to actively foster a culture conducive to collaboration with communities.

Develop the behaviours and skills required to work with communities as equals.

Use primary care networks to catalyse the shift to asset-led working with communities.

Use qualitative data alongside quantitative metrics to inform service design.

ICBs should shift a proportion of budgets to community-led prevention.

Invest, in the capacity of the VCS and service user groups.

How to improve places with the worst population health?

These areas should be vanguards of a Community Powered approach. These communities face marginalisation and barriers to access health provision. An asset based approach is key to working with communities facing deprivation and the NHS should learn from local government to develop asset-based working practice This requires a very different approach and set of skills but there are plenty of examples of how it can be achieved, for example, the North Central London ICB led an approach to engage communities facing health inequality in Edmonton: https://www.newlocal.org.uk/publications/community-powered-edmonton/topline; https://www.newlocal.org.uk/publications/community-powered-edmonton/

Organisational culture must be targeted initially to ensure all understand and lead with a community powered approach, this could be modelled on the approach taken in the Wigan

Deal. A true place-based approach, with pooled funding would be a catalyst for community powered prevention.

New Local authored links that might be useful

- Full community powered health report (we can also pull examples from this if useful): A-Community-Powered-NHS.pdf (newlocal.org.uk)
- The Community Paradigm: The-Community-Paradigm_New-Local-2.pdf (newlocal.org.uk)
- Does economic growth lead to higher happiness? Does economic growth lead to higher happiness? - New Local
- Levelling Up – The labour market and health of the nation: Levelling Up – The labour market and health of the nation - New Local
- Focus on prevention to keep the NHS true to its soul - New Statesman

16 Devolution, health and growth: North of Tyne and wider North East

Henry Kippin, Chief Executive, North of Tyne Combined Authority

The relationship between health and growth is central to the agenda of the North of Tyne Combined Authority, reflecting a long-standing evidence and practice base that has been built across the wider North East for many years. Examples include a major commission on the subject chaired in 2016 by then Public Health England CEO Duncan Selbie, and two successive devolution deals (for North of Tyne and latterly the wider North East) in which health inequality and prevention are important policy threads. The region also worked very closely together during Covid to shape a recovery plan and 'roadmap' based on strong recognition of the health and growth relationship – this has been very influential in the development of the recent NE devolution Deal.

The Selbie report can be found here: **https://northeastca.gov.uk/wp-content/uploads/2018/04/Health-and-Wealth-Closing-the-Gap-in-the-North-East-Executive-Summary.pdf**

Some examples of how this translates into practice are as follows.

- Health and Growth investment plan: The North of Tyne Combined Authority is working with major institutional investors on a 'health and growth' investment plan aimed at delivering a clear economic and wellbeing return through strategic investment in health assets, low carbon housing and place-based regeneration.
- Radical Prevention Fund: the new North East Devolution Deal commits the region to the development of a recyclable prevention fund that will support innovation in prevention (for example through startup and social enterprise activity and digital innovation) - generating new interventions to address public service problems, and delivering a financial and economic return to the region's economy.
- National Innovation Centre for Ageing: the North of Tyne CA has invested in a programme of work called the 'Internet of Caring Things' – led by the National Innovation Centre for Ageing, based in Newcastle – which supports innovative new products and services to support independent living, prevention and longevity. This will translate world-leading research within our universities into business and public services – growing a new business cluster within the region in a way that helps build the social infrastructure for an ageing society. See **https://ioct.uknica.co.uk**

- Commitments around health, social care and prevention: The new North East Devolution Deal commits the region to joint-work with ICS colleagues on the prevention agenda. This includes the prevention fund mentioned above, but more broadly embeds a commitment to pursue collaboration and co-commissioning of activity to support the wider determinants of better health (eg housing, net zero, physical activity etc). The devo deal itself is publicly available and can be found here: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1126764/North_East_Devolution_deal.pdf**
- North of Tyne Wellbeing Framework - the NTCA has embedded a wellbeing framework into its policy and investment process (which means we are considering wellbeing outcomes as well as economic impacts). This was developed this with Carnegie and can be see here : **https://www.northoftyne-ca.gov.uk/wp-content/uploads/2022/01/Wellbeing-Framework-for-the-North-of-Tyne-full-report-Jan-22.pdf**
- Health Equity Network - we are also part of a new network supporting the development of health impact through capital investment (I am on the advisory board) **https://group.legalandgeneral.com/en/newsroom/press-releases/legal-general-establishes-partnership-with-sir-michael-marmot-to-address-uk-health-inequality**

17 Science, technology and data for better health

James Bethell

Introduction

The science of public health and the potential for preventing disease is being transformed by new technologies which are building on the engines of innovation - genomics, artificial intelligence, and big data – to build applications around risk-scoring, diagnostics, and vaccines in a way that heralds a new age for modern medicine.

The engines for innovation – genomics, artificial intelligence, quantum computing, and big data

These innovations are touching many aspects of our health and care system to increase performance (often by combining data from different sources in a way not previously possible), reducing costs (often through automation) and opening new areas of discovery. The area of health prevention is benefiting hugely because these new processes enable a personal approach to prevention when previously public health was often a very blunt tool applied to large populations irrespective of risk assessment to achieve the maximum effect and operational limitations.

We should be planning today for the revolutions these engines for innovation will deliver tomorrow, particularly in risk-scoring, diagnostics, and vaccines.

Risk scoring

Data mining, often using artificial intelligence systems, is seeking out hitherto unseen correlations not obviously visible in the raw data. This enables a much more ambitious approach to stratifying a population for targeted screening, preventative treatments like vaccines, and focusing early treatments to maximise returns on investment.

It was most vividly seen in the pandemic with the implementation of an eight-layer vaccine prioritisation list which was largely based on age but also included many other variables that ensured that the right people received the correct vaccines in the correct order, quantity, and repetition. It was a huge application of risk-scoring, professionally delivered, and became a case study for future population health programmes.

Combined with more personal communications through the NHS app, this means resources can be allocated more efficiently, patient buy-in secured by an evidence-based explanation of the risks, and patient time focused on priority interventions. The NHS Health Check,

QRISK3, and Our Future Health are three existing illustrations of this principle, but we should be leaning in.

Diagnostics

We are seeing a new generation of diagnostic technologies benefiting from artificial intelligence, genomic sequencing, new basic science, and post-pandemic investment on incremental engineering improvements which are catching disease earlier and opening the door for safe, effective personalised treatments and pathways that tackle disease much earlier in its development.

Artificial intelligence combined with big data, which is slowly bringing together personal data from all parts of the health system, and the latest diagnostic instruments is massively improving the sensitivity and specificity of diagnostics, spotting patterns no human radiography could correlate. Consumer diagnostics, based on at-home sampling, open the door to accessible, cheap and frequent testing.

For instance, for cancer tests, a variety of techniques are being used, including protein biomarkers, anti-tumor antibodies, patterns of DNA methylation, and measurements of changes in DNA and RNA sequences. The Grail-NHS trial, unique in the world, sees 140,000 people aged 50 to 77 attending three appointments over two years, about 12 months apart. If successful, the trial could transform early cancer detection in England.

Politically, this is gold dust. It brings alive the new social contract on health, the idea that we can catch disease earlier and prevent illness and death, so long as individuals engage in their own health.

This new generation of "citizen diagnostics" was brought home, literally, in the pandemic when the whole population get used to at-home diagnostics based on the PCR, serology, and the swab test, with billions of tests taken in the UK with high rates of sensitivity and specificity. This shared experience should be the basis for a transformation in the way we do diagnostics.

The power of this was recognised after the pandemic in the Community Diagnostic Centre programme which seeks to take tests out of GP and hospital settings and into the places people live where they are more convenient and less intimidating and infectious. This programme, 160 centres by 2025, should be a much more ambitious platform for a huge-scale prevention agenda that hugely increases the scale of non-symptomatic screening based on risk-scores. From a political point of view, it is the physical manifestation of the prevention agenda, and it attracts the buy-in from communities and their leaders.

Vaccines

The power of vaccines was demonstrated in the pandemic. The mRNA technology, which was previously untested on a mass scale, clearly has the advantage of being adaptable and quick to develop. This technology allows for a faster response to new variants or emerging diseases. It has also paved the way for potential advancements in vaccine development for

various other infectious diseases and even cancer. A modern prevention strategy should include expectations of massive advances in vaccine technologies.

At present, the UK screening and vaccination programmes are slipping backward – e.g., HPV vaccine, cervical cancer, and prostate cancer screening. This is a matter of alarm. Instead of letting these fall backward, we should be doubling down as they have a massive return on investment, they fulfill the new social contract with patients, they get people in the prevention habit, and they will save money in the future.

Change of doctrine

Put together, these technologies represent a change of doctrine. Rather than relying solely on whole-population mandatory measures that are imposed from above by central government on all citizens equally to deliver against our big three public health objectives (longevity, inequality, and healthcare costs), they collectively represent a second suite of tools based on personalised solutions matched to individual risk that requires a new doctrine to health prevention that puts much more emphasis on the personal than the population-wide.

Whilst personalised prevention is not completely new, and whilst there will always be a role in health for whole-population mandatory measures (as there is a role for speed reduction to reduce vehicle emissions or mandatory age verification to protect children from porn), we are seeing a new emphasis, a shift in gravity towards the personal.

Conclusion – the critical importance of new technologies for delivering a modern prevention agenda

Not only are personalised solutions becoming more effective, but it is also politically much easier to deliver voluntary interventions that are targeted to individual risks than cracking the prevention challenge by brute force with population-wide measures. There are only so many times our politicians can go to the public with unpopular measures so if we can put some of the burdens on personalised prevention interventions, we prioritise the most necessary population-wide interventions.

We should embrace these technological advances enthusiastically, partly because they deliver great outcomes and partly because it is a way to get past accusations of Nanny State-ism.

18 Social Finance submission

Social Finance

Summary and recommendations

Currently poor population health drives an overwhelming focus on treatment with no spare capacity for experimentation or prevention. The cost of getting population health wrong is too great - for people, communities, the NHS, and our economy.

Successful investment in population health can break the cycle of an excessive treatment burden and poor health outcomes. There is a significant opportunity to use a new type of social investment from Health Charities to create **Health Improvement Community Funds** (HICFs) for each Integrated Care System (ICS). These would:

- invest in outcomes-based contracts to deliver measurable improvements to population health
- empower communities and health teams to improve health outcomes
- drive accountability for performance and spending, with clarity of purpose and commercial discipline
- encourage flexibility and experimentation that are simple to manage and monitor.

The establishment of five pilot Funds in 2024, followed by the roll-out of a further five Funds per year would leverage c£200M of sustainable transformation funding into the NHS by 2034. Initial outcome payments would be recycled into future projects. Charities would be incentivised to reinvest outcome payments from Integrated Care Boards (ICBs) back into the HICFs, creating an ‘ever-green’ effect.

Unlike other calls on Government, this initiative is predominantly seeking incentivisation and facilitation from DHSC, not substantial funding. Most of the capital comes from health charities with no expectation of return on investment.

Important

The majority of ICBs are managing significant financial deficits. This stifles innovation and improvement and creates a perverse incentive to focus on emergency care, rather than prevention. At the same time, national health charities are struggling to meet the increasing demands for their support and to leverage their impact in a sustainable way. Grant-making increasingly creates a ‘cliff edge’ when funding comes to an end.

Against this backdrop, a new type of repayable grant, paid for via social investment from charities – with no expectation of a financial return – might provide much needed sustainable transformation funding and expert capacity to improve our nation’s health.

Affordable

This approach channels investment and expertise from health charities into the NHS. Charities could act as 'anchor' organisations, supporting place-based charities in improving population health. Evidence shows this approach is more effective and affordable than NHS-run models of care. For example, the **HIV Social Impact Bond** invested money from The Elton John Aids Foundation into place-based charities for health improvement work, with the NHS as facilitator rather than funder or provider.

The investment and the value created would be ring-fenced, with outcome payments recycled across projects and ultimately re-invested. We have demonstrated the potential to recycle outcome payments to maximise investment with the **Macmillan End of Life Care Fund** where we aim to support over £30M of service costs with £16M of social investment. We would like to incentivise an ever-green effect with the HICFs, where outcome payments are reinvested by charities back into ICBs to create long-term health improvement funding.

Possible

Social Finance is a non-profit that helps to design, fund and scale better solutions to complex social problems. We are proposing to build on an established proof of concept with Macmillan Cancer Support. Unlike many social investors, Macmillan does not require a financial return and provides funded expert capacity to the NHS. Re-payments are made based on outcomes and only up to an agreed percentage of the service costs. As part of this, social investment has been included by NHSE in its commissioning guidelines for end-of-life care. This demonstrates significant policy support for this approach. Mathew Taylor's **recent speech** to the Royal Society of Medicine called for all ICS to have social investment contracts.

We are working with Macmillan to scope a social investment programme to improve the health of communities. We have identified several interventions with significant impact. For example, **Community Health Workers** that visit households every month, anticipating and responding to health needs based on a relational model of care. In Brazil, this reduced incidence of Cardiovascular Disease by 34% and a recent pilot in Westminster demonstrated improved access to screening by 97%. This is the type of intervention a social investment approach will help to scale.

What does success look like?

- Improved health outcomes in every ICS evidenced in value to the person, their community, and the NHS.
- Increased investment and capacity for community organisations via national health charities.
- Sustainable transformation funding – a legacy of an outcomes-based fund in every ICS to continue to innovate and improve our nation's health
- Proof of concept that an outcomes-based approach to NHS transformation and innovation can be rolled out to other areas without additional investment.

HICFs avoid typical innovation hurdles. Their framework, clear goals and commercial discipline mean flexibility and experimentation are encouraged, with changes in approach simple to manage and monitor. And because HICFs are co-designed between ICBs and communities, there is a direct stake in improving local population health with key features targeted to fit local priorities.

Another advantage is that HCIFs do not require system change, which can exacerbate institutional inflexibilities. The ICB framework already in place paves the way for co-design of HICFs.

How to get there? What might it cost?

We are developing proof of concept Funds with Macmillan Cancer Support in five ICBs by Summer 2024. We would welcome national backing to incentivise ICBs to take part in this innovative work.

Between 2025 and 2030, we would roll-out a further five Funds per year. We anticipate Government support to further incentivise ICBs to take part e.g., offer of development and top-up funding.

Estimated initial social investment from charities required: c.£100M. There is scope for the total to be c.£200M with match funding from organisations such as Access and Big Society Capital.

Estimated Government support to incentivise the scheme: c.£20M. This could be dependent on ICB needs, but likely to be used for programme management, data analytics or top-up funding for outcomes achieved.

Expert Capacity: c.£500,000/Fund/Year. The aim would be to transition most of this work into the ICBs. The cost is likely to vary from Fund to Fund based on level of capacity/expertise and the nature of the investments themselves e.g. level of innovation.

Conclusion

We have a unique opportunity to build on the momentum for the new type of social investment we have co-created with Macmillan. Together, we can leverage the assets of communities, statutory organisations and charities to radically improve health outcomes over the next 5-10 years and leave a legacy for how to achieve sustainable transformation in health.

Figure 18.1. HICF: Illustrative diagram