A Covenant for Health

Policies and partnerships to improve our national health in 5 to 10 years

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Summary

There is an opportunity to make significant improvements to the health of our nation in just 5 to 10 years, benefiting millions of people, society, our economy and our health systems. This paper explains where and how to do so.

It is urgent to act, the UK has among the worst population health in Europe, the highest levels of obesity, the worst excess drinking levels, very large health inequalities, and very many people become ill much earlier than they should. Our high level of premature, often avoidable ill health, damages lives, our society, localities and our economy. Without resolute action it will get worse. We must act so that lives are not degraded, and to sustain our health services and labour supply.

Because of the urgency, this project explored what could be achieved in 5 to 10 years, looking at key risk factors and population groups. The remarkable conclusion is that a great deal can be achieved by an active government working with all parts of society, with people and communities themselves. In 5 to10 years, we should be able to:

- help 3 million people quit smoking, halving our smoking rate
- help 4 million people avoid becoming obese
- help at least 4 million be more active
- help more children be physically and mentally healthy, fewer at risk of obesity
- reduce the 30,000 deaths a year from poor air quality
- help 5 million people to reduce their risk of CVD, still 24% of all deaths
- help the people and places where health is worst.

This report sets out how to achieve these goals and why they are possible.

Creating a healthier nation with better healthy life expectancy needs a collaboration between people, places, the NHS, and businesses, as well as government. The things that only government can do, it must do, but, above all, it needs to make the case for better health, and empower all parts of society to work to make it happen.

So, we suggest a *Covenant for Health*, a resilient cross-party commitment to build a healthier nation, and to develop partnerships for health with business, local authorities, and key charity groups. Suitably framed, this could be an attractive offer for the public (*see* Annex, page 26).

Surprisingly, this agenda of change should also be affordable; the costs are small compared to the growth of the NHS's budget and they would be born across society as well as by government. The benefits would be great. A new government should move fast, define early what it wants to achieve, prepare for it, legislate, if needed, and make difficult changes early.

There is a fantastic opportunity for any new government to define and promote such a mission.

Introduction

This paper seeks to contribute to manifesto thinking in all political parties and for discussion with organisations concerned about population health.[1] It is good to see ideas beginning to emerge from political parties and others. This paper proposes not just a programme for government action, but a new *Covenant for Health* that brings together business, the NHS, communities and individuals.

There is a great opportunity for any new government to co-create a healthier nation, with healthier air, water, food, workplaces and transport, creating healthier lives for us and our children, and better health in the places where it is worst. The good news is that this is possible; a small number of policies resolutely pursued could significantly and rapidly improve our nation's health and they should be affordable. Too often in the past political leaders have focused on immediate pressures and been timid.

We propose a *Covenant for Health*, a resilient cross-party commitment to build a healthier nation over a generation, robust enough to sustain across governments (*see* Annex, page 26).

[1] This report's focus is England and all data is about England, unless stated otherwise.

1 Why change is imperative

The challenge of our unhealthy nation

We live, on average, 10 years longer than our grandparents, a fantastic gift of extra life. But many people miss out on this gift, as they develop significant illnesses that often could have been prevented or delayed. So, they have worse lives and can contribute less. Moreover, the poorest places in our society develop these multiple illnesses 10 to 15 years earlier than the wealthiest.[i]

The UK has among the worst population health in Europe, its health inequalities are worse than many others: it is the most obese nation in Western Europe, its excess drinking is the worst of 25 countries studied. Women get their first major health condition on average when only 55 years old, in the most deprived places this happens at 47. People in the most deprived places get ill 19 years earlier than people in the least deprived.[ii] This premature morbidity has major consequences.

People who are ill are less happy.[iii] Physical and mental health together are the top driver of individual wellbeing (s*ee* Appendix 1: Subjective wellbeing and mental and physical health, Nancy Hey). The appendices are available **here**.

- It increases demand on the NHS and social care services.
- It reduces labour supply, weakens our economic growth.
- Short working lives, earlier need for health and social care, greatly increase fiscal costs.

Poor health is a structural weakness in our economy.[iv]

- 90% of people who died with Covid-19 were in poor health; a healthier nation would have had fewer death, fewer days of lockdown and less economic damage.
- We need a healthier workforce to cope with growing labour shortages. Almost 2.5 million people in the UK labour force cannot work due to ill health. More people aged 50+ drop out of work now than in the 1970s, health is the main reason. These labour shortages will get significantly worse over the next decade as our population ages.
- Fiscal benefits: more healthy people means lower welfare costs, increased tax revenues, less expenditure on treating ill-health. We must help people to stay healthy and in work for their good and for their contributions, economically and fiscally.

We must do more to limit or delay NHS demand growth. In 2004 the Wanless Report forecast that demand growth would overwhelm the NHS unless we promoted heath. We did not, we focused only on short-term goals, waiting lists and hospitals, now we spend ever more on treating illnesses.

Genetics, environment, and behaviours drive 70% or more of our health status. Treating sickness accounts for less than 30% but still consumes 90% of resources.[v] The NHS

dominates political attention, but the NHS cannot make our country healthier, its priority is treating illnesses.

The current government set a great manifesto goal: '*for everyone to have five extra years of healthy, independent life by 2035 and to narrow the gap between the richest and poorest'.* They also set goals to halve child obesity, to make the country smoke free, both by 2030, to reduce adult obesity and a National Food Strategy to address our unhealthy food system.

But none of these have been strongly addressed, all targets will be missed by miles. These goals were not pursued as there has been weak political commitment, opposition from some ideologues, from some of the media and from some commercial interests. This failure to act and to use the levers for change that are available, has consigned many people to ill health and worse lives.

Preventing ill health has obvious benefits, a person who is in good enough health is likely to be happier, to keep in work, to pay taxes, not to require welfare or social care support, and to be able to support others.[vi,vii] To show that this can be changed we explored what improvements are ***important, affordable, and possible in 5 to 10 years.***

2 Change is possible

We know what works

There is a revolution in our approach to public health, with new engines of innovation in genomics, big data, artificial intelligence and diagnostics to add to our public health toolkit of health awareness, disease prevention, and major programmes on smoking, HIV infections and vaccination. These new tools will create a more personalised, risk-based approach, to detect and catch risks or illnesses earlier. We also understand the need to combine medical science with the wider determinants of health, and the importance of environmental threats like poor air, mouldy homes and junk food. Last, we understand how behavioural science can use fiscal and marketing nudges to make it *easier to make healthy choices*.

To benefit from these in practice will require a coalition for action for a healthier nation between central and local government, the NHS, business, communities and people (*see* Appendix 2: Why is prevention so hard and how can you change the narrative? William Roberts).

The public want change

The public want more action to live longer in good health. In response to the question '*has the government the right policies in place to improve public health?'* only 13% agreed [viii]. The public are more ambitious than government: less than 20% think government has done enough to improve diet, reduce alcohol related harms, reduce obesity, or improve physical activity.

This agenda needs to be re-framed in human terms, as an offer to the public to make it easier to make healthy choices and as a covenant between individuals, business and government at all levels. We should not expect central government alone to make the argument for change or to face the opposition and risks. The goal of a healthier nation, if couched as a new *Covenant for Health*, can be an attractive offer to the public, incorporating other manifesto goals (*see* Annex, page 26).

The Chief Medical Officer (2018) explained where to focus: 'We could prevent up to 75% of new cases of heart disease, stroke and type 2 diabetes, 40% of cancer incidence and reduce dementia if we cut smoking, unhealthy diet, harmful consumption of alcohol and insufficient physical activity'.

Better population health will need:

- combined action by government, employers and individuals to improve the environments we live in and how we behave and reject the myth that spending on illness alone will improve our health
- to harness emerging technologies to improve the nation's health

- political ambition to pursue these goals, ideally cross-party, to win public backing for a programme of actions, and to build a resilient political architecture to support prevention and promote longer healthier lives as our goal.

To explore how to improve our health in 5–10 years, we examined major risk factors, smoking, obesity, excess alcohol, physical inactivity, poor air quality, plus mental illness and two critical population groups, children, and the people and places with the worst health. Last, we explored how better to detect and treat key risks and symptoms.

It is possible to make significant progress in 5 to 10 years if we can agree a new *Covenant for Health* in which business, government, clinicians and individuals agree to collaborate to face down these awful illnesses. Despite opposition from some quarters, there is strong public support for many of the actions, and the opposition can disappear with experience. As George Osborne has recently said, '*no one now would reintroduce smoking in pubs, and no one now would say you shouldn't wear a seatbelt'*.[ix]

Smoking

75,000 die every year, plus half a million hospital admissions, as a consequence of smoking. More than six million people still smoke, and most will die from it. A third of people who live in social housing smoke. The average smoker spends £2,500 a year on it. Smoking tobacco is still the single largest cause of preventable death killing 64,000 people every year in England. On average smokers lose 10 years of life. Smoking is expensive, and the expenditure released could lift around 2.6 million adults and 1 million children out of poverty. Smoking is three or four times as common in some disadvantaged communities compared to the wealthiest. The health care and other social and economic costs smoking imposes on society are far greater than the tax revenue paid, the Khan Review[x] estimating overall costs as £17 billion, of which £2.4 billion falls on the NHS.

The public polling evidence is clear – people want stronger action on smoking. Three-quarters support more government action and a levy on tobacco manufacturers to pay for this. Nearly 70% of smokers want to stop. The political problems come when the issue becomes a libertarian cause and this has held up progress on smoking in countries around the world, so we need an approach that protects politicians from blowback.

We know how to reduce smoking, adopt the Khan Review's four key recommendations and there are ways to make them attractive:

i) much more support to help smokers quit, particularly in areas of deprivation

ii) pay for this by a tobacco industry levy, which must win the support of HMT

iii) prescribe vaping to help smokers quit, accompanied by a fierce clamp down on its general marketing and sale

iv) help smokers to quit at every interaction.

Add to these, the progressive phasing out of smoking, as in New Zealand and as backed by George Osborne. Both the government and official opposition have recently recognised the

power of vaping as a quitting aid for adults and a risk to children, but they need to do more than this.

There is strong public support to make 'Big Tobacco' pay, if the proceeds are used to help people quit. Labour's 2015 manifesto committed to do so (*see* Appendix 3: Helping smokers quit: a blueprint for success, Deborah Arnott).

Conclusion

In 5–10 years we could help halve the smoking rate and help 3 million to quit, especially in the poorest places. We know how to do it. More funding would be needed, but most costs could be borne by the tobacco industry. There is strong public support for this goal and the actions needed.

Obesity and unhealthy diets

Obesity is becoming our greatest population health challenge; it has doubled since 1992. More than 12 million adults are living with obesity, and without action there will be 4 million more by 2030. The NHS spends around £6.5 billion a year (close to 4% of its 2022/23 budget) on treating the consequences of obesity. This is forecast to increase to £10 billion a year by 2050.[xi] Obesity damages lives, limits social life and work. This is a problem across society, arresting it is fundamental to improve lives and limit NHS demand growth. Millions of us want to lose weight.

No country has dramatically reduced obesity levels, but some have made progress – France, Finland, Norway, Korea and Japan – by multifaceted approaches that include public health campaigns, school-based interventions, regulations on food marketing to children and using tax as a nudge.

Yet the UK government to date has focused on individual responsibility and information. But the facts show that information, exercise and willpower will not reduce population levels of obesity. We need to learn from countries like Japan and address the environments that impact on people's food decisions, the incentives for the food industry and culture around food. That is why we propose an approach that combines the efforts of employers, the healthcare system, individuals and, of course, government.

We recommend the rapid implementation of a sugar and salt reformulation tax, as recommended by Henry Dimbleby's National Food Strategy. This would significantly lower average sugar and salt intake and halt weight gain at a population level. Such a mechanism worked well with the Soft Drinks Industry Levy and led to 36,000 fewer cases of obesity in children and teenagers. We must also prevent further weight gain and reduce the risk of complications in those living with obesity.

Arresting the forecast increase in obesity in society would be a great achievement and 4 million people would avoid becoming obese by 2030. Men need to cut 165 calories per day from their diets and women 115 calories on average to meet the goal of halving obesity prevalence by 2030. This is higher for adults living with obesity, where a reduction of 307 calories per day for men and 222 calories per day for women is needed.[xii]

Nesta is exploring how mandatory calorie reduction targets for the food industry could further help to reduce net calorie consumption and ultimately obesity – giving the industry the freedom to decide how to get there. These important proposals will need to be actively explored with the major food manufacturers and retailers (*see* Appendix 4: Shifting the system: tackling obesity through changes to the food environment, Nesta, and Appendix 5: Obesity: key facts and statistics.)

Quality of diet is also important; we consume more harmful highly processed food than any other European country. A customer in a supermarket or down the high street ought to find that the cheapest, most convenient, most attractive options are healthy. Poor families consume what is cheapest, often pre-processed, and take-away food. So, it is necessary to make healthy foods affordable and available to poor families (*see* Appendix 6: Food Foundation evidence, Isabel Hughes).

Transparent data on the food industry is fundamental for a more sustainable food system and mandatory reporting, as now backed by Tesco, Compass Group and Greggs. Investors too need data to make informed decisions about responsible investments and to identify risks.

Conclusion

Obesity is one of our greatest population health threats, and it is urgent to act. We can arrest its increase and help the 40% of us who are trying to lose weight. The reformulation and availability mechanisms, above, are the key ways to start to do so. Most costs would be one-off and be borne by food manufacturers and retailers. There is strong public support for action.

Reducing alcohol harms

Alcohol is the leading risk factor for death, ill-health, and disability among younger people. More working years of life are lost due to it than to the 10 most common cancers (*see* Dame Carol Black's review of the effects on employment outcomes of drug or alcohol addiction and obesity). 1 in 20 hospitalisations are linked to alcohol, and alcohol-specific deaths have increased by a quarter since 2019. In the most deprived decile, the death rate is double that of the least deprived. It can fuel crime and disorder, lead to family breakdown, domestic violence, and puts significant pressure on public services and £8.3 billion in healthcare costs. The volume of alcohol consumed per person has decreased in the past 20 years, and younger people are moving away from it, but the harms it causes continue, and are egregious and expensive.

The aims of policy, we suggest, should be to give access to treatment services to those already dependent or drinking heavily, and to prevent future harm. The biggest future gains come from shifting the whole consumption curve downwards; this would give the best chance to reduce harm and relieve pressures on the NHS and criminal justice system. 48% of people support and 28% oppose applying a minimum price for a unit of alcohol.[xiii]

The Alcohol Health Alliance (*see* Appendix 7: Why a manifesto for health must address alcohol harm, Sir Ian Gilmore and Poppy Hull) recommend three actions:

1. reintroduce the Alcohol Duty escalator, increasing duty by 2% above inflation every year
2. introduce minimum unit pricing in England, as in Scotland, Wales and Ireland. In Scotland, this led to 13% fewer alcohol-specific deaths
3. restrict alcohol marketing which leads people to drink more and at an earlier age, a highly effective way to reduce alcohol harm but will need a political strategy to address the opposition.

Better access to treatment is important. The Public Accounts Committee recently reported that a 'staggering' 82% of the 600,000 people who are dependent on alcohol are not in treatment despite success rates of around 60%. The Committee says government must act on the best available evidence on preventative measures around price, availability, and marketing and also address the funding uncertainty for local authorities and the barriers to accessing treatment.

Conclusion

We can help reduce harm from excess alcohol; we know how to do so, some of the actions needed would generate government revenue, the benefits could flow quite fast.

Physical activity

Physical inactivity is associated with one in six UK deaths. 12 million adults are inactive and so at risk. Physical inactivity sets in strongly during adolescence, especially for females. For adults, 20 minutes exercise a day cuts the risk of developing physical and mental illnesses. A government facing a public health crisis could do much more to promote physical activity and make it accessible for all. It is an important contribution to the culture of self-management and mental wellbeing and is central to the success of countries with better health outcomes.

The answer to this at population level is primarily to hardwire physical activity into people's everyday lives. The government target for 50% of all journeys in towns and cities to be walked or cycled by 2030 is good, but unlikely to be met. Wales and Scotland invest far more proportionately than England on this. So, a new government needs to set a goal that at least one-third of the people who are inactive, 4 million, become active in a decade, especially in places that do little.

Active travel is a good way to address this, it also reduces transport emissions for net zero (*see* Department for Transport's *Cycling and walking investment strategy* from 2017[xiv] and *Gear change* setting out a vision for cycling and walking from 2020[xv]). It is done locally, *see* Essex Pedal Power, a project in Clacton and Jaywick Sands, which reduced physical inactivity from 30% to 11% and cut the average number of car journeys by 30% per week.[xvi] The evidence for the impact on health of active travel is convincing, for example, saving more than 1,000 lives every year, if activity levels simply matched current rates in the most active regions.[xvii]

Planning and local traffic management actions can make walking easier, encouraging schools, parents and children to walk or cycle more to school. Park Run, Park Walk, are impressive community-led initiatives that cost little, provide social contact and are inclusive. Initiatives such as 'This Girl Can' encourage girls and young women to be active, football clubs can reach out to their communities, and more support is needed for those with disabilities too. A new government needs to work energetically with local authorities and advocacy groups to create environments that support and encourage active travel.

Conclusion

Helping us to be active is vital; focus on walking and on those who do little. It will bring benefits for mental and physical health, for climate change and congestion. Build on the good work of Active Travel. It requires a pan-government plan, formed with local government and the NHS. Some capital funding to make localities more safe and pleasant for walking and the benefits would build over 10 years.

Air pollution

Poor air quality, outdoors and indoors, is our largest environmental health risk; between 26,000 and 38,000 people die each year, and many others suffer avoidable long-term ill health from it. It is becoming increasingly clear this is connected to the risk of dementia, as well as physical conditions.

At local level, pollution from road traffic and diesel engines causes up to 70% of air pollution. It is possible to reduce air pollution, as shown by the London Mayor, through regulation and by purchasing cleaner vehicles for public services and public transport; the effect on NOx can be substantial and rapid. Clean air zones need to focus on places with high pollution and high population density and for local authorities to plan them with the communities most affected. A new government should explore how to reach the Environment Act air quality targets earlier than 2040.

Conclusion

Air quality matters, we know how to improve it and the benefits are rapid. Accelerating its implementation would reduce health risks and harms and contribute to climate change. It does have implementation costs, for example, to compensate for early scrappage of older vehicles.

Promote mental health, prevent mental illness

Mental health issues affect almost one-quarter of adults and one-sixth of children and young people. More than half a million people have severe mental illness and 70% of these people are economically inactive and on disability benefit. Mental illness is linked to higher rates of smoking, alcohol, drugs, poor diet, physical inactivity, and lower life expectancy. Many people with mental illness also see their existing physical health conditions neglected. Mental health problems and depression are a major cause of people being out of work, poor mental health costs the UK an estimated £118 billion per year.

Despite how widespread and significant mental illness is, too little attention is given to preventing it or to promoting mental resilience. Most mental health disorders start early in life and the Royal College of Psychiatry suggests that investing in health promotion, prevention and early intervention is the only sustainable way to reduce the incidence. It has called for the development of a cross-government mental health and wellbeing plan, as promised by the government in 2022.

Conclusion

Preventing mental illness is complex but essential. A new government should commission a report to identify practicable interventions to reduce the risks of mental illness with a particular focus on children and young people.

Healthy children

Most parents want their children to be healthy. Yet many children have health risks and conditions and so are more likely to develop early long-term illnesses and later, risk falling out of work. There is no government strategy to improve children's health, OHID have the lead but not the levers. We suggest a focus on four topics: obesity, mental health, physical activity and early years.

Childhood obesity

Nearly one-quarter of children aged 10–11 are living with obesity. They will have much higher risks of poor health in later life, for, when older they will have lived with obesity for so long. There have been strategies, but little action, to address this. We need to implement the National Food Strategy's reformulation recommendations; re-introduce an upper limit on the amount of sugar served to children in school meals and regulate excess sugar in baby and nursery food (*see* Appendix 8: Early nutrition and development, Zoe Birch). Four other recommendations in The National Food Strategy are relevant: launch a new 'Eat and Learn' initiative for schools; extend eligibility for free school meals; fund the holiday activities and food programme and expand the Healthy Start scheme.

Children and adolescent mental health

Most lifetime mental disorders arise in childhood. One in six children aged 5–16 have a probable mental health disorder, a big increase since 2017. Childhood mental health disorders lead to much higher risks of adult mental health disorders and worse educational and employment outcomes. It is essential to make early diagnosis and treatment much more available. The serious delays for assessments are harmful. Open access mental health hubs for young people and specialist mental health support in every school could be very important. The NHS must ramp up the training and recruitment of mental health support for children. Schools and colleges too need to support the mental health and wellbeing of pupils and to build youth resilience. Anti-bullying programmes; social and emotional learning; and relationships, sex, and health education in schools are all vital.

Active childhood

If activity becomes habitual when we are young, it benefits us all our lives. Yet, physical activity levels drop precipitously in adolescence, especially for girls. Active travel to school helps children develop the habit of walking and cycling. Active Travel is funding Bikeability cycle training and funding safe routes to school, including School Streets, and bike training. Sport England's local delivery pilots activate communities to lead more physically active lives. Local government, national government, agencies and charities all need to work to raise the levels of physical activity significantly in children and teenagers.

Early years

Cross-government investment in the early years is vital to put children on a path to good health and reduce lifelong inequalities. Yet it has been hard to sustain cross-government funding, action and policy in the early years across administrations. A new government could tackle this, changing how government works and seeking long-term cross-party consensus.

Conclusion

Helping our children to keep healthy is essential for them and for society, many start adult life with high health risks. Much stronger action on obesity, physical activity and better mental health interventions is needed. A pan-society, pan-government plan is required to improve children's health and other outcomes with commitment from Department for Education and schools, and with the above areas as priorities.

Early detection, earlier treatment

If the NHS were better at detecting and treating a small number of high-risk factors and symptoms it would help millions of people live longer healthy lives. We are not doing well, more than 7 million people have untreated or poorly treated high blood pressure; more than 40% of adults have cholesterol levels above national guidelines; five million people have high blood sugar, with 3.5 million undiagnosed. These three risk factors are the main drivers of CVD, which accounts for 24% of all deaths. A person in the most deprived areas is almost four times more likely to die prematurely from CVD than someone in the least deprived (*see* Appendix 9: Early detection and treatment of chronic disease, Veena Raleigh).

Diagnosing and treating these risks is 'medically' simple, low cost, and brings great benefits to individuals and the health system. As the Hewitt report recommended, integrated care boards (ICBs) must make early detection, treatment and help to change behaviours a priority.

The start to improving this is the further development of regular health checks, focusing hardest on people and places with high risk of premature ill health, as the Deanfield Review of the NHS Health check has shown. But to be effective these checks must be matched with effective treatment and help with changing behaviour. We need many more annual health checks for the common high-risk factors, and, above all, to ensure that a health check leads to action.

Many ICBs have integration strategies and set clear success goals for this work. Others need to publish them. Ambitious success goals are important – for example, that 80% of people with high blood pressure are identified and 80% of these get effectively treated; and that in 5 years everyone aged 50 plus gets an annual check-up. More than 5 million people would then have lower risks.

Post Covid-19, many places have worse health risks, people are struggling with higher inflation, and many have less agency to address their own health improvement. So, it is essential to raise levels of detection and treatment in in the poorest places where premature ill health is worst. The standard NHS offers of health checks will not be enough. Much earlier action is needed help people keep healthy, many stop work for health reasons in the poorest places and it can be too late to address this when they are 50 or older. So regular offers of support for healthier lifestyles may be essential for people aged 20 and 30 before problems become entrenched.

The NHS has to get vastly better at working with communities and local organisations to shape their service offers and support so that detection and treatment levels for those risks and symptoms are much better (see Appendix 10: Increase secondary prevention to develop a renewed NHS, Dr Paul Corrigan).

The prevention of multimorbidity and helping those living with multiple long-term conditions are both vital. Multimorbidity will increase greatly in the next decade. This has a large impact on patients, healthcare systems and economies yet should be more preventable, as common clusters of risk factors and conditions are responsible for majority of this burden.

Conclusion

We need to develop a much better system for higher rates of detection and effective treatment, doubling down on a small number of things where the evidence is strong and the benefits great.

Concentrations of risks and inequalities

In the most deprived places in England women get their first long-term health condition when they are only 47 years old, on average. In such places, environments and risk factors are worse – poor food, poor-quality housing, air pollution, smoking, obesity, excess alcohol, inactivity, and multimorbidity levels are all much higher. People spend many more years in poor health *and* die earlier than elsewhere. These chronic concentrations of ill health degrade people's lives and hamstring the economic and social success of their locality. Mainstream policies often do not reach or work as effectively in such places. The different risks and needs of differing ethnic groups also need to be addressed (*see* Appendix 11: Race and health, Runnymede Trust and Appendix 12: Concentration of risks, David Buck). We suggest four strategic shifts.

Focus on people and places with worst risks and worst healthy life expectancy: all national and local policies and programmes need to bend their policy goals to help such people and places. Identify these places, perhaps looking at the 20% of upper-tier authorities with worst

health scores and the wards within them where high risks and poor health are concentrated. We have done this before, with evidence of success,[xviii] as with the NHS's current approach to health inequalities, core20plus5.

Bend ICS support to these places for 10 years: ICSs must focus much more on reducing risks and symptoms in these places, this requires more effort, creativity and funding than serving a 'converted' population. The ICS partnership and the ICB should jointly develop and fund integrated wellness services, focused on clusters of health behaviours in their populations and communities, addressing behaviours as sets to support people over time, with psychological and other support (*see* Appendix 13: Putting prevention and population health at the heart of integrated care systems, David Buck and Dominique Allwood).

Fund £10mn to every local authority with worst health: this will allow these areas to invest over ten years in community development and community budgets, targeting areas with high deprivation and low social infrastructure and community networks. These places have high NHS costs, so this preventative funding for community development should come from the local ICS.

Early years: cross-government investment in the early years is vital to put children on a path to good health and other outcomes and reduce lifelong inequalities.

These specific initiatives are evidence-based and will make a difference, but the funding, incentives and performance management of the local public sector, including the NHS, need to focus on the concentration of risks to health in people and places. The direction of travel is correct, with the creation of ICSs and the focus on devolution, but this needs to go further and faster.

Conclusion

It is essential to prioritise action to address the very poor health and wellbeing in some of our poorest places if we are to level up and reduce the shocking gap in healthy life expectancy in our society. It is essential for their local economies too.

Conclusions on priorities and proposals

This overview of nine issues has shown that, remarkably, a great deal can be done to improve our health, rapidly and for relatively low cost, but it will require a collaboration from employers, the NHS, individuals, charities and, of course, central and local government. There are good enough strategies, just waiting to be acted on. The big message to all political parties is *Just Do It.* We know what needs to be done and could achieve remarkable gains in 5 to 10 years' time.

The case for doing so ought to be overwhelming, the waste of human lives, the ballooning costs to the NHS and the damage to our economy and public finances from premature preventable illnesses.

Acting hard on these nine topics through central and local government, the NHS, businesses and wider society would significantly improve our health. Couched as offers of help, in a

Covenant for Health, they would make an attractive public offer. They are possible, affordable, and important and would:

- help the 70% of smokers who want to quit to do so
- help us lose weight, most of us want to
- help our children to be healthy, most parents want this
- help us keep well, we all want this
- help places where health is worst, local leaders know this is essential.

As Chris Whitty, Chief Medical Officer, said in 2019: '*There is a bunch of things that we know work that are simply not happening, but if they happened to most people at risk, things would improve really quite fast.'*

3 Making it happen

Population health must be a pan-society goal driven by many agents over many years. As well as the fast focus on the nine topics above, system changes are also needed to ensure continuing attention to what benefits our population's health over the long-term, as below:

- the politics of population health
- listening to the public
- government leadership
- partnerships for health with NHS, local government and public
- alliances with business and charities
- science and technology
- funding better health.

The politics of population health

There are political challenges to improving population health, with powerful vested interests, and damaging preconceptions by public and politicians (*see* Appendix 14: The politics of population health, James Bethell). Shifting the political discourse is essential, to promote a positive vision for better health, tying in broad cross-party and cross sector support for a new *Covenant for Health* for change, built on four legs:

Social justice: supported by many politicians and civic leaders from economically marginal communities, plus campaigners for disadvantaged groups, and trade unions.

Economic growth: HMT and business groups seeking better productivity, and labour supply for now and the future, financiers and economists who want economic growth and resilience.

NHS sustainability: to reduce or delay pressures on the NHS and social care. The health industry looking for growth in preventative medicine and healthtech.

Personal health: addressing our own wish for a good life, with good physical and mental health, celebrating and enabling our own role as engaged citizens and communities in promoting this.

All these interests need to coalesce around a realistic agenda for change, and to campaign collectively for, say, five significant goals for the next 5 to 10 years.

Listen to the public

The phrase, *the nanny state,* has damaged people's lives. It is right to have an active, enabling state and to use its powers for better health, this is why we have the NHS. The polling evidence does not support the *Daily Mail* narrative; the public in general, want stronger action by government to improve population health.

We need both an active, enabling state and active citizens. Each of us has a responsibility to try to stay healthy, a view supported by over 95% of the public. The role of government, nationally and locally, is to empower people with the information, environments, stimuli and support to act on this and to offer easier healthier choices, especially for those for whom the barriers are far higher.[xix] For example, it is cheaper to get calories from poorer foods, and poverty drives poorer 'choices'.

The public strongly believe that government is responsible for controlling harmful products. A tougher regulatory approach is essential, adopting policies recommended in the Khan review, to make the UK smoke-free by 2030, and in the National Food Strategy, to halt the increase in obesity.[xx]

Locally, it is essential to build with the public an understanding of how poor health damages communities, and to build local commitment to improve it. This way of working with the public must become embedded in all local authorities and ICSs (*see* Appendix 15 What does integrated leadership look like to drive health in a place? Laura Charlesworth and Jessica Studdert).

Communities know a lot about their lives and challenges. Harnessing this understanding for better health is essential, as it is locally where social differences play out and where community assets may be harnessed.[xxi] So, strengthen support for community-based prevention. We suggest a pilot of a new dedicated non-medical workforce to work with individuals to address wider factors of ill health from poor diet and exercise to lack of access to secure work.[xxii]

Government leadership

Better population health requires widespread actions across society, but only government can make this a national ambition, legislate, and brigade the finances. We suggest the following:

Make the case, do what works, empower others: government must promote better health, post Covid-19, as a goal for all of society and inspire the nation with a sense of mission, as it has on climate change. It must do what works and where needed, use taxation, regulation, support, and incentives to drive the changes and to confront vested interests that block reasonable policies. But it must also work with others to deliver these goals and be a catalyst to empower key partners and communities, not relying solely on top-down dictats.

Senior leadership: the PM and Chancellor will need to affirm this goal because the policy levers for population health sit across many departments. Senior ministerial leadership is essential to promote the goal across government and to the NHS, local government, business and wider civic society. In the Department for Health and Social Care (DHSC) better population health has been subordinated to the NHS's problems. So, we suggest a **Chief Secretary for Population Health** supported by an enhanced Office of the Chief Medical Officer, to promote change across government and society, based either in the Cabinet Office or in DHSC. The Chief Secretary for Population Health needs to sit in Cabinet.

The government abolished Public Health England (PHE) and replaced it with the Office for Health Improvement and Disparities (OHID) and the UK Health Security Agency (UKHSA), yet neither have yet found the institutional momentum and way of working to deliver impactful public health leadership and both risk becoming marginalised. To help redress this, the Chief Medical Officer's Office in partnership with local government Directors of Public Health should be charged with promoting *Health in all Policies* in both central and local government.

An independent review of HMT's policies and taxes to contribute to better health: the Treasury is sceptical that prevention will reduce NHS and social care costs for the claims of savings are legion but hard results are rare. But it is not only NHS costs that should concern us. A healthier nation is fundamental for our economic and fiscal sustainability as well as the great wellbeing benefits for each of us from more years of life without serious illness.

The fiscal reasons for delaying ill health are wider than just NHS costs. The Office for National Statistics (ONS) projects that the number of people of pensionable age for every 1,000 people of working age, will increase from 280 in 2020 to 341 by 2045, a 22% increase in just 25 years, a staggering demographic shift. It is critical for fiscal reasons to minimise the number of people who stop work because of ill health, and then pay less tax and make early ongoing demands for welfare, health, and social care support. So, we argue, the Treasury itself must own the goal to reduce health risks and not be a critical bystander.

Health in all Policies: the wider social, environmental, economic and commercial determinants of poor health need to be persistently addressed. So, adopt *health in all policies* at both central and local level to assess the health impact of policies, and publish them transparently. The devolved administrations need to be included too; while health is devolved there is shared learning to be had and many departments that need to be involved have UK-wide responsibilities. Data on the financial implications of public health is woeful, so the ONS should build on the Health Index and develop a plan to address this. The Office for Budget Responsibility (OBR) should be required to comment on the impact on population health in every budget, as in New Zealand.

Partner with all agents of change: the public, the NHS, local government, business and charities. Central government alone cannot deliver better population health, but it can enable, mobilise and support other key agents: civil society, the NHS, regional and local government, business, technology and charities, as described below. This will require Ministers and top officials to be persuasive, persistent and collaborative.

A National Service for Health

It is obvious that the NHS needs to do more to prevent illness, to detect risks and reduce them and to delay morbidity. It spends billions of pounds trying to keep us alive for a few weeks at the end of our lives, but much less to keep us healthy for many years. The Commons Health and Social Care Committee warned that the new Integrated Care Systems may neglect longer-term issues, such as population health and health inequalities and focus only on short-term, operational challenges.

The Hewitt Review's recommendations on prevention also could have gone further. The proposed 1% uplift in prevention spending by ICSs over 5 years, is worth around £1 billion. The local authority public health grant alone has lost a cumulative £3 billion in real terms value since 2015/16.

We welcome the introduction of outcomes frameworks for ICSs, but these need to reflect and focus on what drives population health and narrows health inequalities, and on populations and places with high health risks, to identity them, and focus resource accordingly.

The NHS must use every opportunity to stimulate better lifestyle choices and self-agency. The NHS needs to engage the public much more as active participants in creating their own health, and, learning from the experience of Covid-19, transfer power to communities themselves where appropriate, and better use technology and system data to identify and improve outcomes for those whose risks and outcomes are worst.

More than 60% of emergency patients admitted to hospital have one or more long-term condition and the exacerbations of these long-term conditions leads many to be admitted to hospital and occupy emergency beds, one of the biggest crises for the NHS. This is largely caused by its failure to work with patients and their carers to enable them better to manage their long-term conditions and reduce time in emergency beds. So, the NHS need to increase the capacity and capability of patients, their carers and families to manage their long-term conditions, using health trainers, social prescribing, making every contact count, and other approaches to provide more support when they are not with professionals directly.

The NHS needs also to engage community groups and the third sector, which often have more skills, time and ability to support people with long-term conditions than statutory services. If this capacity is increased the better outcomes for the NHS are considerable. Patients who are most able to manage their health conditions had 38% fewer emergency admissions than the patients who were least able to do so. The Hewitt report outline ways in which ICBs can financially incentivise such work. ICBs need to take this up with pace.

Conclusion

We need to re design the NHS/ICS system to achieve much higher rates of detection and effective treatment, doubling down on a small number of things where the evidence is strong and the benefits great and to get much better at supporting people to self-manage their long-term conditions. This involves creating financial incentives for the NHS to be much better at primary and secondary prevention (*see* Appendix 10: Increase secondary prevention to develop a renewed NHS, Dr Paul Corrigan).

Local and regional leadership, and devolution

Much of health improvement must be led by local leaders who oversee the places where we live and have the political licence of their local communities to act strongly. Local government is the critical partner as it can connect at all levels from neighbourhood to region.

Local people and communities must own better health as a goal, they understand their local health challenges and are best placed to define ambitions to change them. Reducing smoking

and obesity, and ensuring children grow up healthy, must be pursued with local public involvement and local political backing. Many solutions are rooted in local circumstances and must engage the assets of communities and cohere local partners around the goals. Combined authorities also have a great leadership role to improve population health as shown by Greater Manchester and the emergent plans of the new Combined Authorities and the Marmot Cities (*see* Appendix 15: What does integrated leadership look like to drive health in a place? Laura Charlesworth and Jessica Studdert, and Appendix 16: Devolution, health and growth: North of Tyne and wider North East, Henry Kippin).

A Devolution for Health offer is essential

Re-set the central-local relationship for better health: commit to involve local authorities as key partners, affirm their role, clarify responsibility, involve them in plans.

Jointly agree five national priority goals for health improvement: with local government and the NHS. Set up bi-annual joint planning and review meetings.

Devolve more: for example, local authorities should be able to limit hot-food takeaways, to have a health goal added to local licensing powers, and it should be far easier to stop smoking in parks, beaches, and open spaces, to introduce low-emission zones, to introduce a Levy on new takeaways, and to limit advertising of harms on billboards and bus shelters.

Local funding: the very heavy cuts to local public health grants have led to damaging reductions in smoking cessation and weight-reduction services, and other services. A new government needs to pledge to at least restore the public health grant to its real value in 2015/16, to create more place-based funding agreements, based on jointly agreed outcomes and to end competitive bidding processes.

Business for health

The World Health Organisation advises that: '*public health cannot progress without action on the commercial determinants of health'*. Covid-19 made businesses aware that health risks are critical to businesses too and need to be addressed. Legal and General are sponsoring Michael Marmot's Marmot City initiative and the North of Tyne Combined Authority is working with major institutional investors on a 'health and growth' investment plan. We need strong business involvement in three priorities: workplace health, obesity, and the contributions for health from science, technology and data.

Workplace health: after Covid-19, businesses recognise that poor health damages business, growth, productivity, and labour supply. The organisation Business for Health is giving this agenda leadership, with its partners on the Business Framework for Health and there is rightly substantial government action on workplace health. The realistic priority is to help people to stay in work, not to drop out. The government should support such schemes and has tax, spending and regulatory levers to incentivise health-promoting work cultures.[xxiii]

Obesity: responsible business organisations need to promote change in the sectors that harm health. Voluntary reformulation does not work; a company alone cannot reformulate its

products and shift its marketing as it fears losing market share. Regulation will be essential to promote this shift and so keep a level playing field for competition. If this is done, involving the sector, and backed by clear sanctions, reformulation is possible in 5 years.

Business organisations should discuss with chief executives of the major supermarkets and the largest manufacturers the need to co-operate with this change and work with government on how to reduce the products, practices and additives that damage health. Financial institutions and shareholders should be included as they can influence businesses practices. The Healthy Markets Initiative is one such force for change, a global set of investors with $6.5 trillion of assets, engaging, as shareholders, with the world's largest food manufacturers to seek shifts from over-reliance on sales of less healthy products.[xxiv]

Business for Health too could promote business commitment to healthy foods, obesity management and reducing harmful additives and marketing. Other potential partners for this major shift might be Henry Dimbleby, ShareAction, major health charities and pioneering supermarkets. The risk of reputation harm or divestment may increase for firms who damage health and resist change.

Science, data and technology: preventing illness is being transformed by innovation in genomics, artificial intelligence and big data, and the ability to build applications around risk-scoring, diagnostics and vaccines. Health prevention will benefit hugely as these enable a personal approach to prevention. We should be planning today for the revolutions these innovations will deliver, particular in three applications, risk-scoring, diagnostics and vaccines.

Put together, these technologies can develop a suite of tools based on personalised solutions matched to individual risk. Designing and delivering these at scale through the NHS, across the population means that personalised prevention can contribute to population health, for everyone who needs them (*see* Appendix 17: Science, technology and data for better health, James Bethell).

Charities and foundations

The voluntary, community and social enterprise sector organisations have hugely important roles to play in improving population health, especially in localities. They are crucial providers and deliverers of critical services, co-creators of health and inclusive wellbeing in local economies, and fundamental to supporting and enabling citizens' agency and ability to be healthy. Central and local government and the NHS need to support them to do more.

At national level, charities, foundations, umbrella organisations, such as the Richmond Group and Royal Medical Colleges, play essential roles for better population health. They all want more action on population health and government needs to promote their potentially greater contributions.

Funding the change

There are costs to improve population health, but they are relatively small compared to the costs of treating illnesses, and the returns can be remarkably high. Moreover, the costs fall widely across government, business, and society. For instance:

- clean air zones and food reformulation have mostly one-off costs
- taxing the 'bads' – tobacco, sugar and alcohol – also generates substantial revenues
- the NHS itself should fund much more action on early detection and treatment
- some changes, such as active travel, have mostly capital expenditure
- people and communities must take on some of the burden of change, with the support of an active and enabling state.

A public commitment to match *increases* in healthcare spending to a proportionate increase in prevention would make sense to the public. For example, from every £1 allocated to the NHS, 10p could be designated to promote good health, tightly defined and ringfenced.

It is also important to explore new funding options too, such as social finance (*see* Appendix 18: Social Finance submission) and discussions with major foundations about how they could support more work on prevention. Three other examples may be relevant: Impact Investing Institute's aim to foster capital markets to address social and environmental challenges; the Dormant Asset Scheme's Community Wealth Funds support communities in deprived areas and Legal & General IHE Places Fund will explore how the design and construction of towns and cities can help to address health inequalities. The discipline of invest-to-save metrics may help the public sector to learn how better to deliver genuine savings.

Last, two major innovations about funding should be launched:

- *an independent review* of how HMT's attitudes, policies, taxation could better help to create healthier longer lives
- *a Commission for the Health of the Nations* - a 'Stern Report' to review:
    - the economic case for investment in population health
    - to develop a financial model to assess early-stage interventions and a price/value for additional healthy life
    - to recommend how to pay for prevention.

This, like the Committee on Climate Change, should report publicly on progress.

Conclusions and recommendations

This paper has identified a set of policies and partnerships that could significantly help many people to have improved healthy life expectancy in the next 5 to 10 years – to have healthier longer lives. As Professor Dame Theresa Marteau advised: '*It is a credible to aim to eradicate smoking in 10 years' time, to halt and reverse the upward trend in rates of obesity and narrow the gap in rates between children living in the most and least deprived places, and to reduce air pollution... The main barriers are less financial and more political."*

To achieve these goals in 5 to 10 years, any government needs to act rapidly, we suggest:

- Just Do It' - we know where to focus and what to do
- Do not delay by writing new strategies, good ones exist
- Decide before an election what you want to achieve, plan, and prepare for it
- Legislate, where needed, in the first King's Speech, make difficult changes early.

Annex: A New *Covenant for Health*

Better health can be framed as a positive offer to the public, a *new Covenant for Health*, brigading other manifesto goals under a positive health narrative.

1. The great opportunity of a healthier society
   - the Covenant, the benefits, the vision
   - a partnership between the public, localities, NHS, business, and government.
2. Healthier environments
   - cleaner air, water, rivers, and beaches
   - healthier travel, healthier housing, healthier workplaces.
3. Healthier communities
   - better health for all people, all places, support to do so.
4. Healthier children
   - our ambition and how to realise it
5. NHS for Health
   - early detection, early treatment.
6. Healthier businesses
   - healthy work, healthy workplaces
   - support the leaders, challenge the harms; polluters must pay.
7. Healthier longer lives
   - reducing our risks
   - person-centred early detection
   - make smoking history
   - protect from excess alcohol
   - re-shape our food environment.
8. A mission for government and society
   - how we can achieve this together.

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

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

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

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

Geoffrey, Lord Filkin CBE has held leadership roles in public, private and charitable sectors, as a chief executive, a government Minister, a strategy adviser and Chair. He has been an entrepreneur, founding several organisations and charities, including New Local Government Network, the Parliament Choir and the Centre for Ageing Better. He proposed and chaired the House of Lords Report, *Ready for Ageing,* and with others led and wrote the

two APPG Longevity reports: *The Health of the Nation; A Strategy for Healthier Longer Lives*, 2020 and *Levelling Up Health* 2021.

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

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

Appendices

These appendices have each been written by the organisations shown and they were offered as inputs to this project. We thank them all most warmly for their willing contributions.

The full appendices can be found **here**.

Appendix 1: Subjective wellbeing and mental and physical health, Nancy Hey, Executive Director, What Works Centre for Wellbeing

Appendix 2: Why is prevention so hard and how can you change the narrative? William Roberts, Chief Executive, RSPH

Appendix 3: Helping smokers quit: a blueprint for success, Deborah Arnott, Chief Executive, Action on Smoking & Health

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

Appendix 5: Obesity: key facts and statistics

Appendix 6: Food Foundation evidence. Isabel Hughes, The Food Foundation

Appendix 7: Why a manifesto for health must address alcohol harm, Sir Ian Gilmore and Poppy Hull, Alcohol Health Alliance

Appendix 8: Early nutrition and development, Zoe Birch

Appendix 9: Early detection and treatment of chronic disease, Veena Raleigh, The King's Fund

Appendix 10 Increase secondary prevention to develop a renewed NHS, Dr Paul Corrigan

Appendix 11: Race and health, Runnymede Trust.

Appendix 12: Concentration of risks, Senior Fellow in public health and health inequalities, The King's Fund

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

Appendix 14: The politics of population health, James Bethell

Appendix 15: What does integrated leadership look like to drive health in a place? Laura Charlesworth, Head of Health Research, New Local, and Jessica Studdert, Deputy Chief Executive, New Local

Appendix 16: Devolution, health and growth: North of Tyne and wider North East. Henry Kippin, Chief Executive, North of Tyne Combined Authority

Appendix 17: Science, technology and data for better health, James Bethell

Appendix 18: Social Finance submission

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At the start of this project, we sent out a call for evidence, insights and propositions on how to improve our population health in 5 to 10 years. We are very grateful to all the people and organisations below who contributed.

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Centre for Ageing Better

Faculty of Public Health

Faculty of Sexual and Reproductive Healthcare

Matt Fagg, NHS England

Food Foundation

Greater Manchester Combined Authority

Health Foundation

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Impact on Urban Health

Institute of Health Visiting

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MacMillan Cancer Support

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Think NPC

Tony Blair Institute

What Works Centre for Wellbeing

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Most of the evidence to support this paper will be found in the 18 appendices published in parallel with this report, so we have minimised the footnotes.

The full appendices are available **here**.

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