Institute for Public Policy Research

THE DISEASE OF DISPARITY

A BLUEPRINT TO MAKE PROGRESS ON HEALTH INEQUALITIES IN ENGLAND

Chris Thomas

October 2021

ABOUT IPPR

IPPR, the Institute for Public Policy Research, is the UK's leading progressive think tank. We are an independent charitable organisation with our main office in London. IPPR Scotland, our dedicated think tank for Scotland, is based in Edinburgh.

Our primary purpose is to conduct and promote research into, and the education of the public in, the economic, social and political sciences, science and technology, the voluntary sector and social enterprise, public services, and industry and commerce. Other purposes include to advance physical and mental health, the efficiency of public services and environmental protection or improvement; and to relieve poverty, unemployment, or those in need by reason of youth, age, ill-health, disability, financial hardship, or other disadvantage.

E: info@ippr.org
www.ippr.org
Registered charity no: 800065 (England and Wales),
SC046557 (Scotland)

This paper was first published in October 2021.

The progressive policy think tank

CONTENTS

ABOUT THE AUTHORS

Chris Thomas is a senior research fellow at IPPR.

ABOUT THE ANALYSTS

Analysis for this report was undertaken by:

Rebecca Sloan, consultant, LCP
Linxuan Zhang, analyst, LCP
Rosie Polya, Associate consultant LCP
Mei Chan, consultant, LCP
Jonathan Pearson-Stuttard, partner, LCP

ABOUT THIS REPORT

This report advances IPPR's charitable purpose of educating the public and preventing disadvantage because of illness or disability.

ACKNOWLEDGEMENTS

This paper forms part of IPPR's Better Health and Care Programme. The authors would like to thank the founding sponsors of the programme: Gilead, AbbVie, GSK, AstraZeneca, CF, and Siemens Healthineers.

The author would like to thank Robin Harvey, David Wastell, Abi Hynes, Harry Quilter-Pinner, Clare McNeil, and Richard Maclean at IPPR for their support, feedback and work on this report.

Download
This document is available to download as a free PDF and in other formats at:
https://www.ippr.org/research/publications/disease-of-disparity

Citation
If you are using this document in your own writing, our preferred citation is:
Thomas C (2021) *The disease of disparity: A blueprint to make progress on health inequalities in England*, IPPR. https://www.ippr.org/research/publications/disease-of-disparity

SUMMARY

Health inequalities are wide and widening in England. Today, a child born in the most deprived part of the country can expect to die 10 years before a child born in the least deprived part of the country (ONS 2020a). They can expect to fall into poor health 20 years sooner – in just their mid-50s – and to live a far greater proportion of their life in poor health (ibid). This is unfair and unsustainable – and the scale of health inequality in this country is a key reason it lacked resilience when Covid-19 struck.

Tackling health inequality could be a keystone in delivering the government's stated vision for the country. It could help deliver step-change improvements in population health outcomes; free up money in the NHS; boost economic opportunity; and provide substance to the 'levelling-up' agenda. The secretary of state for health and social care has identified the opportunity, with his first major speech focussing on what he called the 'disease of disparity' (Javid 2021).

The prospective health gains are huge. We estimate that if health outcomes in the country improved to match the levels in the types of places where health outcomes are the best, we would see:

- an increase in England's life expectancy of two years
- an increase in average healthy life expectancy of 3.3 years
- a decrease in depression prevalence from around 11 per cent to around 8 per cent
- a decrease in childhood obesity and overweight prevalence from 35 per cent to 32 per cent.

This would help meet Conservative manifesto ambitions to spread opportunity across the country, and to increase healthy life expectancy in England by five years by 2035.

Additionally, there is a big economic opportunity, too. Covid-19 has proven that good health is about social justice and a strong economy. Health is not a black hole where funding disappears, or a cost to be contained – it is an asset to be unleashed. Indicatively, we estimate that closing the inequality in health between the north of England and the rest of England would generate over £20 billion per year, through increased productivity.

To realise these gains, we must address historic barriers to progress. We have decades of evidence demonstrating and defining the problem of health inequality. The real challenge is translating that excellent evidence into measurable progress. This report identifies six areas where policy incentives are misaligned with an ambition to tackle health inequality:

- the narrow focus on limited output-measures, such as GDP
- chronic short-termism in policymaking
- a lack of effective cross-government working on health
- the NHS' structure
- priorities and definitions of success in the NHS
- the NHS' centralised approach to health policy.

RECOMMENDATIONS

This report makes recommendations across the NHS and the socioeconomic drivers of poor health. Combined, these provide a constructive plan to tackle the 'disease of disparity' in England – and to achieve the health, social and economic gains possible from addressing health inequality.

Optimising the NHS around equality

Recommendation 1: Ministers should increase the amount of funding allocated to the NHS in the most deprived parts of the country. In the first instance, this should mean restoring the amount of funding allocated on the basis of deprivation to 15 per cent (as was the case between the 1990s and 2013). We recommend this comes alongside a specific, achievable and measurable target on inequality for every clinical priority in the NHS Long Term Plan.

Recommendation 2: The government should pilot the countrywide scale-up of community/neighbourhood hub models of care delivery. These hubs would create a 'one-stop shop' for health, social, financial, emotional and spiritual need – with NHS, local authority, religious, charity and social prescribing services co-located within an accessible community setting. This model should include an increase in the number of link workers and care navigators, given their importance in the Improving the Cancer Journey programme in Glasgow.

Recommendation 3: The integrated care white paper should include a fund to develop community health assets, supporting the development of flourishing 'health economies' across the country. This should be allocated transparently, based on publicly published metrics – including deprivation or the NHS' integrated care index – to target areas that need the money most (rather than the current bidding process). We also recommend Integrated Care Systems use their procurement budgets to support public health locally.

Incentivising cross-government action on health inequality

Recommendation 4: As part of a move to a wider dashboard of measures of prosperity, supplementing measures like GDP, we recommend that the government use the ONS' new Health Index as a measure of prosperity. This should see the Health Index reported on at budgets, spending reviews and fiscal statements.

Recommendation 5: The government should introduce health impact assessments across national and local government. This should explore the impact of cross-government policies on population health. Impact assessments should be published, preferably ahead of enactment, for all new policies and for all spending decisions above a set threshold.

Recommendation 6: The UK government should introduce a public health budget in England, modelled on the New Zealand Wellbeing Budget and tied to the Health Index. This would ensure funding and opportunity for long-term focussed policy and investment decisions, based on improving health. This could be put in motion at the comprehensive spending review and delivered in line with the 2022 spring budget. As in New Zealand, and in the first instance, we recommend that the 'public health budget' is used to allocate 5 per cent of total managed expenditure (with flexibility to increase this amount over time). This would make it worth approximately £35 billion per year, if enacted today.

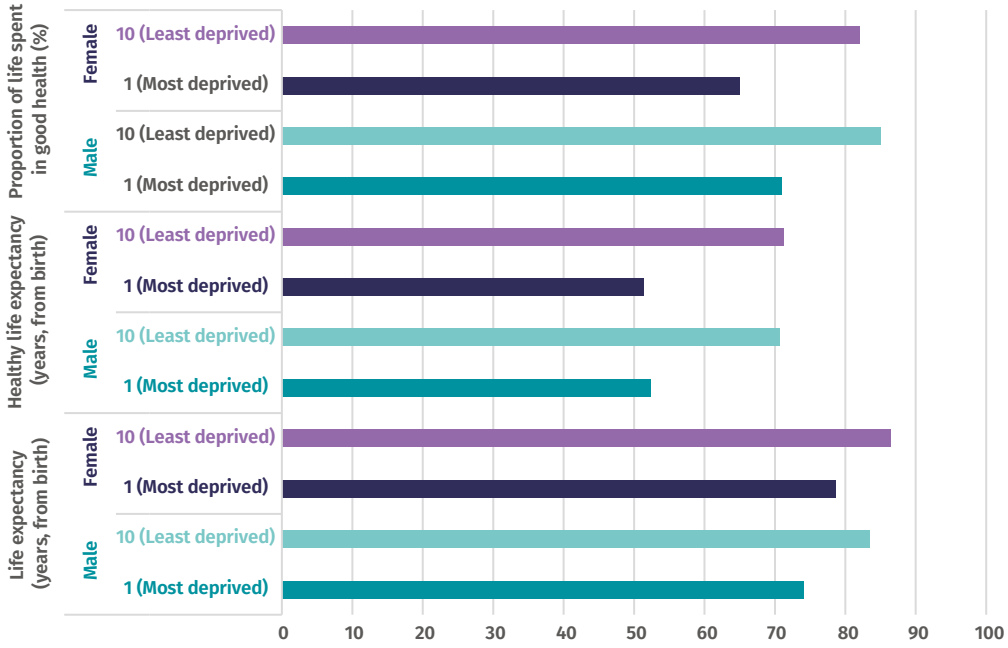
PART 1
DEFINING THE PROBLEM

1.
THE STATE OF HEALTH INEQUALITY IN ENGLAND

Health inequalities are a long-standing reality in England. People born in the most deprived parts of the country can expect to live a decade less overall, and two decades less in 'reasonable' health, compared to people born in the least deprived parts of the country.

FIGURE 1.1: HEALTH VARIES SIGNIFICANTLY ACCORDING TO LEVELS OF DEPRIVATION IN THE PLACES PEOPLE LIVE

Life expectancy at birth (years), healthy life expectancy (years) and proportion of life spent in good health (%) by socioeconomic status, 2017–19



Source: Office for National Statistics, 'Health state life expectancies, UK: 2017–2019' (ONS 2021a)
Note: 1 = Most deprived, 10 = Least deprived

These socioeconomic disparities have a strong geographic component. There is a significant inequality in premature mortality in the north of England, compared to the rest of the country. In table 1.1, each shaded box represents a premature mortality rate higher than the England average. If each counted as one point, the north and the Midlands would score 28 out of a possible 30, while the south and London would score just 1 point from a possible 24. IPPR analysis has also shown this clustering of health need exists at the local authority level, too (Thomas et al 2020).

TABLE 1.1: PREMATURE MORTALITY IS SIGNIFICANTLY HIGHER IN THE NORTH AND MIDLANDS

Under-75 mortality rate per 100,000 population, England, regional analysis

	All causes	CVD	Cancer	Respiratory disease	Stroke	Liver disease
North East	394.74	82.80	152.60	44.20	16.31	25.5
North West	388.39	86.60	145.60	46.30	15.20	25.7
Yorkshire and the Humber	363.18	82.00	141.20	41.20	14.29	19
East Midlands	334.42	73.50	133.40	34.90	12.62	17.5
West Midlands	354.41	78.40	138.30	36.30	13.28	21.3
East	302.12	63.40	126.00	29.80	11.56	15
London	303.32	70.50	120.10	30.30	13.13	16
South East	292.31	59.00	123.60	28.70	10.72	15.7
South West	301.46	61.90	125.60	28.10	11.19	15.9

Source: Author's analysis of Thomas et al 2020 and UKHSA 2020

Beyond place and deprivation, health inequalities can be observed across any number of demographic groups. To give one example, substantial levels of racial health inequality in England were exposed by Covid-19. IPPR analysis shows that, had white people faced the same risk from the pandemic as black people, there would have been 58,000 additional deaths in just the first wave of the pandemic (Patel et al 2020).

INTERSECTIONALITY AND HEALTH INEQUALITY

The new quantitative analysis in this report focuses on inequalities between places. While there is often a correlation to socioeconomic status and multiple deprivation, this is not the only driver of health inequality. Health outcomes are worse for those with protected characteristics, too. Moreover, it is impossible to separate material conditions, identity, geography and socioeconomic status when thinking about health inequalities: they are interconnected, in overlapping and interdependent systems of health discrimination and disadvantage.

ETHNICITY AND HEALTH INEQUALITY

Health inequalities between different ethnic groups are complicated, and efforts to establish them are often undermined by poor data. Nonetheless, data shows that people from Gypsy or Irish Traveller, Bangladeshi or Pakistani communities have far poorer health outcomes. Rates of infant and maternal mortality are higher among black and South Asian groups, while mortality from cancer and dementia/Alzheimer's is higher among white people (Raleigh and Holmes, 2021). Covid-19 has disproportionately impacted people from ethnic minority communities – a strong indication that these groups experience the greatest levels of health vulnerability.

DISABILITY AND HEALTH INEQUALITY

People with a learning disability have worse physical and mental health than people without a learning disability – including a shorter

life expectancy than the general population (14 years for men, 18 years for women) (Mencap 2020). Other research has shown people with learning disabilities are more likely to be admitted to hospital with preventable conditions (NIHR 2020). At worst, there is continuing evidence of seclusion, physical restraint and segregation in health and care settings – for people with a learning disability or a mental health condition, or autistic people (CQC 2020).

SEXUAL ORIENTATION, GENDER IDENTITY AND HEALTH INEQUALITY

The NHS in England recognises that sexual orientation or gender identity can have a significant impact on physical, mental and sexual health. The evidence suggests that health outcomes tend to be worse for LGBTQ+ people (NHS England, n.d.). A review by the AHSN Network and the LGBT Foundation highlighted worse mental health outcomes, worse access to healthcare services, poorer outcomes on the social determinants, and worse experience within the NHS as key dynamics of this inequality (AHSN and LGBT Foundation 2021)

HOMELESSNESS AND HEALTH INEQUALITY

Homeless children and adults have worse health outcomes. The average age of death for a homeless man is 47, and for a homeless woman 43 (Homeless Link 2018). As many as 41 per cent of people classified as 'rough sleepers' have long-term health conditions (UKHSA 2018). And being homeless leaves people at significant risk of physical and sexual violence.

While our analysis looks at place, the conclusions are not limited to socioeconomic status. The ultimate ambition of this report, and its recommendations, is to achieve homogeneity in health outcomes between people – regardless of who they are, where they come from, what job they do, or where they live.

1.1 HEALTH INEQUALITY MATTERS

The extent and impact of health inequality make it one of the key frontiers in social policy today. There are four reasons that the whole policy community should care about health inequality.

1. **Social justice:** Health inequality is a key barrier to achieving social justice. Behind technical-sounding indicator names, health inequality is about lives lost avoidably. The Office for National Statistics' Slope Index of Inequality indicated 380.7 more deaths per 100,000 men and 235.1 more deaths per 100,000 women living in the most deprived areas, compared with the least, in 2019 (ONS 2021c).
2. **Sustainability and resilience to uncertain times:** The next 10 to 20 years will be uncertain, from a health perspective. Pandemic risk is rising; the population is ageing; anti-microbial resistance continues to advance, and climate emergency is advancing. In each case, health inequality will make some people, communities and places unnecessarily vulnerable to shock – as Covid-19 has demonstrated. Tackling inequality is one of the best things we can do to strengthen UK resilience going forward.
3. **NHS capacity and sustainability:** Action on inequalities are also an excellent way to ensure the NHS has the money and the capacity it needs to deliver world-class services. For instance, research shows that almost one-fifth of the total hospital budget is spent on the consequences of socioeconomic inequalities (Asaria et al 2016).

4. **Economic prosperity and opportunity:** There is a clear economic cost to health inequalities. In 2018, the Northern Health and Science Alliance (NHSA) found that £1 in every £3 difference in GVA/head between the north and the rest of England could be explained by health inequalities. At the time of their analysis, this meant that closing health inequalities would be worth £13 billion for the UK economy (NHSA 2018). If this holds true today, the figure would have risen to £20.2 billion per annum (see table 1.2). As such, health inequality is both a key variable in the health of our economy at a national level, and a key determinant in the government's levelling-up agenda.

TABLE 1.2: GVA ACHIEVABLE FROM ALIGNING HEALTH OUTCOMES IN THE NORTH OF ENGLAND WITH HEALTH OUTCOMES IN THE REST OF ENGLAND

Region	GVA/head/ hour	Employed population	Hours worked (paid/week)	GVA gain (£ billions)
North East	30.59	1.2 million	33.0	3.6
North West	32.23	3.4 million	33.2	7.6
Yorkshire and the Humber	29.68	2.5 million	33.1	9.0
Total	20.2 billion			

Source: Thomas et al 2020

1.2 A UNIQUE OPPORTUNITY

As much as health inequalities represent a challenge for the government, it can also be considered an opportunity. Moving the dial on health inequality would ensure significant progress on a range of the government's headline health and economic commitments (table 1.3). It would also constitute a success that has eluded successive prime ministers from across both major UK parties.

TABLE 1.3: HOW TACKLING HEALTH INEQUALITIES IS KEY TO DELIVERING ON THE GOVERNMENT'S STATED AGENDA

Government commitment	Health relevance
Levelling-up the country	Clustering of poor health supresses productivity outside London and the South East. Sir Michael Marmot's 2020 review found that place mattered greatly when it comes to health – to such an extent that life expectancy was five years lower in the most deprived parts of the North East, compared to the most deprived parts of London (Marmot 2020). This contextualises the kind of economic gains possible from reducing health disparities – including the £20.2 billion already outlined in this paper.
Build Back Better	Build Back Better is central to the government's plans to recover from Covid-19, including in health and care. It is hard to see any route forward to globally leading health outcomes – or delivery of the long-term plan's ambitions – without focussing on raising the health of those in the poorest parts of the country, or those groups otherwise excluded from good health.
Increase healthy life expectancy by five years by 2035	Increasing healthy life expectancy by five years is one of the Conservative party manifesto's boldest aspirations – and one in need of a credible plan. Making progress on the substantial gap between the richest and poorest areas is the clearest opportunity to reach this goal.

Deliver the NHS Long Term Plan	The impact of the pandemic has made the NHS' finances much more uncertain. While funding provided through the new health and care levy is helpful, it is likely to remain insufficient in light of the challenges the NHS faces (NHS Providers and NHS Confederation 2021). That will necessitate more inventive ways to meet the NHS Long Term Plan's aspirations – including greater public health interventions, more innovation at scale and focussed progress on health inequalities.

Source: Author's analysis

Notably, none of these aspirations will be achieved, alone, through the money allocated through the new health and social care levy. Beyond scepticism in the sector that the levy provides enough funding to deliver genuine improvements in health outcomes, this report also posits that cross-government action across policy agendas is vital to deliver more equal health. The secretary of state for health and social care recognised this in a recent speech:

> ***"Passing the peak of the pandemic has been like a receding tide, revealing the underlying health of our nation. It's revealed some fractures within. And in many cases, the pandemic has deepened those factures ... these are the symptoms of a different disease: the disease of disparity."***
>
> **Sajid Javid speech at the Grange Community Centre in Blackpool, 16 September 2021 (Javid 2021)**

This report provides a blueprint to, finally, make progress on the 'disease of disparity'. We contribute to the debate in two ways. First, rather than simply restate the evidence, we look at how England's policy environment – what types of ideas are encouraged, incentivised, measured and funded – limit progress on health inequalities. Second, we provide a practical exploration of where the government can achieve the biggest marginal gains. The quantitative analysis presented in this paper constitutes a health-benefit model, based on the ONS Health Index, to provide the kind of evidence most helpful in informing fiscal events and spending decisions – with uses for both the spending review and the 2022 spring budget.

There will be no better time for bold action on health inequality. Covid-19 has increased the political salience of health policy; demonstrated the economic costs of poor health; and driven a greater public understanding around what drives and sustains poor health. Where it has eluded previous regimes, this government must take this unique opportunity to create the right policy environment for sustained and bold action.

2. UNDERSTANDING ENGLAND'S HEALTH INEQUALITIES

To better understand health inequality in England, IPPR partnered with Lane Clark & Peacock LLP (LCP) – the country's leading pension consultancy, analytics and actuarial firm – to understand the key correlates to health inequality between places. This analysis had three objectives:

- to better understand the correlates of health inequalities, building on and updating the wider body of evidence (see for example Marmot et al 2010)
- to provide a practical policy exercise ahead of the 2021 spending review and 2022 spring budget on where health benefits can best be achieved, helping to inform more immediate government investment and prioritisation
- to inform constructive policy recommendations to take forward, which could provide major gains against the new ONS Health Index measure for England.

Analysts took health, education, employment and economic data for England, from between 2015 and 2020. Wherever possible, the raw data and methodology was consistent with the ONS Health Index. Variables not in the index were sourced from the Annual Population Survey and accessed through NOMIS. Data was analysed at an upper tier local authority (UTLA) and change over time analysis was carried out for all years available. Given the implicit limitations of ecological and correlation research methods, our findings were then compared against a literature review and findings from qualitative expert interviews, to inform interpretation. More information on the variables, methodology, correlation analysis and data can be found in the separate technical briefing.[1]

2.1 AN ANALYSIS OF ENGLAND'S HEALTH INEQUALITY

Our analysis showed a range of key drivers of inequality in health between places in England (figure 2.1).

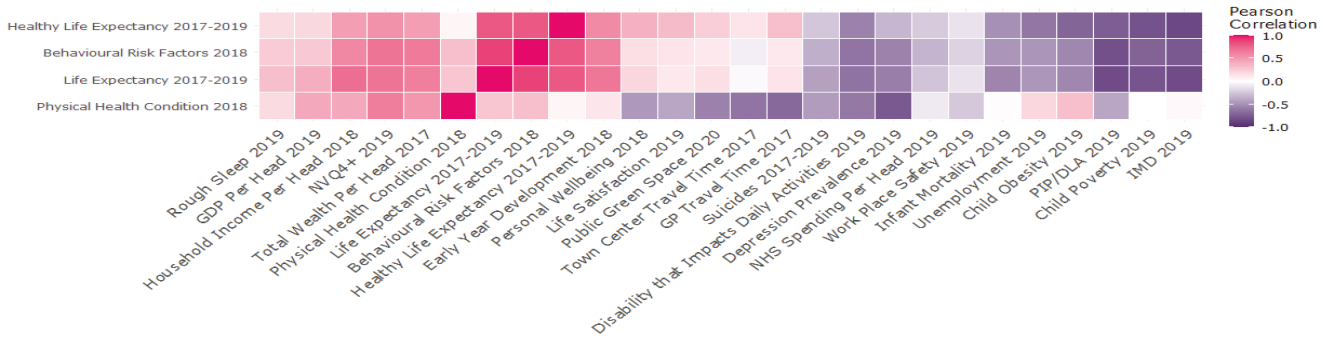
Income and wealth inequalities were correlated most strongly with health inequalities. This is in line with wider evidence on health inequalities, and more recent explanations for stalling life expectancy in countries such as the United States (Case and Deaton 2020). Early years, childhood and educational outcomes were also correlated to a full range of health outcomes. High levels of child poverty were inversely related to good health outcomes, with early years development and level of qualification all predictive of good health in places.

Behavioural risk factors such as smoking, tobacco use, obesity and alcohol consumption were – as would be expected – negatively correlated with life and healthy life expectancy. They were also correlated to socioeconomic variables, suggesting that these variables are less about personal responsibility and more about wider, structural inequality (see for example Hochlaf et al 2019).

1 Available at: https://www.ippr.org/research/publications/disease-of-disparity

FIGURE 2.1: THE CORRELATES OF HEALTH INEQUALITIES BETWEEN PLACES

Correlates of health inequalities between places in England, based on economic, social, welfare and healthcare metrics



Source: LCP analysis

A notable conclusion from the heatmap is that many areas vital to solving health inequalities have experienced significant departmental cuts in the last 10 years (except for the Department of Health and Social Care).

There was only a very weak correlation between NHS spending per head and inequalities in health between places. This suggests that more needs to be done to optimise the health service's role in tackling inequality. In the context of the reduced weighting of deprivation in the NHS' funding formulas – enacted by the Coalition government – this also suggests improvements can be made to the NHS' approach to resource allocation.

2.2 AN ANALYSIS OF HEALTH INEQUALITIES WITHIN ENGLAND

To better understand the geographical patterning of the disparities within England, we also undertook cluster analysis of different parts of the country – using four place-based clusters. More detail on the clustering method is available in our technical briefing.

- Cluster 1: Northern cities and surrounding areas; Midlands cities; coastal cities
- Cluster 2: Rural and coastal rural places
- Cluster 3: Inner-city London boroughs, Bristol, Brighton
- Cluster 4: The home counties and wealthier London boroughs.[2]

This analysis identified several key trends. First, cluster 1 and cluster 2 had significantly worse levels of health than the other clusters. Cluster 1 had the lowest levels of life expectancy, healthy life expectancy, and the highest levels of disability that impacts daily activities. Cluster 2 had the highest incidence of physical health conditions, and both clusters had high levels of depression.

This aligned with lower scores on the variables most strongly correlated with health in the national analysis. Cluster 1 and 2 also had higher numbers of people in receipt of personal independence payment/disability living allowance; lower wealth and household income per head; lower early years development scores; and lower rates of NVQ4+ qualifications. This was compounded in cluster 1 by higher rates of unemployment, child poverty and behavioural risk factors.

2 Westminster was considered an outlier and excluded from analysis.

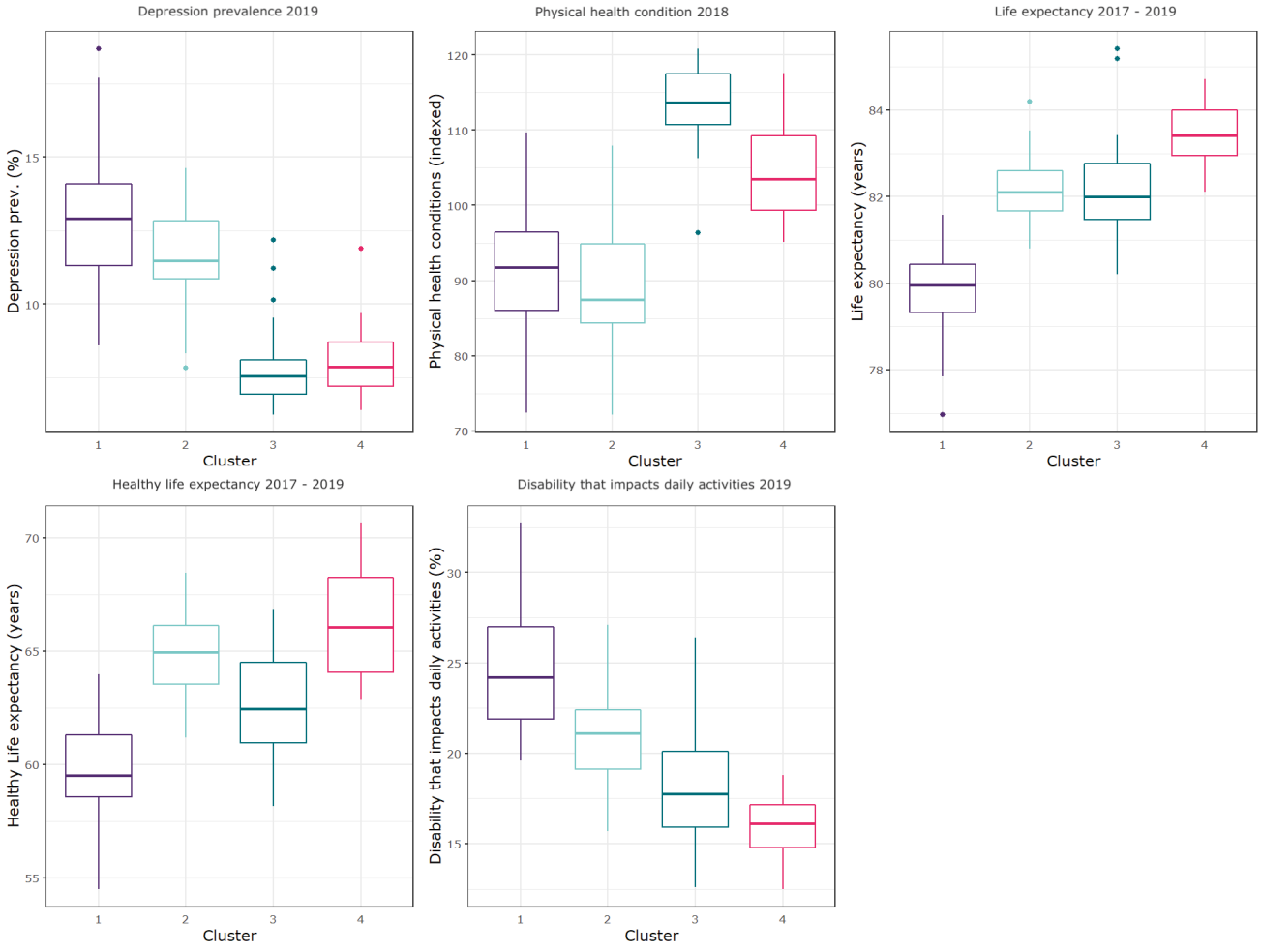
Tackling even these very broad disparities would significantly improve the country's overall health, including on agendas where the Conservative government have made bold commitments. For example, our analysis shows that if health outcomes in the country improved to match the levels in the types of places where health outcomes are the best, we would see:

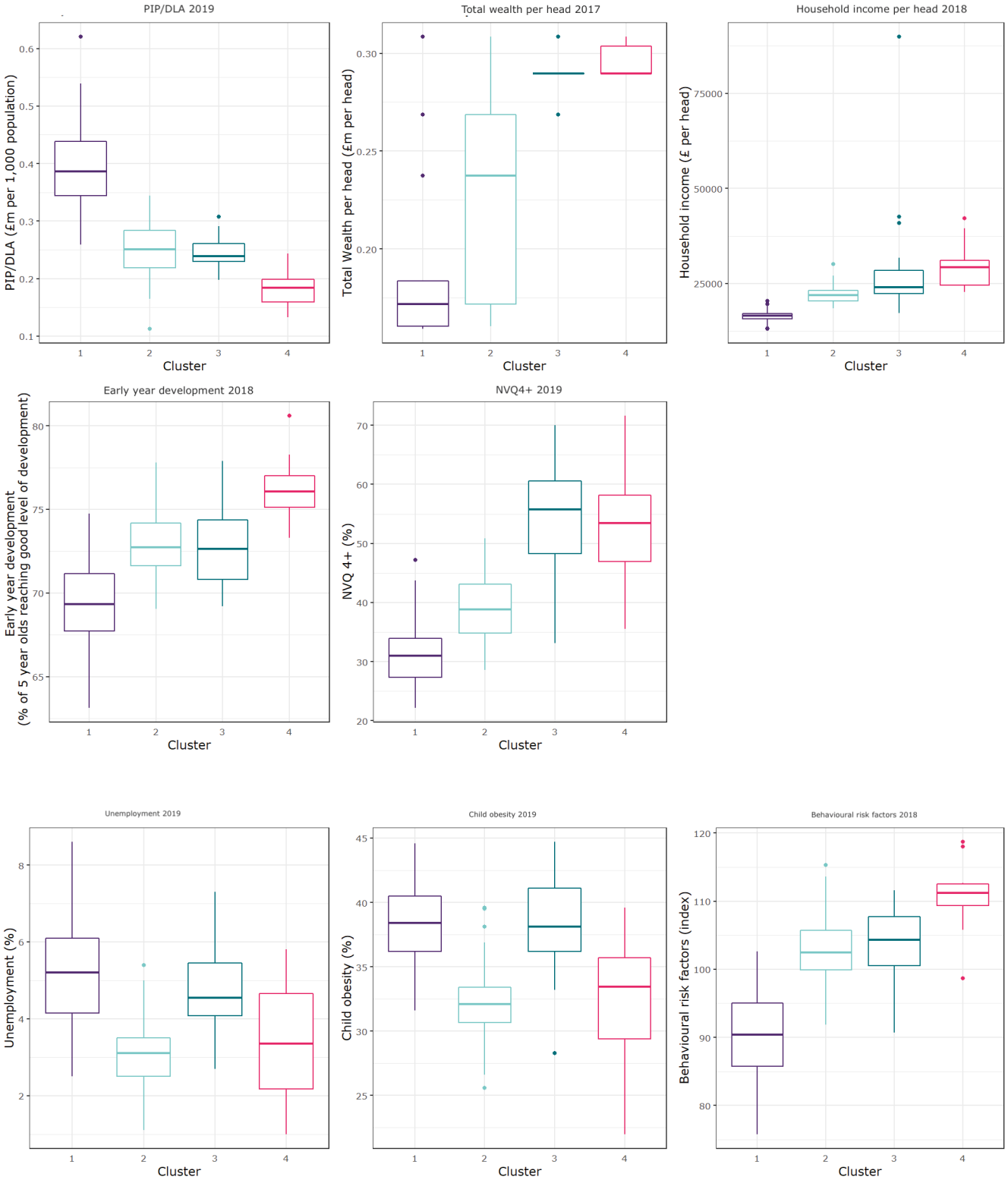
- an increase in England's life expectancy of two years
- an increase in average healthy life expectancy of 3.3 years
- a decrease in depression prevalence from around 11 per cent to around 8 per cent
- a decrease in childhood obesity and overweight prevalence from 35 per cent to 32 per cent.

Combined with the economic benefits calculated in chapter 1, this supports the case for a substantial increase in policy ambition on this agenda – and for that policy to cover public health and healthcare interventions.

FIGURE 2.2: THERE ARE GEOGRAPHIC CLUSTERS OF POOR HEALTH AND SOCIOECONOMIC INEQUALITY WITHIN ENGLAND

Cluster analysis of selected economic, social and health variables (2019 data)





Source: LCP analysis

These clusters add to the existing literature by demonstrating where places are bound by their common experience of material disadvantage, and that this clustering is undermining health (and, by implication, wealth). More plainly, the clustering shows that:

- Life expectancy in Blackpool is nine years lower than in Westminster. And compared to the best performing local authority in England, people in Blackpool also have around one-third of the NVQ4+ qualification attainment levels; have three times the prevalence of depression compared to Hounslow; and have one-third lower levels of children achieving a 'good' standard of development by age five.
- Healthy life expectancy in Nottingham is 14.6 years lower than in Wokingham. At the same time, compared to the best performing local authority (Richmond), on average people in Nottingham are eight times more likely to be unemployed and have one-seventh of the household income per household as those in Kensington and Chelsea.
- So-called 'behavioural' health risk factors – like smoking, obesity and alcohol consumption – were highest in Kingston upon Hull. On average, compared to people in the best performing local authority, people in Kingston upon Hull have just over half the total wealth per person, and child poverty rate is five times higher than in Richmond upon Thames.

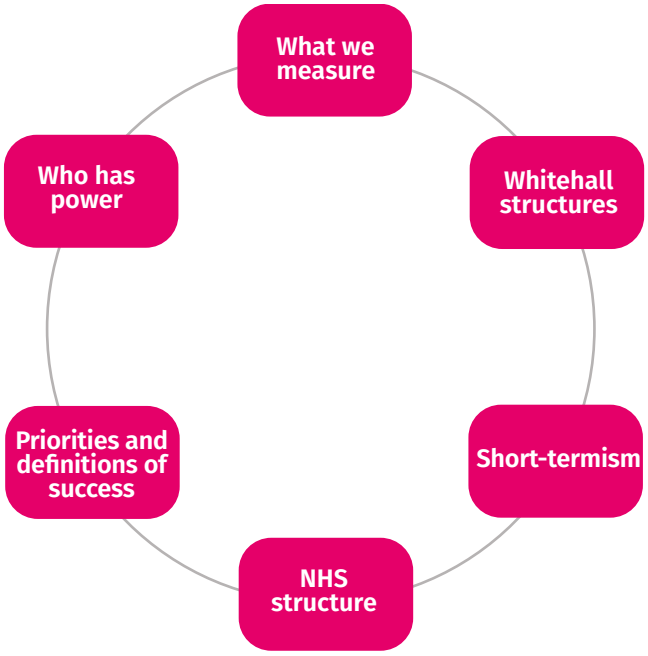
This is what defines the 'disease of disparity' - and might be compared to the 'deaths of despair' trend identified by Anne Case and Angus Deaton in the US.

3.
WHY IS PROGRESS ELUSIVE?

Our analysis reaffirms conclusions reached in wider research, including landmark reviews like the Black report (1980) and Marmot review (2010). This suggests the barrier to change is less a lack of evidence – but rather an inability to put that evidence into practice.

As such, the qualitative component of this research explores how the structure of government and the wider public policy environment impede action on health inequality. Our conclusion is that England's policy environment is inhspoitable the policies best suited to tackling health inequalities. Our interviews identified six key barriers to progress (figure 3.1).

FIGURE 3.1: UNDERSTANDING THE BARRIERS TO ACTION ON HEALTH INEQUALITIES



Source: Author's analysis

3.1 MISALIGNED INCENTIVES WITHIN THE HEALTH SECTOR

Barrier 1: The structure of the NHS

The NHS was created to provide acute care to people with acute illnesses. This reflected the different health needs of the mid-20th century. Cancer diagnosis came with an average life expectancy of one year, compared to six today (Macmillan Cancer Support, n.d.). Tuberculosis and diphtheria remained major killers, as did Polio. In 1961, there were 166,000 deaths from coronary heart disease in Great Britain – compared to 80,000 in 2009, despite significant population growth in that period (BHF 2011).

Today, the NHS faces different health challenges – including chronic and multiple chronic conditions. Estimates suggest that both the incidence of chronic conditions and multiple conditions will rise between now and 2035 – with the proportion of people with 4+ diseases doubling (Kingston et al 2018). This is driven by sharp rises in chronic diagnoses such as mental ill health, diabetes and arthritis. But it is also supported by a change in characteristics of conditions previously considered acute – many types of cancer now present as chronic conditions, and the life expectancy from diagnosis has risen from one year to six years since the advent of the NHS.

While there are cases of NHS evolution, there are also many ways it is still behind the curve in adapting to this big societal change. Most notably, we do not have a health system that has fully wrestled with the reality of preventable illness. Nor do we have a health system that is organised around helping people manage chronic illness, rather than just treating it. This is a clear driver of inequality, with avoidable illness, avoidable mortality and the total burden of preventable illness all highest among people in the most deprived parts of the country.[3]

Barrier 2: How we define success

The definitions of success in the NHS are not conducive to action on inequality. Our qualitative work identified a few, consistent metrics that 'very senior managers' in the NHS consistently feel (personally) accountable to:

- A&E waiting times
- cancer waiting times
- workforce shortages and rotas
- annual financial deficits
- CQC ratings.

While many leaders clearly care personally about whether their services address inequality, and provide inclusive healthcare, it rarely featured at this top table of considerations.

It is notable that the list above strongly overlaps with areas that trusts have defined targets, where there is regular reporting, and where there is significant public, media, or sector scrutiny. By contrast, health inequality targets are usually poorly defined, and subordinate to other, larger goals. A common framing is 'diagnose 3 in 4 cancers at an early stage by 2028 and do something on inequalities' – an approach that isn't sufficiently ambitious to drive progress.

Barrier 3: Who has power

Though there has been progress since its formation, the NHS remains a centralised system. This is unsurprising given its original design: Nye Bevan famously declared that the sound of a dropped bedpan in Tredegar should reverberate around Whitehall.

Centralisation was intended to avoid inequality, by standardising the service. However, it is likely that the NHS' centralisation of power is stalling progress today. As the quantitative analysis in this report has shown, different parts of the country experience different levels of health need – which, in turn, is underpinned by factors unique to that locality. A centralised system tends to a one-size-fits-all approach, where these highly localised drivers of inequality are harder to act on.

3 The same is often true of people from marginalised communities and backgrounds.

Prioritising health inequalities is likely to mean prioritising more and more meaningful devolution within the health system. Local leaders are best placed to identify and act on the needs of their population. It is also likely to rely on the ability to build thriving and effective health economies within places – so that local leaders have the tools and relationships they need to make a difference.

3.2 MISALIGNED INCENTIVES ON THE SOCIAL DETERMINANTS

Barrier 4: What we measure

Recently, there has been increasing concern around whether a small number of output indicators – most notably, Gross Domestic Product (GDP) – incentivise the best policies. These indicators are currently the dominant determinant in policy and investment decision-making, but there is a concern they do not adequately capture all the things that make a country prosperous (sustainability, wellbeing, health, and so on). As such, they can lead to important policies being overlooked or undervalued.

The challenge posed by overreliance on GDP has been, perhaps, best articulated by the climate sector. For example, Kate Raworth has demonstrated how a focus on GDP pushes decision-makers to shun sustainability and to avoid the actions necessary to avert long-term climate disaster (Raworth 2017). The same critique can be applied to health – GDP does not prescribe good health a value.[4] This is likely to disincentivise policies to support good health as a primary aim.

More challengingly, while GDP doesn't value health, it does value illness. It does this in two ways (arguably, double counting ill health).

1. In the first instance, GDP values many of the activities that make us sick: such as the production and consumption of alcohol, tobacco and low-nutrition foods and drinks.
2. GDP then also counts public sector acute sector activity that swings into effect when we become sick, namely in the NHS.

That is, both the outputs that cause – and that treat – our illness are double counted – further incentivising policymakers away from investment in up-stream and preventative interventions.

Barrier 5: Chronic short-termism

To some extent, short-termism is a reality in our economic model. Governments are elected on (maximum) five-year terms, leading them to prioritise policies that have an impact within that period. In other ways, this short-sightedness is compounded by the power of the Treasury. HM Treasury has highly competent staff, huge decision-making power over policy, and two powerful cabinet ministers – giving it unusual political power (Wilkes and Westlake 2014). However, the Treasury is also the department where incentives towards short-termism are strongest. It is often held to account on its ability to limit spending, or at least to deliver results for the money it is spending. Moreover, the rhythm of the department – defined by regular annual fiscal statements, annual budgets and the three-yearly spending review – all support short-term thinking.

However, it takes time to narrow inequalities. This was a harsh reality for those involved in the England Health Inequalities Strategy (1997–2010). At the time of the 2010 general election, there had been at best marginal impact. Due to the lag effect of many of the initiatives, it took time for the benefits of the strategy

4 Indeed, the drivers of climate emergency are almost identical to the factors which are increasing our global vulnerability to major infectious disease outbreaks (see Thomas and Nanda 2020)

and investment to be established in the evidence – by which point, it was far too late (Barr 2017).

Moreover, reducing health inequality often relies on investment in preventing need – whether avoiding illnesses altogether, diagnosing them as early as possible, or ensuring they do not get worse. Short-sightedness within policymaking does not lend itself to this kind of investment. Indicatively, the Office for National Statistics attributes only 5 per cent of total UK government expenditure on healthcare to prevention – traditionally, covering the public health grant, screening services and Public Health England[5] budgets (ONS 2020b).

Barrier 6: Whitehall's structure

Much of what determines health inequality is defined by departments outside of the Department for Health and Social Care or NHS England. Some of this is intuitive: for instance, much medical research is coordinated by the Office for Life Sciences and much of the life science sector's infrastructure is overseen by the Department for Business, Energy and Industrial Strategy (BEIS). Elsewhere, it is notable that all the key correlates of health inequalities in this report's analysis sit outside health, in other government departments.

This creates a challenge. For example, if the Ministry of Housing, Communities and Local Government (MHCLG) eradicates homelessness, overcrowded housing or category 1 hazards within homes, then there will be huge health benefits – felt by millions. But the cost of the policy will fall on MHCLG, while the savings from the policy will fall on the NHS. This does not encourage action – particularly during periods where financial envelopes are tight.

Moreover, there is little to encourage officials and ministers – outside the Department of Health and Social Care – to consider the health impact of their decisions. Unlike the chancellor or the prime minister, the health secretary has few levers to make health a key consideration for their colleagues (beyond their personal influence). Moreover, the criteria on which officials make decisions – and particularly spending decisions – have little reference to health. Attempts to change this, notably the Social Value Act (2012), have not come alongside enforcement mechanisms and have had little impact on decision-making.

5 Now the Office for Health Improvement and Disparities, launched 1 October 2021.

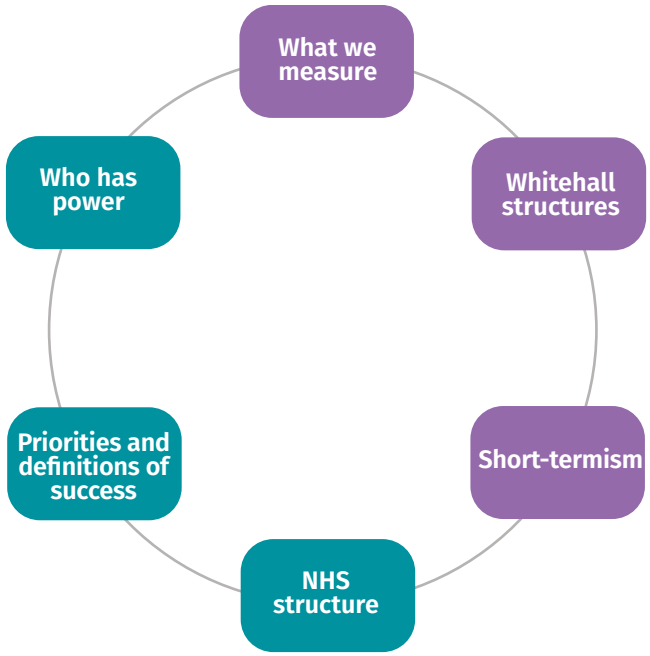
PART 2
OPTIMISING THE POLICY ENVIRONMENT

4. DESIGNING HEALTHCARE AROUND EQUALITY

Healthcare is the largest single item of day-to-day government expenditure, rising from from 27 per cent in the 1990s to 42 per cent in 2019/20 (Stoye and Zaranko 2019). From a budget of around £400 million on formation in 1948, it now operates a budget of £150 billion.[6] Given that level of investment, there should be an onus on the NHS to make a far greater contribution to tackling health inequality.

Where it can do that within its current system, it should. However, where the modern reality of health inequality requires a fundamental rethink in how the NHS is structured, that should be in scope, too. This chapter explores the changes the NHS should make to provide a better foundation for sustained progress.

FIGURE 4.1: BARRIERS TO PROGRESS EXPLORED IN THIS CHAPTER (GREEN)



Source: Author's analysis

6 Since 1951, NHS spending has doubled as a percentage of GDP.

4.1 PRIORITIES AND DEFINITIONS OF SUCCESS

Money should follow inequality – and the NHS should have bold, specific, and measurable targets on healthcare inequalities

Our analysis showed only a very weak correlation between NHS spend per head and health disparities.[7] This aligns with other studies and conclusions accepted in the health policy community. As former chief executive of the NHS in England, Lord Simon Stevens, has put it:

> ***"The layers of the onion ... stretch out to things that are obviously beyond a healthcare system's direct control, including the obesogenic food environment that children and poorer communities are exposed to ... Countries where more than half the population are overweight have had 10 times more Covid deaths."***
>
> **Source: Neville (2021)**

While this report implicitly accepts some truth in this idea – the next chapter focuses on the layers of the onion that do stretch beyond the healthcare system – we believe that any sense of fatalism around what the health service can achieve on inequality is misplaced. The NHS should not leave inequalities to other departments. Rather, it should make health equality its overarching mission.

Specifically, it should look to ensure variables like NHS spend per head have a stronger bearing on closing the health inequalities between places.

Attempts to alleviate inequality by including deprivation – not just age – in NHS funding formulas has taken places since the 1990s. However, in 2013, the Coalition government made a little-noticed change to the weighting of deprivation within the formula – essentially, reducing it from 15 per cent to 10 per cent. This meant less money for poorer parts of the country, and more money for more affluent areas (where the average age was higher).

The Advisory Committee on Resource Allocation (ACRA) – the body responsible for the formula – has stated that it believes there is little objective basis behind the weighting given to deprivation in the formula. ACRA suggests that it is a political decision for ministers – based on the extent to which health inequality feature as one of their priorities. Given that health inequalities are widening in England, there is a clear case for the formula to be restored to its 15 per cent level. Naturally, this should come alongside a proper funding settlement for the NHS – based on supporting not only recovery, but aspirations to build back better.

These changes should be combined with explicit targets on inequality. The NHS Long Term Plan set out several clinical priorities and set tangible goals to improve outcomes on these priorities through this decade. However, the content on health inequalities – including both inequalities in longevity, and inequalities in healthy life expectancy – is evidently lacking (see table 4.1). In a limited number of places, there is reference to variation (but not specific inequality). However, none of the commitments made across these clinical conditions represents a specific, measurable or time-limited ambition.

7 Note, this does not mean NHS spend can be reduced without impacting health outcomes. While there is evidence that public health interventions are the best way to make big marginal gains on inequality, that does not mean divesting a universal healthcare service would not have a significant impact – or that healthcare investment is not needed to support improvements in population health as a whole.

TABLE 4.1: HEADLINE COMMITMENTS ON CLINICAL PRIORITIES IN THE NHS LONG TERM PLAN FOR ENGLAND

Priority	Headline commitments
Cancer	75 per cent of cancers diagnosed at stage 1 or 2 (early).
Cardiovascular disease	Prevent 150,000 heart attacks, strokes and dementia cases this decade; the best cardiac rehabilitation in Europe, with 85 per cent of those eligible accessing care.
Stroke	Best performance in Europe for delivering thrombolysis to all patients who could benefit; a tenfold increase in the proportion of patients who receive a thrombectomy after a stroke.
Diabetes	Flash glucose monitors for patients with type 1 diabetes; reduced variation between CCGs on diabetes treatment targets.
Respiratory disease	An increase in rehabilitation access; improved response to pneumonia; reduced variation in detection and diagnosis of respiratory problems.
Mental health	Expansion in Improving Access to Psychological Therapies (IAPT) so an additional 380,000 adults can access IAPT services; greater choice over care for 370,000 adults through new models of care; a 24/7 crisis response service for all; specific waiting time targets for emergency mental health services from 2020 onwards.

Source: Author's analysis

There is some, inconsistent reference to variation. But exactly none of the commitments made across these clinical conditions represents a specific, measurable or time-limited ambition on closing unjust health inequalities.

This poses a risk. Almost all the goals set out above could be achieved by focussing on 'low-hanging fruit' – that is, on improving outcomes disproportionately for people with less complicated needs, who are unlikely to experience the health consequences of inequality. This would increase inequality, by improving health for the top 80 per cent, while allowing health for the poorest 20 per cent to stagnate – or even worsen.

Indeed, the internal set-up of the NHS makes this outcome more likely. The NHS' health inequality function sits separately from the National Programme teams, giving them little direct remit to hold senior leaders accountable to progress on variation. There is little binding commitment, or accountability, for National Programme directors to make health equality one of their top priorities – or to follow through on that prioritisation with investment.

In the aftermath of the disruption caused – and still being caused – by Covid-19, the NHS will need to do significantly more to meet the aspirations it set out in its long-term plan in 2019. Ensuring that clinical progress is maximised for those in the poorest parts of the country – or other excluded or vulnerable demographics – is a vital part of that equation. As such, we recommend the NHS sets out a specific and measurable goal on each clinical priority, based on closing inequalities. These ambitions should be funded from 2023 onwards, as part of the funding negotiation for the second five years of the 10-year NHS Long Term Plan. These ambitions should be directly tied to the health secretary's existing (but poorly defined) legal duty to pay due consideration to health inequalities.

Recommendation: Ministers should increase the amount of funding allocated to the NHS in the most deprived parts of the country. In the first instance, this should mean restoring the amount of funding allocated on the basis of deprivation to 15 per cent (as was the case between the 1990s and 2013). We recommend this comes alongside a specific, achievable, measurable and time-limited target on inequalities, across every clinical priority in the NHS Long Term Plan.

4.2 NHS STRUCTURE

We should invest in more holistic, integrated community health services

One of the most promising ways to tackle inequalities is a shift towards multi-agency, integrated care, located in the places people live. People who experience the impact of inequality are likely to experience a) more barriers to accessing centralised healthcare settings, and b) more complicated needs, making multisector community interventions worthwhile. Holistic, integrated, and nearby care services are better suited to these population health needs.

There are several case studies that show the power of multisectoral, community-based health services. For example, the Improving the Cancer Journey programme in Glasgow has had great success. In short, the programme identified that cancer doesn't just affect physical health, but rather all aspects of people's lives: from emotions to finances. People using the service received a visit from a link worker to talk about all their needs, health or otherwise. Working from a care plan, the link worker then helps each individual access services, activities, local businesses and charities that are right for them. The pilot has had significant success – with most users coming from the most deprived parts of the city, and people's overall self-reported need reducing significantly (Edinburgh Napier University and Macmillan Cancer Support, n.d.).

Elsewhere, 'hub models' have had success. One example of care moving out of hospitals and into the community is Community Diagnostic Hubs. These provide a one-stop shop for diagnostics, helping people (and general practitioners) easily access the tests they need. In other places, community hub models have seen health and social services co-locate to help link up a range of NHS primary care, local authority, and voluntary sector services.

In many cases – and, particularly, given the development of collaborative systems like Primary Cancer Networks (PCNs) and Integrated Care Systems (ICSs) – there is no reason why hub models couldn't have more aspiration. With the right estate, relationships and empowerment, hub models could combine general practice services, social care assessments from local authorities, community diagnostics, voluntary sector services and social prescriptions. That would mean a wide range of people's needs being available from the point they walk through the door – whether they leave without a formal diagnosis or need help managing the consequences of a long-term condition.

To that end, we propose that the government formally pilot this more ambitious form of hub working, either in purpose-built buildings or by using vacant commercial estates – in the first instance, through Primary Care Networks working in the most deprived parts of the country. If successful, the government should aim to develop the hub model – on a basis of one hub per PCN.

Recommendation: The government should pilot the countrywide scale-up of hub models of primary and community care. These hubs would create a one-stop shop for health, social, financial, emotional and spiritual need – with NHS, local authority, religious, charity and social prescribing services offered a chance to co-locate within an accessible community setting. This model should include link workers, given their importance in the Improving the Cancer Journey programme in Glasgow.

4.3 WHO HAS POWER

More should be done to build capability for devolution and local action on population health

In principle, integrated care offers a viable way to tackle inequality through devolution. By bringing the health and care sector together into a more collaborative style of working, under local leadership and in places, it (theoretically) offers a way to make care more patient-centred and relational. For those with more complicated needs, or living with multiple conditions, this could ensure more seamless and proactive care.

However, the government's reforms are unlikely to deliver this unless they make significant efforts to build capability in places. Devolution without resource, capability or power is not really devolution at all. As IPPR research has previously shown, different places are starting from very different positions when it comes to integration – thanks to their starting levels of integration, the varied impact of policies like austerity, and unequal population health contexts (Patel 2021). Ensuring these places can thrive within the framework of the government's reforms are crucial.

To support this, we recommend that the government facilitate a community health building scheme. This would:

- provide £4 billion of funding over the rest of the parliament
- be allocated transparently, through a formula based on publicly available data, to NHS footprints with low levels of integration and high levels of need
- be entirely devolved.

The purpose of the fund shouldn't be to support 'business as usual' healthcare functions, but rather to develop the 'health economy' within local places where it is most needed. For example, the funding could be used as patient capital for exciting health innovators or social enterprises; as part of a scheme to support new, small charities; to ensure the availability of social prescriptions; or to fund and maintain community groups. Importantly, the funding should be entirely devolved.

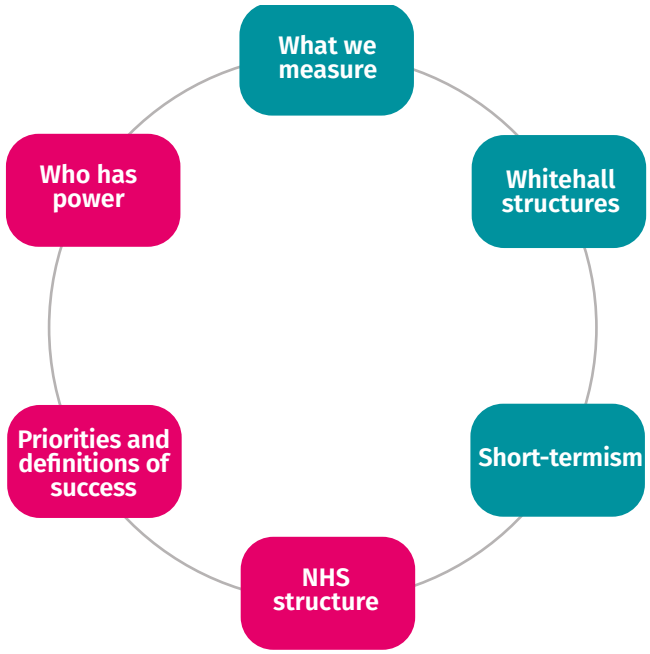
There are other ways the government and the NHS could create strong community health – using tools pioneered through community wealth building, in places like Preston (CLES 2019). One of the most promising opportunities from the change in procurement rules is the potential to take an asset-based approach to commissioning, which actively seeks to build up the human, social and physical capital of local communities (LGA 2020). To support this, government, NHS England and ICSs could work to create RightCare packs for each NHS Integrated Care System footprint – using the ONS Health Index and results presented in this report to develop areas of focus for community health building across the country. This would reflect that different social or economic variables may have a bigger or smaller impact in some localities.

Recommendation: **The integrated care white paper should include a fund to develop community health assets, supporting the development of flourishing 'health economies' across the country. This should be allocated transparently, based on publicly published metrics – including deprivation or the NHS new integrated care index – to target areas that need the money most (rather than the current bidding process). We also recommend Integrated Care Systems use their procurement budgets to support public health locally.**

5.
USE HEALTH TO DEFINE PROSPERITY

Beyond the NHS, changes should be made to ensure health is a stronger feature of how we define and measure prosperity – and therefore, what we do and invest in to achieve prosperity. This chapter addresses the final three barriers discussed in chapter 3.

FIGURE 5.1: A POLICY ENVIRONMENT THAT LINKS HEALTH AND PROSPERITY



Source: Author's analysis

5.1 WHAT WE MEASURE

Measure what matters

It's important that our measures of prosperity genuinely capture the things that matter (Colebrook 2018). Recently, there has been a convergence on supplementing GDP with a dashboard of metrics, which better measure the full range of what makes a country or society prosperous. In 2018, IPPR recommendations for a new dashboard included:

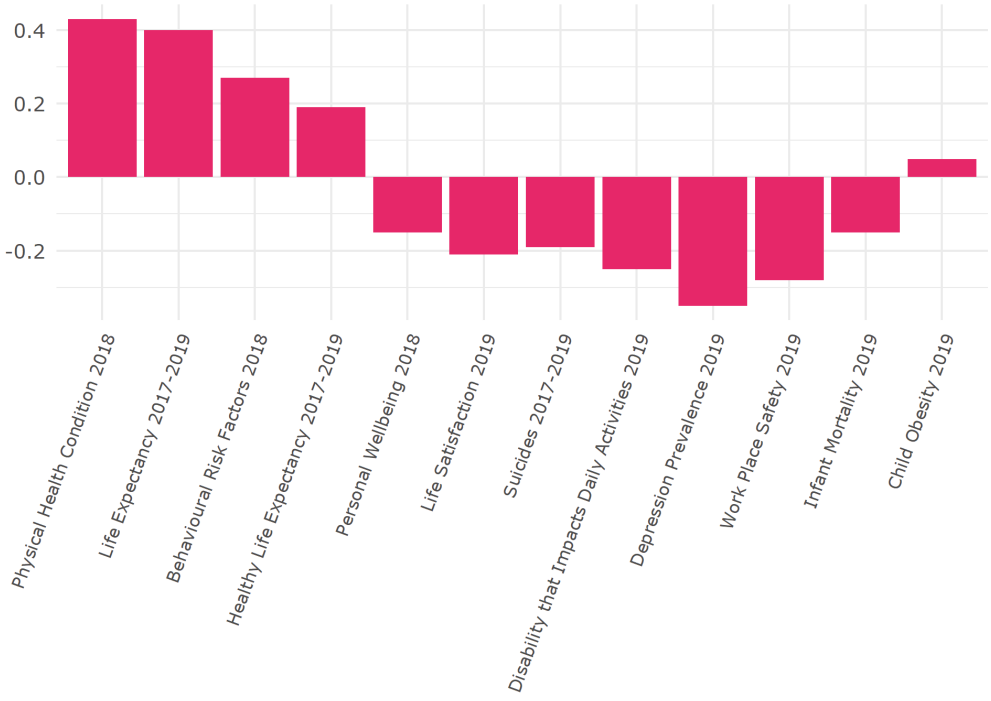
1. the distribution of the gains from growth
2. poverty among children and adults
3. wellbeing levels, disaggregated by income
4. the gap between median income of the poorest region of the UK, and the richest
5. the gap between projected carbon emissions and the cost-effective path to decarbonisation (ibid).

Other recent, popular dashboard proposals include the 'Donut model', developed by economist Kate Raworth and designed to put sustainability at the heart of our economy (Raworth 2017). In Scotland, the national performance framework provides a further, useful precedent for reorienting public spending towards outcomes.

The pandemic has shown the importance of including health in a wider reorientation of public spending towards outcomes (rather than outputs). First, it has shown the economic costs of poor health – and that any measure of wealth that does not explicitly include health misses something very important. It has shown that our current metrics of prosperity do not always encourage the best public health strategies, and that this can itself undermine the economy. The Eat Out to Help Out scheme provides a case study of a policy designed as a stimulus – but which, by not considering health sufficiently, failed to deliver any economic benefit, and has been linked to public health harms (Fetzer 2020). Delays over lockdown or hasty pushes to get public sector workers back in the office (for instance in September 2020) are case studies of the same. A definition of prosperity that included and measured good health might have led to different, better policies.

FIGURE 5.2: GDP DOES NOT PREDICT INEQUALITIES BETWEEN PLACES

Pearson correlation between health measures and GDP



Source: LCP analysis

Our analysis reiterated that our current measures do not adequately predict good health. GDP was not a consistent predictor of health in places. This doesn't mean health and wealth aren't related at all – the evidence is clear that health increases wealth, and that economic variables and inequalities can undermine health (see

for example Marmot et al 2010). Rather, it means that a rise in wealth does not predicate a rise in health. Put another way, GDP is not sufficiently sophisticated to account for the intricacies of the relationship between health. One indicative reason for this is the fact it doesn't measure the distribution of income and wealth – where our analysis has shown income and wealth disparities were an important correlate of health inequality.

We cannot leave our health to GDP (or other equally limited output measures). Recently, our ability to measure health in a sophisticated way has grown through the development of the ONS Health Index (ONS 2020c). The aim of the Health Index is to provide a holistic and single measure for the health of the nation. It measures 58 indicators including mortality, physical health, difficulties in daily life, life satisfaction (including happiness), mental health, risk factors, key social determinants of health, and the material condition of places. Including this as a key feature within Treasury reporting – as part of a move to a wider 'prosperity dashboard' (Colebrook 2018) – would facilitate significantly better health policy, more coherent health and economic strategy, and a truer reflection of the things that matter in government policymaking.

Recommendation: As part of a move to a wider dashboard of measures of prosperity, supplementing measures like GDP, we recommend that the government use the ONS' new Health Index as a measure of prosperity. This should see the Health Index reported on at budgets, spending reviews and fiscal statements.

5.2 WHITEHALL STRUCTURES

Make the measures that matter count

With the right measures in place, the next step is ensuring health has an impact on decisions. Measuring what matters is important, but it must also influence cross-government policy and investment decisions.

That means ensuring health is considered and informs decisions across the whole of Whitehall – and local government.

One way of achieving this would be to implement health impact assessments across government. Approaches of this kind are already employed in several local and combined authorities in the UK. The system would require all national and local decision-makers to provide an assessment against prospective impacts of new spending decisions on health – identifying potential positive outcomes to maximise, and putting in place tangible plans to alleviate negative impacts. These should be publicly published (ahead of enactment) to foster accountability and scrutiny.

Recommendation: The government should introduce health impact assessments across national and local government. This should explore the impact of policies on population health. Impact assessments should be published, preferably ahead of enactment, for all new policies and for all spending decisions above a set threshold.

5.3 SHORT-TERMISM

Back what matters

Finally, it is important that funding flows from central government to the right budgets – and that headline policy commitments are conducive to better health. This often requires priority of long-term benefits, that tend not to sit neatly with incentives. As such, it is likely that a formal mechanism to facilitate investment in population health improvement is needed.

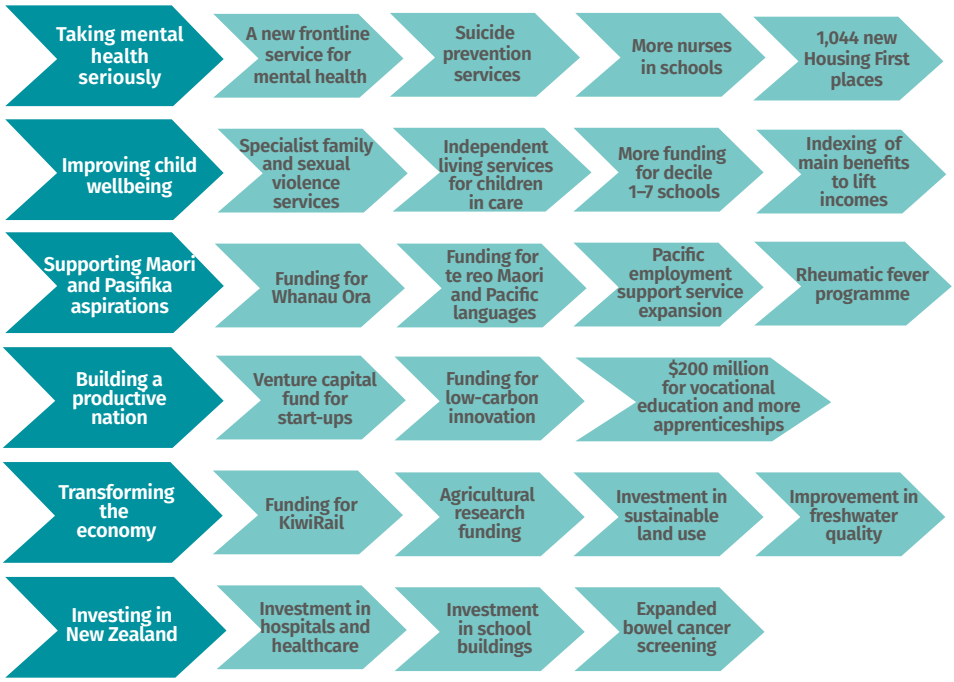
This idea of bespoke financial events – to facilitate long-term focus on policy areas poorly served by existing fiscal events – has been implemented elsewhere. New Zealand's Wellbeing Budget is one of the most practical examples of something besides an output-measure having a significant impact on fiscal decisions. Since 2019, the New Zealand government has allocated funding – totalling NZ$25.6 billion over four years – to take forward discrete wellbeing priorities (IBP 2020).

In the aftermath of the pandemic, there is a strong case for a public health budget. Like wellbeing, composite measures of health push the government to focus on many important factors – including distribution of wealth and income, quality of life, and happiness – less well captured by GDP. In fact, as this analysis of the ONS Health Index has shown, it is very hard for policy to cheat health measures in the long term: sustained unfair or sub-optimal policy decisions will widen health inequalities and supress overall health.

At an operational level, we recommend that the UK government uses the infrastructure developed in New Zealand. This would mean linking the equivalent of 5 per cent of public spending to the overarching goal of improving public health. Given the new health and social care levy, we suggest that this covers priorities explicitly outside of the National Health Service. In England, 5 per cent of total managed expenditure is approximately £35 billion per year. This should be a starting point, with an aspiration of allocating more public spending on the basis of output-measures over time.

Figure 5.3 shows the initial six funding priorities of the New Zealand Wellbeing Budget.

FIGURE 5.3: THE NEW ZEALAND WELLBEING BUDGET 2019, KEY PRIORITIES



Source: Author's analysis of New Zealand Government 2019

As in New Zealand, the public health budget need not use new money – but can fit within wider economic strategy and existing fiscal rules. New Zealand's implementation of a wellbeing budget has remained consistent with its wider

approach to tax and borrowing. There are wider economic arguments that suggest fairer tax, increased revenue and greater investment in public services are the right policy priority, but a public health budget exists as an independent policy (see Dibb et al 2021). Rather, it would simply ringfence a certain amount of the annual fiscal envelope for long-term public health priorities – and embed a more holistic, outcome-driven and accurate definition of prosperity in public spending.

Recommendation: The UK government should introduce a public health budget in England, modelled on the New Zealand Wellbeing Budget and tied to the ONS Health Index. This would ensure funding and opportunity for long-term focussed policy and investment decisions, based on improving health. This could be put in motion at the comprehensive spending review and delivered in line with the 2022 spring budget. As in New Zealand, and in the first instance, we recommend that the 'public health budget' is used to allocate 5 per cent of total managed expenditure (with flexibility to increase this amount over time).

6. AN INAUGURAL PUBLIC HEALTH BUDGET

The analysis presented in this report doubles as a practical exploration on what an inaugural public health budget should prioritise. This final chapter gives indicative ideas for what could be included at a public health budget, if taken forward in spring 2022. The recommendations map onto the strongest correlations identified in our quantitative modelling, cross-referenced against the ideas and priorities identified in our qualitative analysis. It is not exhaustive, but it is a roadmap to where some of the largest immediate marginal gains might be found.

TABLE 6.1: A PUBLIC HEALTH BUDGET FOR THE COMPREHENSIVE SPENDING REVIEW

Theme	Indicative priorities	Justification from our analysis
Early years and child poverty	Reform universal credit and mental health capacity in schools	Childhood variables had a consistently strong correlation to health inequalities
Work and skills	Investment in adult skills and fair work	Income inequality and skills a key correlate of health inequalities
Prosperity and productivity	Investment in the life sciences, focussed on levelling-up	Income and wealth variables are key correlates of health inequalities, and cluster analysis exposed stark differences in multiple health outcomes between regions
Social care quality	A programme of investment in community social care	Disability a key and consistent correlate of health inequalities
Targeted action	Action on intersectional component of health inequality, via healthy eating scheme, more action on blood-borne viruses and Housing First rollout	Data quality meant it was difficult to include all relevant characteristics systematically – however, the wider evidence base is clear on the severe extent of these inequalities

Source: Author's analysis

6.1 ACTION ON CHILDHOOD POVERTY AND THE EARLY YEARS

Inequalities at the start of life – combined with childhood poverty – were one of the most consistent themes in our analysis of national health inequalities. It is vital that the government do more to give every family a healthy foundation for life. One of the clearest priorities in addressing poverty is reform to the welfare system. To that end, the government should consider:

- providing childcare claimed through universal credit up front, rather than in arrears (McNeil et al 2021)
- maintaining (or, if relevant by the budget, reversing the decision to cut) the £20 uplift of universal credit introduced at the beginning of the pandemic – the uplift should be extended to legacy benefits
- removing the two-child limit from universal credit.

Increasing the health support available in schools should also be a priority. As it stands, the health infrastructure in school settings is not sufficient to meet children's physical or mental health needs. On the latter, a 2020 IPPR study showed both that teaches feel they do not have the knowledge or support they need to address trauma among their students, and that parents would overwhelmingly support a greater focus on mental health in schools and the classroom (Quilter-Pinner and Ambrose 2020).

6.2 INVESTING IN GOOD JOBS AND SKILLS

Income inequality was a key correlate across our analysis. Beyond increasing the amount provided through universal credit – outlined above – decent rates of pay in work, combined with sufficient and reliable hours, should be immediate priorities. Qualification levels were also key correlates, suggesting prioritisation of skills.

In New Zealand, fair pay agreements have been introduced to improve pay standards. These bring together unions within a sector to bargain for minimum terms and conditions for all employees in that industry or occupation – creating industry-wide pay deals. While useful, there are limits in the scope of these agreements – namely, that they cover pay but not security. In line with recent IPPR Scotland analysis, we suggest that Fair Work Agreements are considered (Statham et al 2021).

The government has made recent steps on increasing skills, including a £2.5 billion National Skills Fund, as part of the wider Plan for Jobs. This is designed to help adults improve their job prospects, and to support the immediate economic recovery. The prime minister has also announced a 'Lifetime Skills Guarantee'.

While this is welcome, it remains short of the investment the skills system needs. If further education funding had kept up with demographic pressures and inflation over the last decade, previous IPPR estimates show we would be spending £2.1 billion a year more on adult skills and £2.7 billion a year more on 16–19 further education (Hochlaf and Quilter-Pinner 2020). To help continue to progress on this deficit, the government could consider:

- an increase in per pupil spend for 16–19-year-olds in colleges and sixth forms from £5,200 today to £8,300 by the end of the parliament
- establishment of a job training scheme, as part of ongoing reforms to the job retention scheme – with a focus on providing a training budget for all those who lose their job in the aftermath of furlough ending
- immediately suspending conditionality on people on universal credit who want to retrain, or are training.

Implemented correctly, these policies would be in line with theories of progressive universalism – that is, they would benefit the whole country, but would most benefit the people and places with the highest need.

6.3 LEVEL-UP THROUGH MEDICAL RESEARCH

The UK has huge advantages when it comes to medical research – globally reputed universities, significant academic talent, a history of discovery and scientific advance, a unique medical research charity sector and some state-of-the-art infrastructure. Despite those advantages, our life science strategy is defined by missed opportunity.

At a national level, the missed opportunity is overall investment. UK research investment has stagnated, compared to comparable countries, in the last 30 years. Having invested around the average for an OECD nation in the 1980s, we now spend less relative to the size of our economy than China,

France, Germany, Japan, Denmark, the US and the average of OECD nations. Cumulatively, had our investment in R&D tracked the OECD since 1981, we would have invested £222 billion more in research and innovation over the period (Thomas and Nanda 2020).

Missed opportunities on R&D investment are not felt equally across the country. A significant proportion of public money is invested in the south of England and, specifically, the 'golden triangle' of London, Cambridge and Oxford. Only a very small amount of health research investment goes to the north of England, the Midlands, Wales, Scotland or Northern Ireland (ibid).

This is not because of a lack of potential in these places. Indeed, despite the lack of public money, many regions have developed exciting niches.

- **Scotland's Central Belt:** The central belt in Scotland has huge expertise in health technologies, including the internet of things, data analytics and advanced manufacturing. It is home to the James Hutton Institute, the Scottish Association for Marine Science, the Advanced Forming Research Centre, the Centre for Innovative Manufacturing, and the Fraunhofer Centre for Applied Photonics.
- **Greater Manchester and Cheshire:** Digital maturity in this region is 18 percentage points higher than the UK average (ibid). It has growth potential in precision medicine and the realisation of real-world clinical trials.
- **Yorkshire and Leeds city region:** Local authorities in North and West Yorkshire are pioneers in medical technology. Almost 10 per cent of patents submitted in the UK originate in Leeds city region, and the region produces as many as 12,000 MedTech graduates per year.

These are the kind of hubs that the government should be empowering to compete globally. There is an opportunity to create productive, high-growth sectors, and to translate that prosperity into better lives and better health for people. As Richard Jones has argued elsewhere, R&D is key to spreading productivity – a key challenge for the UK economy since the 2008 financial crash (Jones 2020).

We recommend significant government efforts to empower the places where there are high levels of health need, to scale their health R&D sectors. This should mean direct investment in these places, to help 'crowd-in' private sector investment. It should also mean significant investment in infrastructure, including skills, patient capital, transport and digital connectivity – as previously recommended by IPPR (ibid).

6.4 ENSURE SOCIAL CARE SUPPORTS FLOURISHING LIVES

While the prime minister's focus on reducing catastrophic care costs is clearly a helpful step forward in social care, there is little in the government's social care reform plan designed to improve care quality, and ensure it supports flourishing lives. This is in contrast to the United States, where President Biden has made community care a core part of his economic stimulus – correctly identifying it as an excellent way to boost growth, increase employment opportunities, and improve wellbeing. Specifically, President Biden has invested $400 billion over the next eight years in community care infrastructure. The equivalent commitment in the UK – adjusted for size of economy and population – would be £5 billion per year, invested over five years.

In the UK, there is strong evidence from deliberative studies that people support a preventative model of social care – designed to prevent need from the earliest point. This would mean a care system designed around delivering much more care in people's homes and communities (Thomas 2021). To achieve that, we reiterate recent IPPR recommendations that the £5 billion be made available

– with half allocated to increasing access to care in homes and communities, and half allocated to introducing and scaling examples of innovation and better practice (ibid). As well as improving care quality, this would offer the opportunity for significant efficiency savings – community care is around one-third of the price of residential care (ibid).

6.5 TARGETED ACTION

Finally, the budget should target specific drivers of inequality among vulnerable groups, above and in addition to action on place-based inequalities. In many cases, these work on the principle of proportionate universalism – they target a specific inequality, but have a much broader benefit too. Policies could include:

- **Better prevention of diabetes and heart disease:** As already noted, incidence of heart disease and diabetes are much higher among Black and South Asian people. The best way to address this is with support for secure access to a healthy, nutritious and sustainable diet. The July 2020 obesity strategy is limited by its preoccupation with making unhealthy food less accessible – by banning promotions and restricting advertising – rather than making healthy food more accessible. But the latter is equally important. Evidence, including a *Lancet* review led by Professor Corinna Hawkes, shows that food subsidies are an effective way to increase healthy food consumption, decrease unhealthy food consumption and improve weight outcomes (Hawkes 2015). Moreover, locally led pilots of small healthy food subsidies have shown a huge impact on family diets and wellbeing. A £21 a week healthy food subsidy for all families who need support would have a maximum cost of £1.5 billion per year and help tackle the disproportionate rates of food insecurity among black communities in the UK.
- **Eliminate threat of blood-borne viruses:** The UK government has signed up to commitments on blood-borne viruses, including elimination of hepatitis C as a public health threat by 2030, and zero HIV transmissions by 2030. However, evidence suggests that – while progress on these goals is good – they will be missed if strategies are not adapted through the next decade (Brizzi et al 2021). We recommend that the government make a multi-year commitment to fund local authorities' rollout of pre-exposure prophylaxis (PrEP) treatment between now and 2030. We also recommend a reversal to cuts to drug, alcohol and sexual health services in England, which are down £400 million since 2014/15 (Thomas 2019). The uplift should support harm reduction services, and specifically initiatives to increase testing and decrease needle sharing (The Hepatitis C Trust 2020). We also recommend that the government deliver targeted campaigns, notably to men who have sex with men over the age of 45 – who evidence suggests might be harder to reach – and move to an opt-out model of HIV testing, in the places where uptake of testing is lowest (as per HIV Commission 2020).
- **A nationwide Housing First programme:** The response to the Covid-19 pandemic provided signs that an end to homelessness is possible. The best, long-term step would be a nationwide expansion of the Housing First model. This has been successfully used in Finland, is fast becoming standard in Scotland, and English trials in Manchester, Liverpool and the West Midlands were also successful. In line with Crisis' plan to end homelessness, we recommend the public health budget funds a national rollout of the model from 2022 onwards (Crisis 2018). Research has shown that – alongside welfare increases, fundamental increases in the affordable/social housing stock and evidence-led drug and addiction services – Housing First is among the most impactful approaches to homelessness (Crisis 2021).

REFERENCES

Academic Health Science Networks [AHSN] and LGBT Foundation (2021) *Call to address LGBT+ health inequalities.* https://www.ahsnnetwork.com/lgbt

Asaria M, Doran T and Cookson R (2016) 'The costs of inequality: Whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation', *Journal of Epidemiology & Community Health*, 70(10). https://jech.bmj.com/content/70/10/990

Barr B (2017) 'Investigating the impact of the English health inequalities strategy: Time trend analysis', *British Medical Journal.* https://www.bmj.com/content/358/bmj.j3310

British Heart Foundation [BHF] (2011) *Trends in coronary heart disease, 1961–2011*. https://www.bhf.org.uk/~/media/files/research/heart-statistics/bhf-trends-in-coronary-heart-disease01.pdf

Brizzi F, Birrell P, Kirwan P, Ogaz D, Brown A and Delpech V (2021) 'Tracking elimination of HIV transmission in men who have sex with men in England: A modelling study', *The Lancet*, 8(7). https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(21)00044-8/fulltext

Case A and Deaton A (2020) *Deaths of despair and the future of capitalism*, Princeton University Press. https://press.princeton.edu/books/hardcover/9780691190785/deaths-of-despair-and-the-future-of-capitalism

Centre for Local Economic Strategies [CLES] (2019) *Community wealth building: A history.* https://cles.org.uk/tag/the-preston-model/

Colebrook C (2018) *Measuring what matters*, IPPR. https://www.ippr.org/publications/measuring-what-matters

Care Quality Commission [CQC] (2020) *Who cares?* https://www.cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf

Crisis (2018) *The plan to end homelessness* (Chapter 9, 'The role of Housing First in ending homelessness'). https://www.crisis.org.uk/ending-homelessness/the-plan-to-end-homelessness-full-version/solutions/chapter-9-the-role-of-housing-first-in-ending-homelessness/

Crisis (2021) *The homelessness monitor: England 2021.* https://www.crisis.org.uk/media/244702/crisis-england-monitor-2021.pdf

Dibbs G, Jung C, Parkes H and Nanda S (2021) *Prosperity and justice after the pandemic*, IPPR. https://www.ippr.org/research/publications/prosperity-and-justice-after-the-pandemic

Edinburgh Napier University and Macmillan Cancer Support (n.d.) *Evaluation of Glasgow Improving the Cancer Journey Programme.* https://www.macmillan.org.uk/_images/Glasgow-improving-the-cancer-journey-programme-full-evaluation_tcm9-301271.pdf

Fetzer, T (2020) 'Subsidizing the spread of COVID19: Evidence from the UK's Eat-Out-To-Help-Out scheme', CAGE working paper no. 517, University of Warwick. https://warwick.ac.uk/fac/soc/economics/research/centres/cage/manage/publications/wp.517.2020.pdf

Hawkes, C (2015) 'Smart food policies for obesity prevention', *The Lancet*. http://repositorio.uchile.cl/bitstream/handle/2250/133565/Smart-food-policies-for-obesity-prevention.pdf?sequence=1

HIV Commission (2020) *How England will end new cases of HIV.* https://www.hivcommission.org.uk/wp-content/uploads/2020/11/HIV-Commission-Full-Report_online_final_pages-2.pdf

Hochlaf D, Quilter-Pinner H and Kibasi T (2019) *Ending the blame game: The case for a new approach to public health and prevention*, IPPR. https://www.ippr.org/research/publications/ending-the-blame-game

Hochlaf D and Quilter-Pinner H (2020) *Going further*: *The case for investing in further education and adult skills*, IPPR. https://www.ippr.org/research/publications/going-further

Homeless Link (2018) 'NHS Long Term Plan must address shocking health inequalities for homeless people', news article. https://www.homeless.org.uk/connect/news/2018/nov/05/nhs-long-term-plan-must-address-shocking-health-inequalities-for-homeless

International Budget Partnership [IBP] (2020) *Reinventing public finance: A closer look at New Zealand's well-being budget experiment.* https://internationalbudget.org/2020/06/reinventing-public-finance-a-closer-look-at-new-zealands-well-being-budget-experiment/

Javid S (2021) 'The hidden costs of COVID-19: The social backlog', speech to the Centre for Social Justice at the Grange Community Centre, Blackpool, 16 September 2021. https://www.gov.uk/government/speeches/the-hidden-costs-of-covid-19-the-social-backlog

Jones R (2020) *Innovation, regional economic growth and the UK's productivity problem,* Soft Machines, website. http://www.softmachines.org/wordpress/?p=2285

Kingston A (2018) 'Projections of multi-morbidity in the older population in England to 2035: Estimates from the Population Ageing and Care Simulation (PACSim) model', *Age Ageing*, 47(3): 374–380. https://pubmed.ncbi.nlm.nih.gov/29370339/

Marmot M, Goldblatt P and Allen J (2010) *Fair society, healthy lives* (The Marmot Review). https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

McNeil C (2021) *No longer 'managing': The rise of working poverty and fixing Britain's broken social settlement*, IPPR. https://www.ippr.org/research/publications/no-longer-managing-the-rise-of-working-poverty-and-fixing-britain-s-broken-social-settlement

Mencap (2020) 'Health inequalities', webpage. https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

National Institute for Health Research [NIHR] (2020) *Better health and care for all.* https://evidence.nihr.ac.uk/themedreview/better-health-and-care-for-all/

Neville S (2021) 'NHS chief Simon Stevens: "You've got to make the weather"', *Financial Times.* https://www.ft.com/content/3747c7f1-ac3f-4062-998e-4506b4a131f4

New Zealand Government (2019) *The Wellbeing Budget.* https://www.treasury.govt.nz/sites/default/files/2019-05/b19-wellbeing-budget.pdf

NHS Providers and NHS Confederation (2021) *A reckoning: the continuing cost of Covid-19.* https://nhsproviders.org/media/692003/a-reckoning-continuing-cost-of-covid-19.pdf

Northern Health and Science Alliance [NHSA] (2018) *Health for wealth: Building a healthier northern powerhouse for UK productivity.* https://www.thenhsa.co.uk/app/uploads/2018/11/NHSA-REPORT-FINAL.pdf

Office for National Statistics [ONS] (2020a) 'National life tables – life expectancy in the UK: 2017–2019', dataset. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2017to2019

Office for National Statistics [ONS] (2020b) 'Healthcare expenditure, UK health accounts: 2018', dataset. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2018

Office for National Statistics [ONS] (2020c) 'Developing the Health Index for England: 2015 to 2018', dataset. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/developingthehealthindexforengland/2015to2018

Office for National Statistics [ONS] (2021a) 'Health state life expectancies, UK: 2017–2019', dataset. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2017to2019

Office for National Statistics [ONS] (2021b) 'International comparisons of GDP during the coronavirus (COVID-19) pandemic', dataset. https://www.ons.gov.uk/economy/grossdomesticproductgdp/articles/internationalcomparisonsofgdpduringthecoronaviruscovid19pandemic/2021-02-01

Office for National Statistics [ONS] (2021c) 'Socioeconomic inequalities in avoidable mortality in England', statistical bulletin. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/socioeconomicinequalitiesinavoidablemortalityinengland/2019

Patel P (2021) *The integration puzzle: Delivering on the promise of integration in health and care*, IPPR. https://www.ippr.org/research/publications/solving-the-integration-puzzle

Patel P, Kapoor A and Treloar N (2020) 'Ethnic inequalities in Covid-19 are playing out again – how can we stop them', blog post, IPPR. https://www.ippr.org/blog/ethnic-inequalities-in-covid-19-are-playing-out-again-how-can-we-stop-them

Quilter-Pinner H and Ambrose A (2020) *The new normal*: *The future of education after Covid–19*, IPPR. https://www.ippr.org/research/publications/the-new-normal

Raleigh V and Holmes J (2021) *The health of people from ethnic minority groups in England*, The King's Fund. https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england

Raworth K (2017) *Doughnut economics: Seven ways to think like a 21st-century economist.* Random House

Statham R, Parkes H and Gunson R (2021) *Delivering a fair work recovery in Scotland: Securing a living income for all*, IPPR Scotland. https://www.ippr.org/research/publications/delivering-a-fair-work-recovery-in-scotland

Stoye G and Zaranko B (2019) *UK health spending*, Institute for Fiscal Studies. https://ifs.org.uk/publications/14552

The Hepatitis C Trust (2020) 'Report indicates more investment in harm reduction needed to tackle hepatitis C', blog post. http://www.hepctrust.org.uk/blog/oct-2020/report-indicates-more-investment-harm-reduction-needed-tackle-hepatitis-c

Thomas C (2019) 'Hitting the poorest, worst? How public health cuts have been experienced in England's most deprived communities', blog post, IPPR. https://www.ippr.org/blog/public-health-cuts

Thomas C, Round A and Longlands S (2020) *Levelling-up health for prosperity*, IPPR. https://www.ippr.org/research/publications/levelling-up-health-for-prosperity

Thomas C and Nanda S (2020) *The science-based economy: The role of health research*, IPPR. https://www.ippr.org/research/publications/the-science-based-economy

Thomas C (2021) *Community first social care*, IPPR. https://www.ippr.org/research/publications/community-first-social-care

UK Health Security Agency [UKHSA] (2018) 'The inequalities of homelessness', UKHSA Blog. https://publichealthmatters.blog.gov.uk/2018/02/09/the-inequalities-of-homelessness-how-can-we-stop-them-dying-young/

Wilkes G and Westlake S (2014) *The end of the Treasury*, Nesta. https://media.nesta.org.uk/documents/end_of_treasury.pdf

Institute for Public Policy Research

The progressive policy think tank

GET IN TOUCH

For more information about the Institute for Public Policy Research, please go to www.ippr.org

You can also call us on +44 (0)20 7470 6100, e-mail info@ippr.org or tweet us @ippr

Institute for Public Policy Research

Registered Charity no. 800065 (England & Wales), SC046557 (Scotland), Company no, 2292601 (England & Wales)