Institute for Public Policy Research

HEALTHY PLACES, PROSPEROUS LIVES

IPPR discussion paper

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January 2024

DISCUSSION PAPER

This report is an IPPR submission of evidence and ideas to the Commission on Health and Prosperity. It does not necessarily reflect the full views of commissioners, and the commission will publish its full blueprint in 2024.

ABOUT IPPR

IPPR, the Institute for Public Policy Research, is an independent charity working towards a fairer, greener, and more prosperous society. We are researchers, communicators, and policy experts creating tangible progressive change, and turning bold ideas into common sense realities. Working across the UK, IPPR, IPPR North, and IPPR Scotland are deeply connected to the people of our nations and regions, and the issues our communities face.

We have helped shape national conversations and progressive policy change for more than 30 years. From making the early case for the minimum wage and tackling regional inequality, to proposing a windfall tax on energy companies, IPPR's research and policy work has put forward practical solutions for the crises facing society.

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The progressive policy think tank

CONTENTS

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ABOUT THIS PAPER

This report advances IPPR's charitable objective of advancing physical and mental health.

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SUMMARY

The first interim report of the IPPR Commission on Health and Prosperity showed that the UK is getting poorer and sicker. This report – the third major commission paper – shows how this trend is not equal across the country: poorer and sicker areas are getting poorer and sicker the most quickly. Our analysis shows a 'double injustice', whereby places with poorer health also experience lower household income, higher poverty and lower wealth. Most tangibly, we show an association between places with high levels of sickness and economic inactivity – suggesting that this fiscal threat is not felt equally across the country. People living in the most deprived local authorities are one and a half times more likely to experience economic inactivity and are twice as likely to be in poor health.

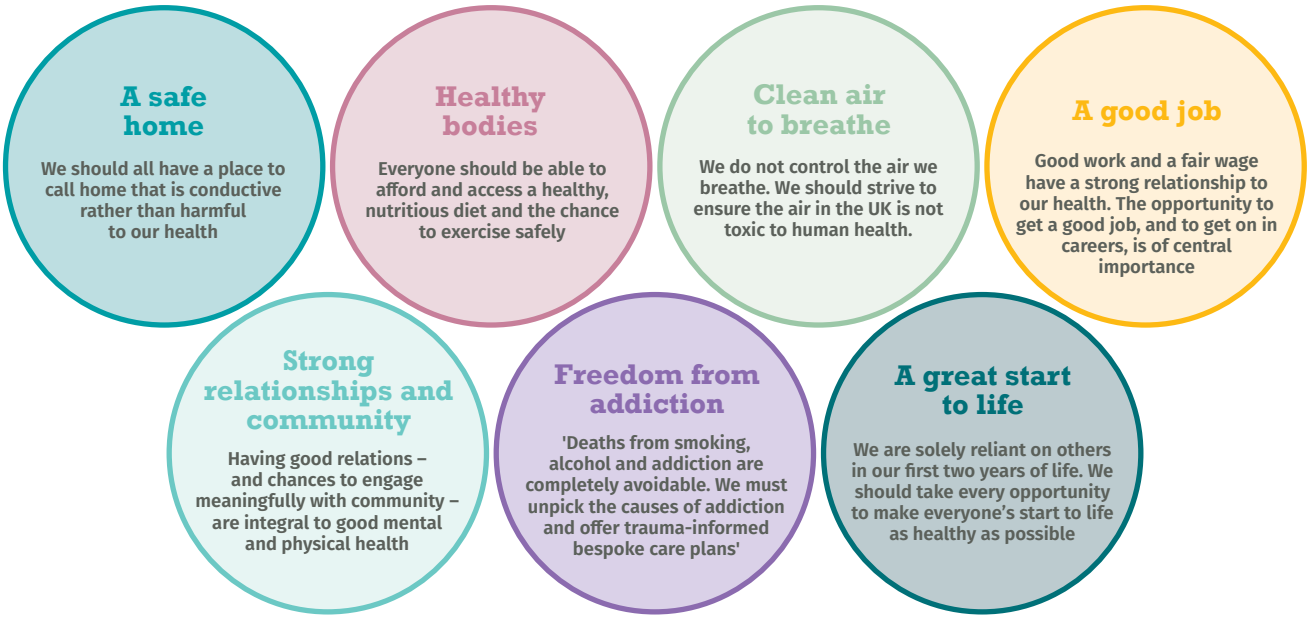
To help develop a path forward, IPPR held a series of multi-day deliberative workshops across the country - each exploring people's understanding of health, its relationship with prosperity, and priorities for change. We found that people wanted better health to be a priority and had a clear sense of how their local environment, neighbourhood and community impacted their health. They also had a clear sense of what should change but felt powerless to take control of the reins when it came to their health.

There were four key themes:

- **People see safety, security, opportunity and stability as the foundations of a healthy life**: this encompasses the quality of local jobs, safety from crime and opportunities to improve their lives through and beyond education.
- **Spaces, places and relationships are key priorities**: public spaces and places were seen as the anchor for improving relationships, ensuring connection and community, and having a profound impact on people's mental health, happiness and enjoyment of their place.
- **Power and community cohesion are central**: people want an active role in determining their health, but currently feel disempowered – as individuals and as communities.
- **Good health should be everyone's business**: participants noted the limits of individual responsibility and saw the role of business (big and small), central, regional and local government, the NHS, and communities in delivering better health.

Based on these priorities, we have developed a new framework: 'Seven for Seven' – or seven foundations for seven healthy life years – which aims to improve the conditions that sustain health and economic inequality within places. There is currently a seven-year disability-free life expectancy gap between the most and least deprived local authorities in this country. Seven for Seven aims to close this gap by building the foundations for healthy lives everywhere.

SEVEN FOUNDATIONS FOR A HEALTHIER, MORE PROSPEROUS AND FAIRER COUNTRY



Source: Authors' analysis

The seven foundations are anchored in what people told us during our deliberative research and have been verified through a comprehensive review of research on the social determinants of health.

For each of our foundations, this report identifies examples of transformative place-level interventions, either in the UK or internationally, which are already making a difference. Each suggests that real change is possible at the place-level, and that there is a lot that existing leaders can do to make substantive progress on health and prosperity. However, the fact that these schemes are often isolated and at limited scale raises an equally important question: why is public health innovation not diffusing by default, wherever there are people who would benefit? This is the central challenge the policy recommendations in this report look to address.

Specifically, we recommend the creation of **Health and Prosperity Improvement Zones (HAPI)** – as a new mechanism to diffuse innovation to support the seven foundations across the country, targeted at places where need is highest. These zones would contribute to the Commission on Health and Prosperity's core mission: that the UK should strive to be the world's healthiest country in a 30-year period. Simply put, they would do for our health what targeted approaches like Clean Air Zones have done for climate and health, in providing a place-based delivery mechanism for the achievement of a bigger, national and long-term mission.

Our proposed delivery plan for Health and Prosperity Improvement Zones works as follows:

- Design the footprints: HAPI footprints should be designed according to need – based on health outcomes, economic outcomes, and any specific inequalities faced by communities with characteristics protected by the Equality Act 2010.
- Co-design the plan: as opposed to top-down health inequality targets and deliver frameworks, we recommend HAPIs – with local authorities in the driving seat – should have control over their overall priorities, and their plans to make progress. This should include meaningful co-creation with residents, based on the principle: 'nothing about us, without us'. The agreement of each plan should be finalised in a forum of national government, local government,

health stakeholders from Integrated Care Systems (ICS) and Primary Care Networks (PCN), relevant businesses, and civil society stakeholders and citizens - helping coordinate activity and align local and national priorities.

- Create the right institutions: missions require evidence and accountability. To support this, we recommend a new What Works Centre to curate evidence on health inequalities and support the translation of ideas into practice. We also propose the new Office for Local Government is given powers to hold Local Authorities to account for HAPIs – to ensure action, and to learn from success and failure. This should include extensive use of the Health Index to identify new opportunities and monitor success.
- Provide strategic resource: meaningful long-term progress will require short-term investment in capacity. We recommend a new local health creation fund, with £3 billion investment created by national levies of health harming industries in the first instance. As a supplement, recognising that some local places may want to go further than central funding allows – or may want to include fiscal tools in their specific health creation strategy – we suggest a range of levies of health harming industries are devolved locally to enable additional revenue. While we recognise that any revenue creation is likely to be regressive, we posit that the income benefits of prevention are so significant as to make this highly justifiable – particularly where those who pay the levies are also those who benefit from increased spending.
- Crowd-in partners: business, civil society, employers, and a wide range of public services, all hold real influence over public health. To crowd in their support, we recommend refining the Social Value Act to include health more explicitly, and to incentivise businesses that create good health; a health hub in every HAPI to coordinate public services; social investment programmes to create thriving health eco-systems; and a new Health Volunteering Service to help enable communities to take action.

1. A DIVIDED KINGDOM

The First Interim Report of the IPPR Commission on Health and Prosperity showed that the UK is becoming poorer and sicker (Thomas et al 2023). It also showed that these are not unrelated trends: rising inequality is making the UK sicker, and poor population health is making the UK poorer in turn.

This new evidence supports a growing consensus that good health is not only a precondition for the things that make life worthwhile - maintaining relationships with friends and family, taking part in the community, and engaging in passions and hobbies - but is also vital for our economic lives (Bambra et al 2018, Bryan et al 2022). In the context of the UK's comparatively poor population health – in relation to similar countries – this suggests good health is the country's clearest untapped path to greater wellbeing, happiness and prosperity (Health Foundation 2023, Times Health Commission 2023).

WHAT IS 'GOOD HEALTH'?

This report takes a broad view of good health. We do not define it as simply the 'absence of a health condition' – but rather, as a state in which our health enables us to lead a good, happy and flourishing life. This might be because we don't have a health condition, or it might be because we have the support and care needed to lead a good life alongside a long-term condition or impairment. Equally, someone without a clinical diagnosis might not be 'healthy' if they are in an environment that puts them at significant risk of sickness – damp, cramped housing or a high-stress low paid job.

However, a risk with any national analysis is that it can obscure important local trends and inequalities. This, in turn, can lead to one-size-fits-all solutions that do not tackle place-based[1] challenges. This report focuses on local trends in health and prosperity.

HEALTH AND PROSPERITY DIVIDE THE COUNTRY

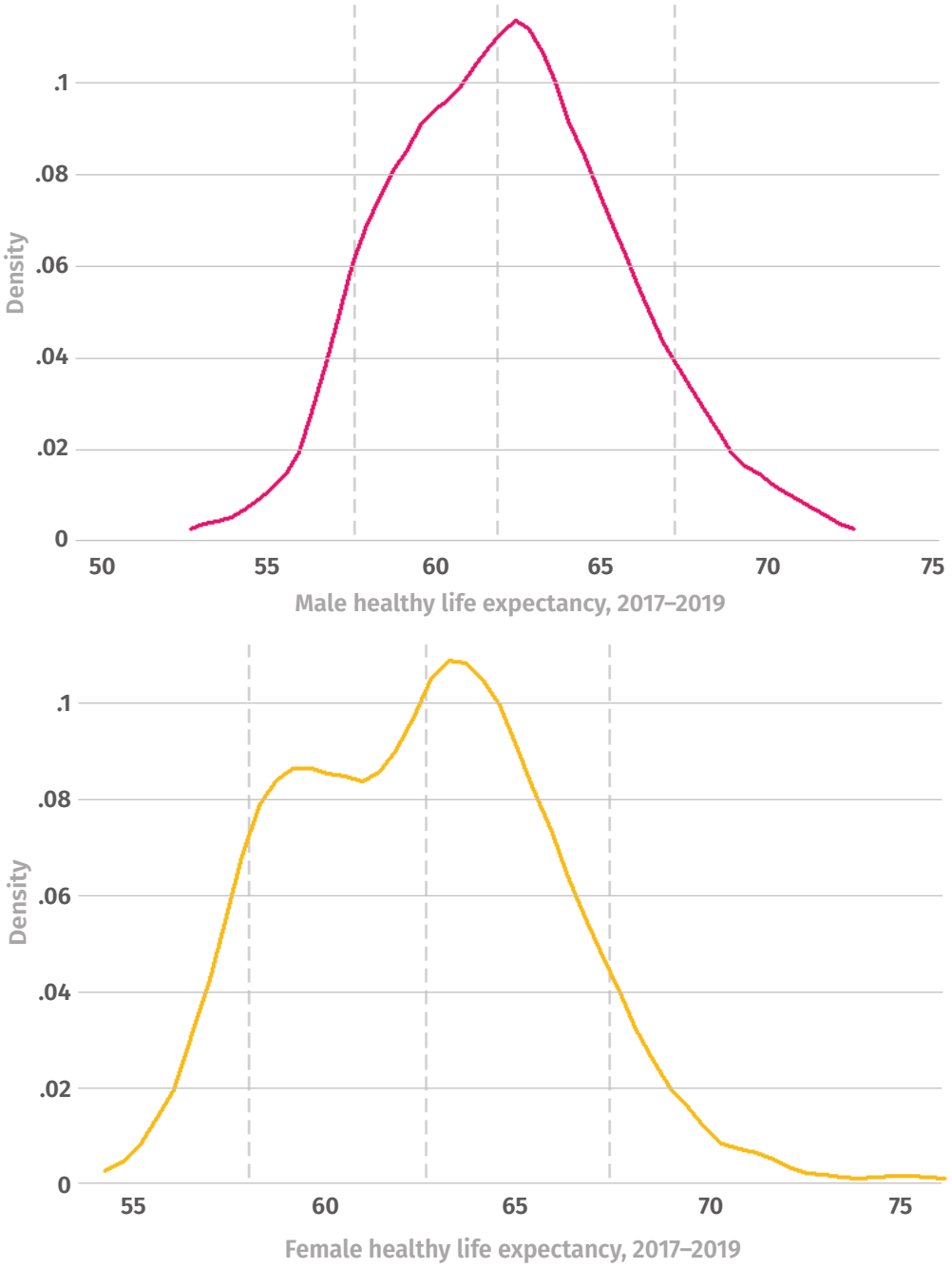
There are significant health inequalities across the UK, as shown in figure 1.1 and figure 1.2. Figure 1.1 maps healthy life expectancy[2] (which can be defined as the average number of years that a person can expect to live in 'good' health) and life expectancy by local authorities in England. It shows that as many as a quarter of local authorities have a female healthy life expectancy below 58 years old, while another quarter of local authorities have a female life expectancy over 67.4 years: a gap of nearly 10 years. For men, the gap between the top and bottom quartile of local authorities is also nearly 10 years of healthy life expectancy. This indicates that the place where we are born is still important in shaping our expected health outcomes.

1 The term 'place' is common in public policy, but rarely defined. For the purposes of this paper, we define 'place' as a defined spatial area with shared social connection, history and community. We further define places as 'practices' –areas within which people grow, play, work and learn in their day-to-day lives (see Cresswell 2009).

2 The average number of years a person can expect to live in 'good health'- estimated using a combination of mortality rates, historic data and self-reported health status.

FIGURE 1.1: HEALTH OUTCOMES DIVIDE THE COUNTRY

Variation in healthy life expectancy at birth by local areas in the UK, 2017–2019[3]



Note: Local areas are upper-tier local authorities in England, local authorities in Wales and council areas in Scotland.

Source: Authors' analysis of ONS (2022a)

Figure 1.2 compares the average, quartile and min/max life expectancy of 'Middle Super Output Areas' (MSOAs) within each English region and British nation. It shows

3 Similar patterns can be observed in 2018–20 data, with the healthy life expectancy gap between the healthiest and least healthy local authorities standing at 23.5 years for women and 21.2 years for men.

that even within the same regions, life expectancy can vary by as much as decades. Levels of inequality in health outcomes are highest in Scotland, the North East, the North West, and Yorkshire and the Humber.

FIGURE 1.2: HEALTH INEQUALITY IS SUBSTANTIAL WITHIN PLACES

Difference in life expectancy by MSOA, years different to average, 2016–2020

Note: A boxplot showing the deviation from the mean life expectancy of each region in Great Britain.[4] The boxes indicate where 25-75 per cent of the data points lie. The whiskers indicate the other data points that are at the extremes of the distribution. The dots represent outliers which are MSOAs that have extreme values of life expectancy. *Scotland's unit of analysis is not at the MSOA level but at the intermediate zone, which means that results are not fully comparable as they are at slightly different units of analysis.

Source: Authors' analysis of ONS (2021) and Public Health Scotland/National Records of Scotland

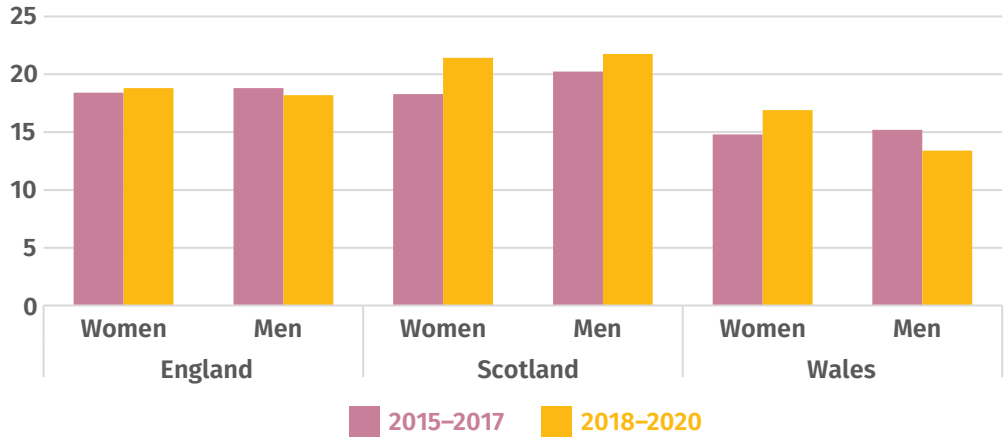
We also find that health inequalities correlate with levels of multiple deprivation.[5] Figure 1.3 shows the gap in healthy life expectancy between the most and least deprived parts of the country in England, Scotland and Wales. While inequality is slightly lower in Wales, it is substantial in all three nations – with a nearly 22-year healthy life expectancy gap between people living in the most and least deprived places in Scotland.

4 Data for Wales is unavailable at this level of geography, but there is evidence of large variations in health in Wales (see Public Health Wales 2022). Moreover, these inequalities are widening.

5 Using the government's Indices of Multiple Deprivation (IMD).

FIGURE 1.3: PEOPLE LIVING IN MORE DEPRIVED PLACES EXPERIENCE WORSE HEALTH

Differences in healthy life expectancy at birth between most and least deprived areas, by gender and nation



Source: Authors' analysis of ONS (2022e)

Economic disparities equally divide the country. Figure 1.4 shows a substantial inequality in productivity by English region and UK nation. By comparing Gross Value Added (GVA) per head between regions and UK nations with the UK average, it shows that the South East and London are the only two regions with above average productivity. It also shows that the gap between high productivity and low productivity regions has increased markedly over the last 15 years.

FIGURE 1.4: LESS HEALTHY REGIONS HAVE LOWER LEVELS OF PRODUCTIVITY

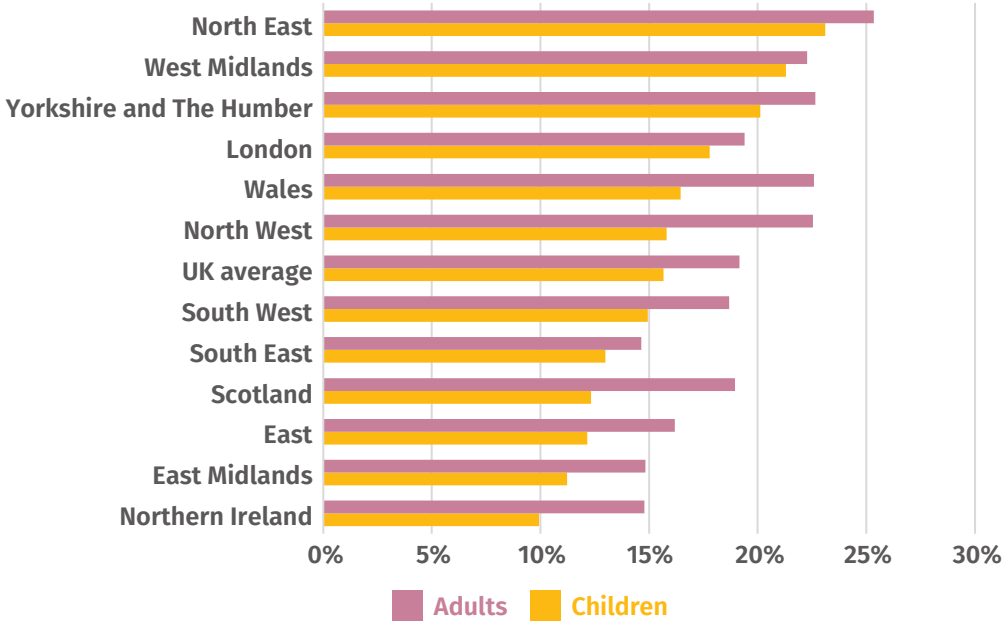
GVA per head (balanced) by English region and UK nation, difference from UK average in selected years (five-year intervals 2006–21 (latest data)

Source: Authors' analysis of ONS (2023a)

We observe a similar trend when looking at material deprivation. There are large differences in the proportion of children and adults living in material deprivation across the UK. We find that in the North East, 25 per cent of adults and 23 per cent of children are living in material deprivation, compared with 14 per cent of adults and 10 per cent of children in Northern Ireland (figure 1.4).

FIGURE 1.5: THERE IS SIGNIFICANT DISPARITY IN LEVELS OF MATERIAL DEPRIVATION ACROSS THE UK

Proportion of children and working age adults in material deprivation, 2019–22



Note: Material deprivation is defined as adults and children in families who are unable to afford certain items or activities that are widely considered essential. Data is the average of 2019/20 and 2021/22, with 2020/21 omitted due to pandemic-related data issues.

Source: Authors' analysis of DWP (2022)

WORSE HEALTH AND WORSE ECONOMIC OUTCOMES CLUSTER IN THE SAME PLACES ('THE DOUBLE INJUSTICE')

Not only does the UK have high levels of health and economic inequality, but we also find that health and economic disparities cluster in the same places. IPPR has previously termed this the 'double injustice' – or the tendency for health and economic inequality to occur concurrently.

THINKING THROUGH CAUSALITY

The relationship between poor health and economic outcomes is bidirectional. As the work of Michael Marmot and others has shown, poor economic prospects and poverty lead to worse health outcomes. But poor health outcomes limit economic opportunity and outcomes. In other words, health and economic inequality exist in and create a vicious cycle.

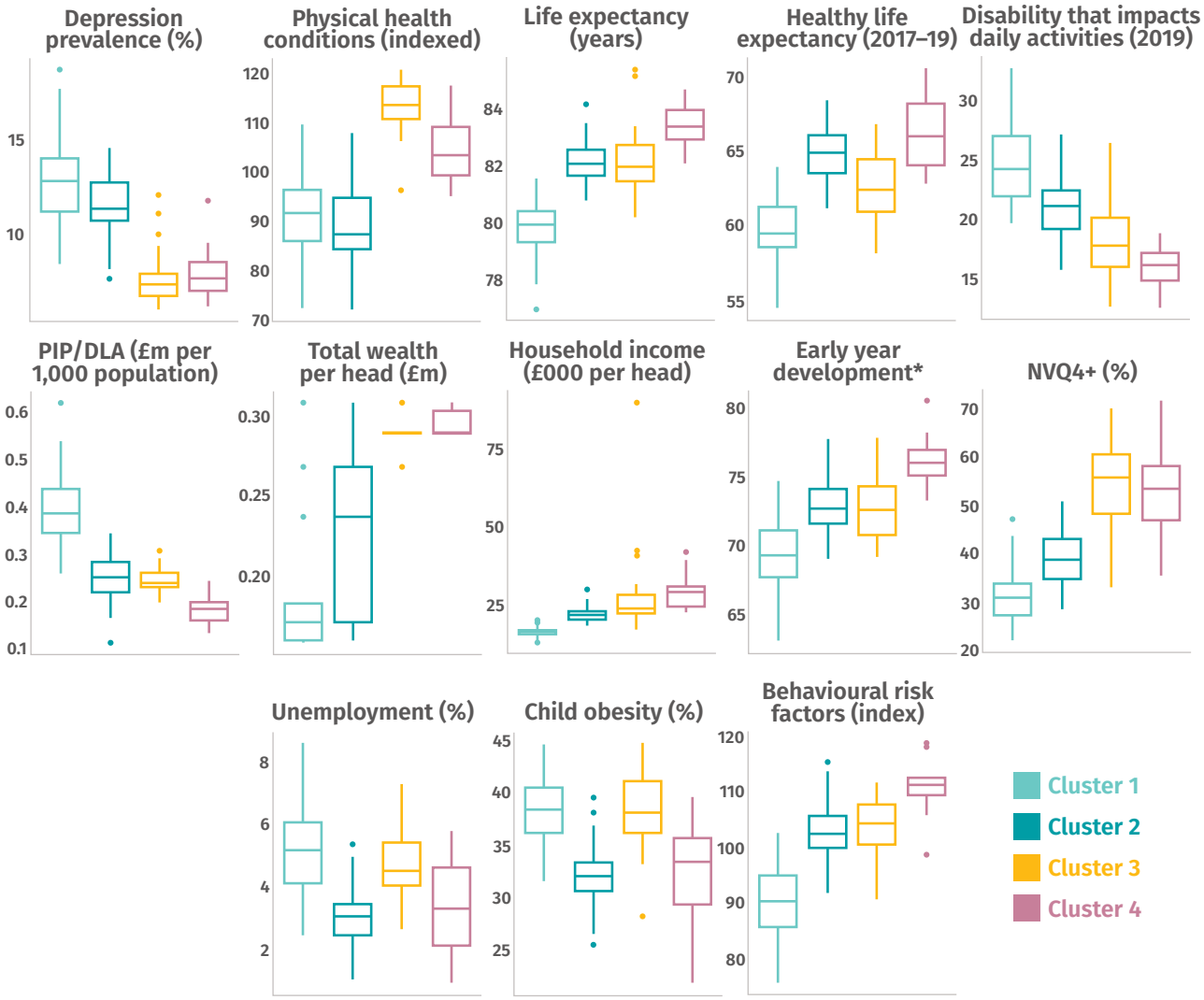
Our analysis with LCP has shown how poor health and poor economic outcomes tend to cluster in the same types of place. First, our analysis identified four types of clusters:

- Cluster 1: Northern cities and surrounding areas, Midlands cities, coastal cities
- Cluster 2: rural places
- Cluster 3: inner city London boroughs, urban Bristol and Brighton
- Cluster 4: home counties and wealthier London boroughs

This analysis shows some clear trends. Clusters 1 and 2 (and in some cases 3) had the lowest levels of life expectancy, healthy life expectancy, disability that impacts daily activities and depression. They also had high numbers in receipt of personal independence payments, lower wealth, lower household income per head, worse early years development scores and lower rates of NVQ4+ qualifications.

FIGURE 1.6: POOR HEALTH AND BAD ECONOMIC OUTCOMES CLUSTER IN THE SAME KINDS OF PLACES

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



Note: *This is defined as the percentage of five-year-olds reaching a good level of development.

Source: LCP analysis

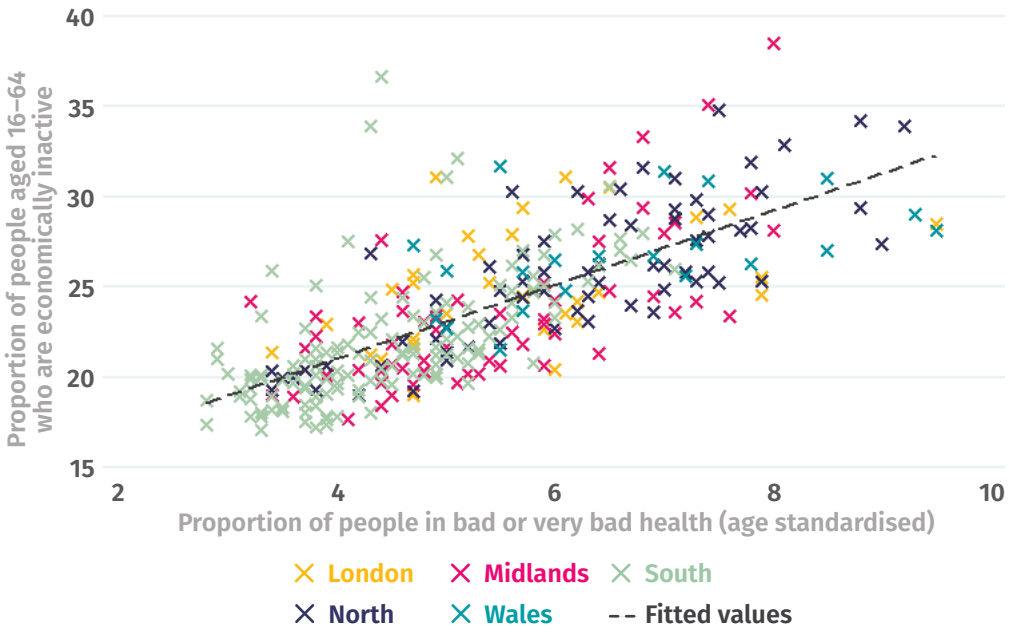
Even tackling this broad level of inequality could have a significant impact. We estimate that if health outcomes in the clusters of places with worse health outcomes were improved to the levels seen in the home counties, healthy life expectancy would increase 3.3 years, depression would reduce by three percentage points, and childhood obesity would decrease by three percentage points (for technical methodology see Thomas 2021).

There is perhaps no more topical example of the 'double injustice' than the relationship between place, health, and economic inactivity. As economic institutions like the Office for Budget Responsibility (OBR) and the Bank of England have highlighted regularly, weakness in the UK labour market – and particularly, high levels of ill health-related inactivity – is one of the most profound fiscal threats faced by the UK (eg, OBR 2023). It also illustrates how health inequalities can undermine prosperity in places.

Figure 1.7 reports on new linear regressions exploring the relationship between health and economic inactivity within local authorities. It shows that the level of this inactivity is closely correlated with the level of poor health in each place. Indeed, a one per cent increase in the number of people reporting bad or very bad health is associated with a 2.1 per cent increase in the proportion of working age people who are economically inactive.

FIGURE 1.7: POOR HEALTH PREDICTS HIGHER OVERALL ECONOMIC INACTIVITY (ALL REASONS) AT THE LOCAL AUTHORITY LEVEL

Per cent of local authority population who are in bad or very bad health activities and those of working age who are economically inactive in England and Wales.



Source: Authors' analysis of ONS (2022f, 2023b)

Table 1.1. expands on the level of inequality between places. Wales has 1.5 times the proportion of people in bad or very bad health compared to the South and 1.2 times the proportion of people who are economically inactive. This suggests that the overall challenge of high economic inactivity in the UK – and the specific challenge of economic inactivity due to sickness – has a strong relationship with place. In turn, it is likely to need local responses, as well as national policy, to fully reverse.

TABLE 1.1: THERE ARE WIDE DISPARITIES IN HEALTH AND ECONOMIC INACTIVITY

Proportion of English and Welsh population in bad or very bad health and those who are economically inactive (16–64) by region 2021 (n = 329)

	Per cent economically inactive	Per cent bad or very bad health (age standardised)
London	24.84	5.63
Midlands	23.33	5.35
North	25.62	6.16
South	21.91	4.47
Wales	26.82	6.74
Average	**23.60**	**5.28**

Note: City of London and Isles of Scilly excluded due to missing data. The North East, the North West and Yorkshire and Humber constitute the North, the East and West midlands constitutes the Midlands, the East of England, the South West and the South East constitute the South.

Source: Authors' analysis of ONS (2022f, 2023b)

We also find that the clustering of sickness and inactivity tends to be highest in more deprived parts of the country. Using Indices of Multiple Deprivation data (and therefore reducing the scope of our analysis to England, we show people living in the most deprived parts of the country are more than twice as likely to report being in poor health than people living in the most affluent – and that they are around 40 per cent more likely to report economic inactivity (for any reason). While this is a correlative rather than causal analysis, this commission has already shown a strong relationship between sickness and labour market outcomes, controlling for other confounding factors (see Thomas et al 2023).

TABLE 1.2. THERE ARE WIDE DISPARITIES IN HEALTH AND ECONOMIC INACTIVITY

Proportion of English population in bad or very bad health and those who are economically inactive (16–64) by region 2021, by deprivation quintile

IMD Quintile	Proportion Inactive (Census 2021)	Proportion in bad or very bad health
1	20.1	3.5
2	21.4	4.3
3	22.9	5.0
4	24.6	5.9
5	28.3	7.2

Note: City of London and Scilly Isles dropped due to missing data.

Source:

THIS REPORT

Based on the levels of health and economic inequality observed between places, this paper explores how the UK can create better health in the places that most need intervention. We aim to put forward a blueprint for healthier, more productive places – in support of the Commission's challenge that the UK should strive to be the healthiest country in the world over a 30-year period.

Chapter 2 describes the results of our participatory research, grounding this report in how people themselves understand health, its relationship to prosperity, and what they want for the future.

Chapter 3 outlines the building blocks for better health – exploring what can be done at the place level to support better health and greater prosperity. It outlines the most transformational case studies, both internationally and in the UK, providing a repository of examples for local leaders.

Chapter 4 explores the question: if we can identify isolated examples of transformational approaches to health inequality, why are these not being widely adopted by default in places that would benefit? To deliver on a twin aspiration to supercharge innovation and tackle health inequalities, we propose creating new Health and Prosperity Improvement Zones that would set an aspiration to deliver the foundations of healthy, prosperous places, backed by new resource, capacity and the right institutions, and that would explicitly look to work beyond government to optimise good health.

2. WHAT ARE THE PEOPLE'S PRIORITIES?

In chapter 1, we demonstrate the ways that health and economic inequality clusters within places. We now need to consider the question, is there an alternative? To address this, IPPR held a series of multi-day deliberative workshops across the country: in Lambeth, London; Salford, Greater Manchester; and Leith, Edinburgh.[6]

METHODOLOGY

IPPR ran multi-day deliberative research across the UK. We chose Leith, Lambeth and Salford because they shared some key similarities:

- Every location had a history of poverty, with continued high levels of deprivation in various parts, but was also experiencing a wave of demographic change through the new economic opportunities and developments that had been underway in recent years.
- All areas had a history of public health challenges, from food poverty to addiction.
- All local and combined authorities representing these areas were attuned to these needs and had undertaken innovative approaches to make this shift - ie, Salford's asset-based approach, Lambeth's mental health model and the Scottish government's public health strategic plans.

To ensure demographic representation, we used the most recent census data and recruited across ethnicity, income, gender and how they voted in the most recent general election (2019). We worked with a recruitment agency to ensure each group was representative of the demographic makeup of each area.

Each workshop was spread over two-day weekends within those places. The activities combined pair, small and large group activities to delve into discussions around what people enjoy about their place, what makes their place healthy and supportive of their wellbeing, and what they would change/adjust to better suit their own health needs and those of their local community.

All workshops were undertaken in three urban areas: Lambeth, Leith and Salford. As of 2022, 56.2 million people in the UK live in urban areas (Statista 2022). Therefore, urban areas present unique challenges for public health and need urban-focused policy solutions.

Each workshop featured the following sessions:

- What are the things, places, activities, that make you feel healthy and happy in your area?
- Would you like to get involved or become more involved in opportunities to make your place healthier?

6 Our choice for urban areas is explained in the methodology box.

- A creative exercise where every participant was able to cultivate and design a healthier, alternative place that would support health and wellbeing.
- Who has power over our health in your area?
- Would you like these powerful individuals/groups to use their power differently? How and why?
- What would you like them to keep doing? Why?

Each session was followed by reflection exercises to share how participants found the discussion, and to hear from other pairs and groups to identify similarities and differences in their experiences and perspectives.

IPPR designed the research around non-extractive principles. Firstly, we ensured that among researchers in the room, we guaranteed that at least one was also a resident who lived and/or worked in that area. We also ensured that all participants were renumerated for their time, and food and travel expenses were provided for all. We also used a range of participatory methods – from discussion to small group work, and highly visual methods – to cater for the whole group. Finally, we ensured the sessions were designed around participants as capable agents – with capacity to diagnose their political challenges and define solutions, in line with Hammond 2019.

Overall, our deliberative research showed that people prioritise health, have a keen understanding of what drives good health and wellbeing – including its relationship with prosperity – and want to see health prioritised by politicians, communities, large and small businesses, and other power holders and partners. This chapter outlines the common principles that sat behind that vision.

PEOPLE WANT SECURITY AND OPPORTUNITY

> ***"You had the right to buy and now it has had a knock-on effect on social housing."***
>
> Salford

Safety, security, and opportunity were expressed as the healthy foundations required to live a healthy and prosperous life. Safety was expressed as the risk of becoming victims of crime such as anti-social behaviours and violence – including, and particularly, violence against women and girls. But participants also went further and discussed home and road safety, from the standard and size of their homes to cycling lanes that make active travel safe and a healthy mode of travel for living locally.

Security referred to the types of contractual agreements people may have with the council, their landlord, employer, or even mortgage lenders. A desire for affordable housing was a consistent theme throughout our research, with the housing crisis discussed as a core barrier to blocking secure, healthy lives.

Secure lives were often seen as pivotal to people's capability to have a family and stay within their locality over an extended period. The lack of that security led to changing demographics, and many being pushed out of town to more affordable places offering more opportunities.

> ***"Because obviously now with the cost of living and the struggle to provide a visa, imagine your job security."***
>
> Leith

People expressed the quality of their jobs via their contractual agreements with their employer, their work benefits, and flexible working options that impact their health and wellbeing. It was widely understood that well-paid, secure jobs were deeply linked to a person's ability to have a joyful and secure life.

Opportunities were not simply identified as lacking but were seen as not being equally accessible to people living locally. This was expressed across the locations regarding education - ie, further and higher education and work opportunities, whether that was starting new businesses or being employed locally as the result of new jobs being created.

RELATIONSHIPS, SHARED HISTORIES AND COMMUNITY COHESION ARE KEY TO PEOPLE'S VISIONS FOR HEALTHIER, MORE PROSPEROUS PLACES

> ***"What we appreciate most is the camaraderie, the family spirit within the community. Lovely public houses and the people that are in there."***
>
> Salford

Communities expressed that they often feel left out of the key decisions made about their health. But there was also a sense of pride in place and community relationships being strong, even when excluded from high-level decisions that impact their place, health, wellbeing and quality of life. Much of what was described to us when discussing local relationships could be understood as the Community Spirit Level (CSL) (Royal Society for Public Health (2022). CSL is defined as the quality of relationships, a sense of belonging, social cohesion and collective action (ibid). There was significant value in these relationships, but they were expressed as volatile in nature due to growing wider inequalities.

Across all three locations, people identified that they had collective power which could be used when local leaders fail to respond to local needs. The following anecdote shows how this happened in Leith, Edinburgh, where the council were not responding to complaints about a contracted housing association.

> ***"The housing associations have neglected a number of their assets in the area, but these different community groups have gone to them and got the council and said you need to put pressure on those employers to fix it."***
>
> Leith

People have a clear vision of what health and prosperity mean. They have an intuitive understanding of the relationship between the two and – even in different places – a common sense of the barriers which prevent that relationship being optimised. But as this chapter shows, there is often a sense of disempowerment in achieving it. People did not feel that local authorities valued or cared about their input in democratic processes.

> ***"They don't look at us as being able to have power to say anything. They look at us like we are no one, and that they are bosses, and why should they listen to us when they already have a plan."***
>
> Lambeth

HEALTHY PLACES DEPEND ON THE SPACES AND PLACES WE LIVE, MEET, PLAY AND GROW

Spaces and places were often discussed as the heart of what constitutes the social fabric of communities. It is the place where people meet, play and socialise.

Participants expressed a view that communal places were in decline, whether because they had been closed or they had become inaccessible.[7] Yet the very relationships that people discussed were often the source of pride and identity for the place they live in, and therefore the decline of local spaces and places was a threat to the culture, heritage and identity that often makes communities unique.

> ***"My mum is from Mauritius yea, and she has a lot of Guyanese friends and people of other ethnicities and they all used to go to the bingo hall. It's quite good but a lot of them have closed like the one in Elephant and Castle and the ones they used to go to, so they don't have that community space anymore."***
>
> Lambeth

When exploring what makes a place feel healthy, many participants expressed green spaces as key, and negative feelings were more associated with the lack of upkeep, pollution, fly-tipping or lack of safety that persisted across their parks, docks and pedestrianised spaces. The repetition of the same gyms or services on every corner isn't necessarily what people want. The new spaces and places needed to reflect a shared identity of who people are and what they want their place to look and feel like.

> ***"Nowadays you see a gym on every corner, and that's good for the youth. But it's all the green spaces they've taken away now."***
>
> Salford

Having a variety of spaces and places alone was not enough without the enabling conditions to support access, affordability and comfort. Feeling safe getting to and from these spaces was as important as having a variety of options.

> ***"I'm a cyclist and I feel very unsafe, and the roads have put me off. I have seen people knocked down. The cycling infrastructure is not properly built."***
>
> Lambeth

> ***"It's not that safe in the dark for women especially."***
>
> Lambeth

PEOPLE SEE HEALTH AND PROSPERITY AS EVERYONE'S BUSINESS

> ***"It's not clear how from the lowest level of the politician, what they're doing to make sure that they've got their finger on the pulse of what's going on in their community."***
>
> Leith

Health policy has often been defined by a split between those who advocate for big state – that government should do everything, and small state – that responsibility for health should lie with individuals ('personal responsibility'). Both have had significant bearing on policy: the principles of the former are hardwired into the NHS, while the principles of the latter have defined much public health policy over the last four decades (Theis and White 2022).

7 For example, a leisure centre closing, but several high price gyms opening

But the visions outlined by participants in our deliberative research did not see good health as either the responsibility of the state or, particularly, the responsibility of individuals. Rather, they saw health and prosperity as a relationship impacted by multiple stakeholders – from schools to local leaders, to communities, to businesses big and small. And they wanted each of these actors to do more to deliver better health within places.

Participants valued public services within their community. Schools, hospitals and other services were often seen as integral to delivering health and prosperity:

> ***"Having that hospital, I wouldn't want to go to any other hospital. That's how I used to feel. What's it's like now? I don't really know, but it was amazing, so that was sort of comfort blanket in terms of your health, how you felt having that hospital on your doorstep."***
>
> Salford

Participants had less trust in politicians, local and national. They felt there was little transparency and accountability around decision making – and there was a disillusionment about the ability of the democratic process to deliver on their priorities.

Businesses were seen as integral to delivering good health: through what they produce, their employment practices, and their ability to intervene in public health directly (eg, supermarkets giving food waste to food banks). But there was also a feeling that corporate structures had too little accountability to communities themselves, and a desire for greater action and transparency from a full range of businesses.

People saw themselves and their communities as having the least amount of power. Indeed, there was a feeling that health and prosperity would require a substantial redistribution of power towards people, communities and local representatives.

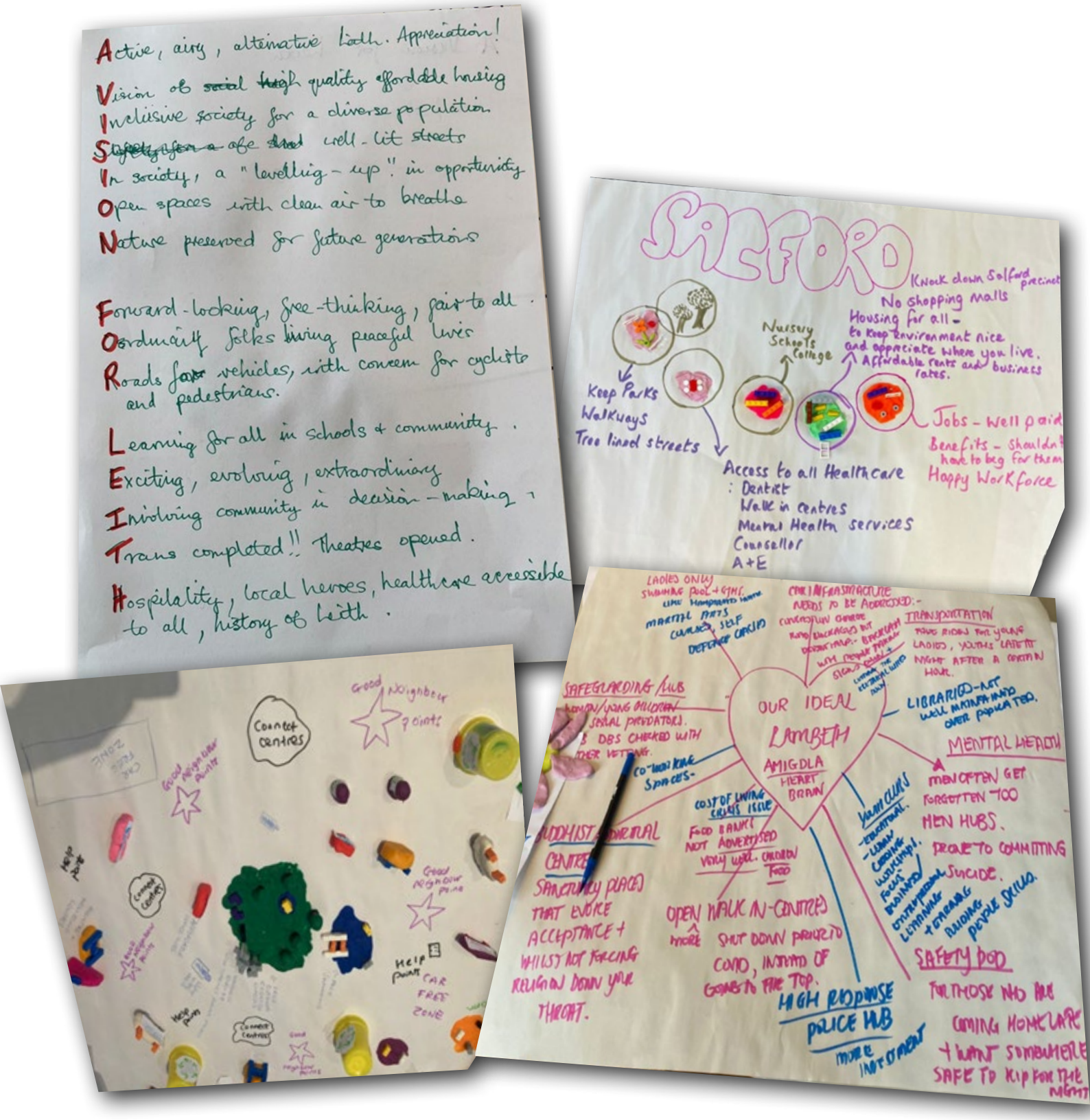
> ***"Could you get a group of just say 10 people from Leith, like a church minister, the GP, a head teacher from school and create a group of 10. Then they are given a say and more power because the danger in giving individuals power is they may have an ulterior sort of motive."***
>
> Leith

> ***"You see more activists now, people now having a political stance, or if there's a new consultation going on at that school or a new development, you see a lot of interest in that now, I never saw that before. I think people are more connected to what is happening around them."***
>
> Lambeth

Any approach to health and prosperity is likely to benefit from a collectivist approach – what we have previously called a 'whole society approach' (Hochlaf and Thomas 2020) – with people and communities in the lead.

The rest of this report explores how – guided by the priorities and themes expressed in our deliberative research – we can do better at bringing people to the forefront of place-based health interventions, ensuring local leaders are accountable to people, and that people are governed by consent with real institutional power to make decisions over their lives.

DELIBERATIVE VISIONS OF PRINCIPLES FOR HEALTHIER PLACES



3.
SEVEN FOUNDATIONS

In their belief that change is both necessary and possible, our deliberative research participants are backed by the best wider evidence. There is good reason to believe policy can support significant progress in creating healthier, more prosperous places:

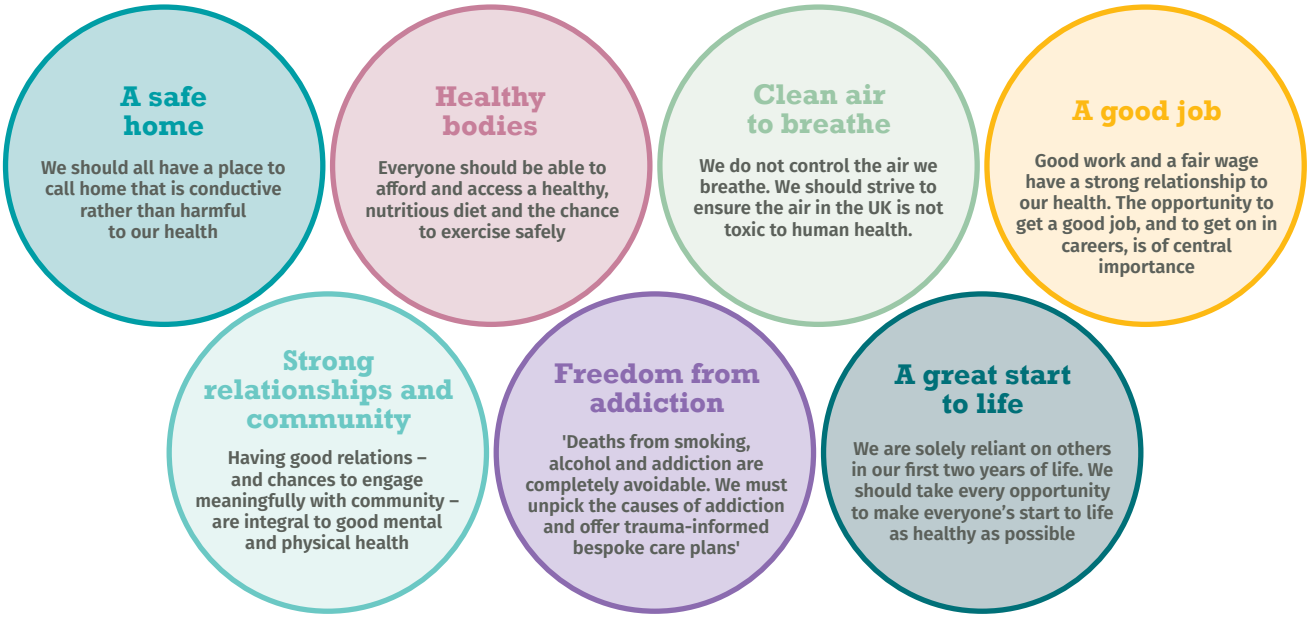
1. **International examples**: Some comparable countries have much lower levels of health inequalities than the UK. Indeed, international evidence suggests the UK has among the largest health inequalities of any advanced economy. In some cases, other countries have moved towards greater equality very quickly, such as in Germany following reunification (Bambra 2016; 2022; 2009).
2. **Domestic precedent**: The UK has managed to close health inequalities previously, albeit only with sustained and cross-government effort. Evaluation shows that the 1997-2010 health inequalities strategy is one of the few examples of a successful government approach to reducing inequalities (Barr 2017).
3. **What works evidence**: As this report has already argued, there is an extensive evidence base on what variables are causally linked to health inequalities, and what change might be needed to support healthier, more prosperous places.

To help translate that into insight that can support change, this chapter presents a new framework for action, which we call **seven foundations for seven years of extra good health** or 'Seven for Seven'.

Seven for Seven is rooted in our finding that if Disability Free Life Expectancy (DFLE) were the same in every local authority (or UK equivalent) as it is in Surrey,[8] the average local authority would gain seven years' extra DFLE (slightly more among women, slightly less among men).[9] In turn, it suggests seven core foundations that every place should be able to offer every person, in delivering the fundamentals for a healthy life – and in giving people and communities back some control over both their health and prosperity.

8 Chosen as the highest performing authority for DFLE for men and women, excluding outliers.
9 Authors' analysis of ONS (2022)

TABLE 3.1 SEVEN FOUNDATIONS FOR HEALTHY PLACES, PROSPEROUS LIVES



Source: Authors' analysis

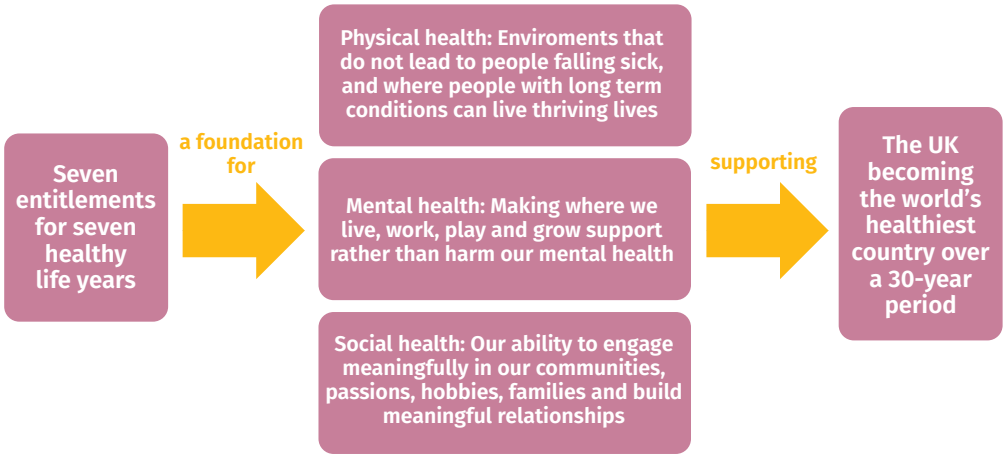
In many parts of the country – namely, healthier, more prosperous and more affluent parts – most people already benefit from each of our seven foundations. Many have access to strong social networks, secure work, and an affordable, nutritious diet. In other parts of the country, many of these things are much harder: a precarious, low paid job might put healthy food or a secure home out of reach; in turn, people might be at greater risk of material deprivation, child poverty, mental health problems, social isolation or addiction. In particular, mental health conditions can be the by-product of the worsening standards of a person's life, making them more vulnerable to substance abuse, economic inactivity and broken relationships.

Given that, it is easy to see why some people and communities feel broadly powerless over their health. Seven for Seven is a plan to put in place the fundamentals that give communities the foundations needed to exercise agency and autonomy over their lives.

There is a significant prize for getting this right. If in the first interim report of the Commission on Health and Prosperity we recommended a new mission to make the UK the world's healthiest country in 30 years, then it is worth acknowledging that if every local authority was as healthy as Wokingham, Buckinghamshire, Surrey, or Aberdeenshire – to name a few – then we would have achieved this goal.[10]

10 Based on the four-year current healthy life expectancy gap between the United Kingdom and Japan (the best performing nation).

FIGURE 3.1. SEVEN FOR SEVEN'S ASPIRATION



Source: Authors' analysis

This report makes two contributions to operationalising Seven for Seven as a policy intervention. **First, in this chapter**, we set out the evidence behind each part in our **Seven for Seven** framework. Most importantly, we provide a collection of case studies of best practice within local communities, to give local leaders inspiration and tangible ideas for implementing changes to support health and prosperity.

However, we also recognise that finding isolated examples of transformative case studies sparks the question: why isn't this happening everywhere already, automatically? That it is not indicates that places do not have the resources, capacity, accountabilities or powers they need to make change autonomously, and based on their most salient needs. Given this, it would be an oversight to simply document case studies. **The fourth and final chapter** of this report engages with what is needed to enable the spread of the most innovative, exciting public health programmes across the whole country – and to make Seven for Seven a genuinely viable concept in every city, town and community across the country.

A SAFE HOME

Focus group participants in Leith (left) and Salford (right)

THE PROBLEM WE FACE

Homelessness

There are 300,000 people experiencing 'core homelessness' in Great Britain this year (Crisis 2022). Core homelessness is higher in England than Scotland or Wales (Ibid).

People experiencing homelessness have ten times the mortality rate of wider population, and a 30-year lower life expectancy (National Institute for Health and Care Excellence 2021).

Shelter found that one in five British adults said a housing issue has negatively impacted on their mental health (Shelter 2017).

Sub-standard and expensive housing

Over 3 million occupied homes in England did not meet the decent homes standard. 2.2 million had serious hazards for damp (DHLUC 2020).

Damp, mould and poor insulation are causally linked to a range of health conditions including asthma and respiratory infections, and prevalence is higher in the most deprived areas.

17,000 people in England died in 2018 because they were unable to heat their homes (ibid), while the 2022 heatwave periods in July and August 2022 saw an excess mortality of 3,271 (ONS 2022b).

Supported and accessible housing shortages

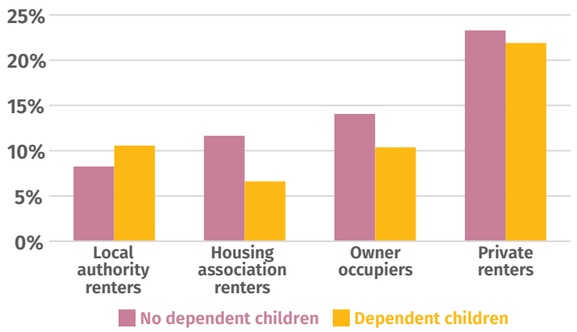
Accessible homes which enable independent living contribute savings for the NHS and social care worth over £3,000 per year.

Poor housing increases the risk of falling at home, a major source of hospital admission. Each year, 1.6 million people over 80 experience a fall at home (Housing LIN 2019).

Only 9 per cent of UK homes have accessibility features, meaning 400,000 wheelchair users in England live in homes not adapted to their needs (Each Other 2022; Equality and Human Rights Commission 2018).

FIGURE 3.2: PRIVATE RENTERS ARE MORE LIKELY TO BE IN HOUSES THAT POSE A SERIOUS AND IMMEDIATE RISK TO THEIR HEALTH AND SAFETY

Prevalence of non-decent homes by housing tenure.

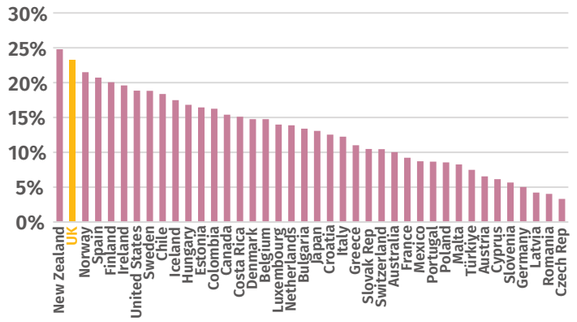


Note: A home is considered non-decent if it contains a Category 1 hazard under the HHSRS (a hazard that is a serious and immediate risk to a person's health and safety).

Source: DHLUC 2023

FIGURE 3.3: PRIVATE RENTS ARE PARTICULARLY HIGH IN THE UK

Share of private renters spending more than 40 per cent of disposable income on rent, 2020 or latest year



Source: OECD 2021

GETTING IT RIGHT

Housing First (HF): Helsinki, Finland

Housing First is simple: it gives homeless people a home. The programme has the tenth lowest rate of homelessness in Europe (Greater Change 2022).

In 2020, the Finnish Government developed a strategy to eradicate homelessness by 2027. This included house building, health and social services. The programme offers a permanent home from the start rather than a long and costly ladder of progression from shelters to temporary accommodation and on to a permanent home.

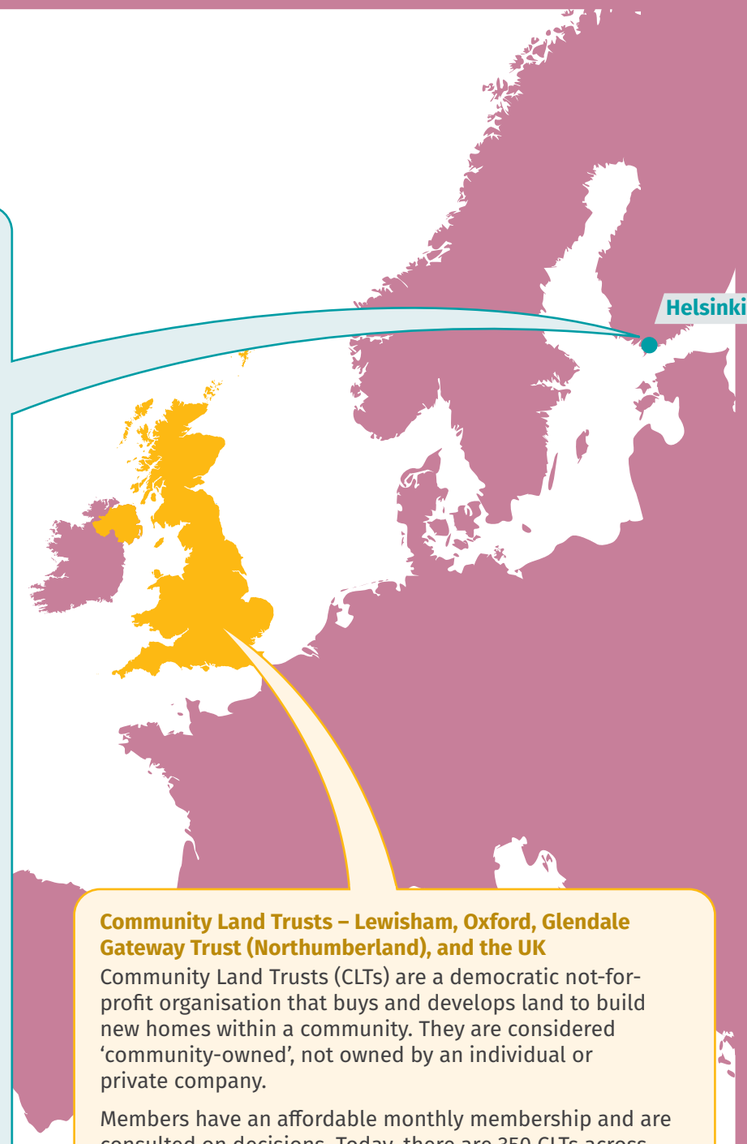
The initiative, co-created by the Y-Foundation, has provided over 3,000 units in Helsinki since 2008.

People are given a high level of autonomy and are encouraged to work towards sobriety and find employment to develop independence and consequently contribute to the local economy (World Habitat 2023).

The Housing First model has been built on previous housing policy. For example, the municipality of Helsinki owns 70 per cent of the land in the city and maintains a policy that 6,000 units must be built per year. Housing laws ensure that there is at least 25 per cent of social housing across every district (World Habitat 2023).

Mental health and physical health are key components in eradicating long-term homelessness in the city (Kirsi Raitakari and Ranta 2022).

Since 2008, there has been a 76 per cent reduction in homeless people in hostels or boarding houses (Housing First Europe no date). The HF programme has saved up to €15,000 every year per homeless person who is now in permanent housing.



Community Land Trusts – Lewisham, Oxford, Glendale Gateway Trust (Northumberland), and the UK

Community Land Trusts (CLTs) are a democratic not-for-profit organisation that buys and develops land to build new homes within a community. They are considered 'community-owned', not owned by an individual or private company.

Members have an affordable monthly membership and are consulted on decisions. Today, there are 350 CLTs across England and Wales, with a further 209 currently being explored. The sector has changed over time with most CLTs now being in large towns and cities.

There is significant market opportunity to expand CLTs which could be up to 278,000 homes built or renovated, coming into community ownership. This would increase its national value from £550 million to £47 billion. (Community Land Trust 2023). This can only happen with the use of partnerships and collaborative working between local governments and the private sector (Community Land Trusts 2023).

They have a broad social and economic value: to support communities at risk of displacement and create a shared asset among communities to ensure 'affordability in perpetuity' (New Economics Foundation 2018).

FREEDOM FROM ADDICTION

Focus group participants in Leith

THE PROBLEM WE FACE

4,860

Deaths from drug poisoning in England and Wales in 2021 (▲6.2% from 2020)

Overdose

There were 4,860 deaths from drug poisoning in England and Wales in 2021 – 6.2 per cent more than 2020 (ONS 2022c). While drug deaths in Scotland fell in 2021 (National Records of Scotland 2022), they remain among the highest in Europe (Euro news 2023).

Scotland, Wales and – to a lesser extent – England, observe much higher deaths from drug overdose than G7 peers (Global Burden of Disease 2020). Over the last decade, heroin-related deaths have more than doubled and cocaine-related deaths have grown fivefold (The Health Foundation 2022a).

▲ 27.4%

More alcohol-related deaths in 2021 compared to 2019

Alcohol

The pandemic also saw an increased demand for support with alcohol and substance related problems (Roberts et al 2021).

Since 2019, there has been a large increase in alcohol-specific mortality in England and Wales (27.4 per cent more deaths in 2021 compared to 2019) (ONS 2022d). In 2021, there were 20,970 alcohol-related deaths in England, with the highest mortality rate in the North East of England (Office for Health Improvement and Disparities 2023).

1/2

Half the difference in life expectancy between the richest and poorest people in the UK is explained by smoking

Tobacco

Smoking explains half the difference in life expectancy between the richest and poorest people in the UK (Action on Smoking and Health 2022).

Cancer Research UK analysis shows that the most deprived 10 per cent of the population in England won't be smoke free for over 27 years – 20 years behind the government target (Wedekind 2023).

500

Up to 500 deaths by suicide each year are related to gambling

Gambling

Gambling disorders increase mortality for individuals aged 20-74 years old compared to the general population, and an even higher probability increase in suicide mortality (Karlsson and Håkansson 2018).

Up to 500 deaths by suicide each year are related to gambling. The societal cost of these years lost is estimated at between £241.1 million and £961.7 million (Public Health England 2023).

Gambling can have a range of other impacts on health; people who gamble are more likely to have lower self-esteem, develop sleep disorders and have poor appetites and diets (Royal College of Psychiatrists no date).

GETTING IT RIGHT

Minimum Unit Pricing (MUP) in Scotland

In May 2018, the Scottish government used devolved powers to set the minimum price of alcohol at 50 pence per unit.

Five years on, evaluations indicate the policy had a positive impact on health outcomes. Alcohol sales in shops and supermarkets fell by 1.1 per cent but rose in England and Wales over the same period by 2.4 per cent. There was no impact on the volume of sales in pubs and restaurants.

This policy has been associated with a statistically significant reduction of 13.4 per cent in deaths wholly attributable to alcohol consumption (Wyper et al 2023).

Research by Alcohol Focus Scotland now shows widespread support for increasing the minimum unit price to 60 pence (Alcohol Focus 2021) – with other research showing the higher rate would likely be even more effective (Alcohol Focus 2021b).

Evaluations have also indicated that MUP has not harmed the economic performance of the alcoholic drinks industry in Scotland, which has reacted to the regulation through product reformulation and investment in new categories (eg, 'low and no' alcoholic beverages).

Overdose prevention centres (Drug consumption rooms) (Across Europe, highest number in the Netherlands, Germany and Switzerland and mostly recently, Glasgow)

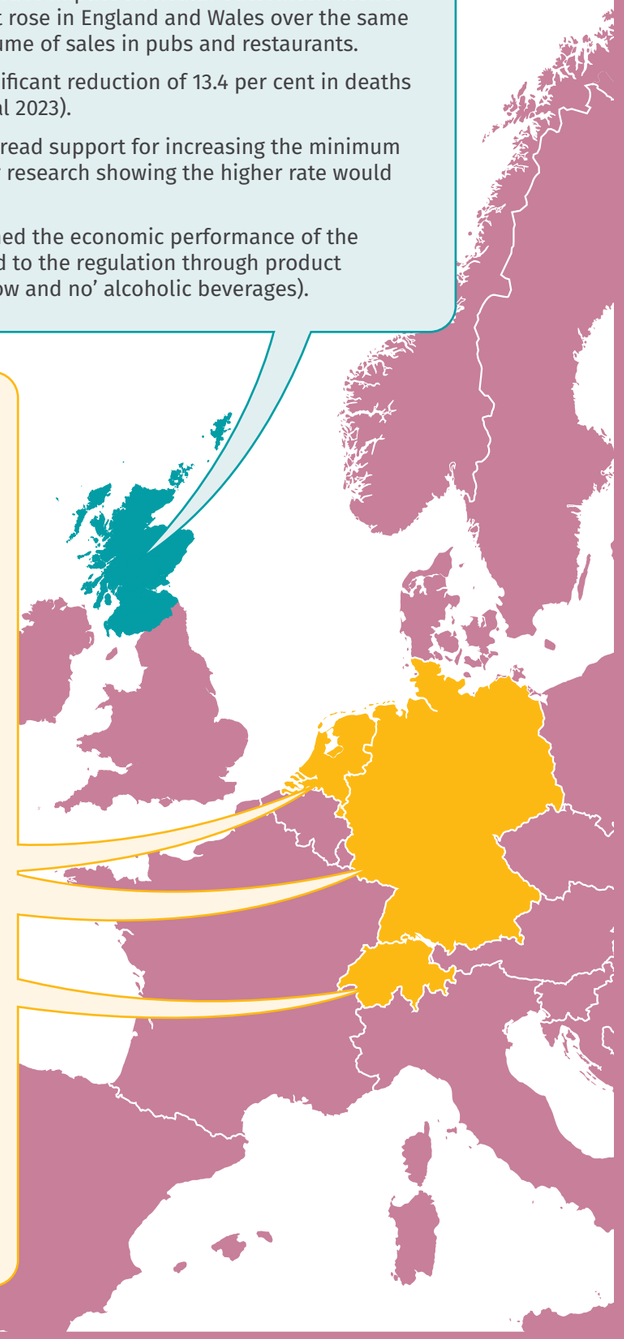
Drug consumption centres are harm reduction centres providing safe controlled environments for consumption, while ensuring monitoring to prevent overdose. These rooms are for those at very heightened levels of drug addiction, where trained professionals can intervene and offer medical support in the case of an overdose.

The success of these centres cannot be determined solely by a fixed study as they require community support and further care for people struggling with substance abuse.

This service has been introduced on a global scale, across 14 countries, with around 130 sites (Holland et al 2022). Drug consumption rooms in Denmark have supported a reduction in stigmatisation, and this preventative approach opens the path for discussions on treatment and referrals to clinics and social services (Kappel Toth and Tegner et al 2016).

In neighbourhoods with high rates of overdose, these centres have been proved to reduce the number of people dying as well as the number of dangerous drug consumption behaviours such as the use of unclean and broken needles (Holland et al 2022).

Recent studies have shown that businesses and residents have reported less public drug use after the introduction of these rooms (Tran Reid Roxburgh and Day 2021).



STRONG RELATIONSHIPS AND COMMUNITIES

Focus group participants in Leith (left) and Salford (right)

THE CHALLENGE

Loneliness and social isolation are impacting the most vulnerable

The UK experienced a sharp increase in social isolation during the pandemic and we are still living with the aftermath of many local spaces and businesses closing or struggling to function. By February 2021, around 3.7 million adults were socially isolated (Mental Health Foundation 2022).

People aged 16-29 are more than twice as likely to report loneliness than those over the age of 70 (Campaign to End Loneliness 2023).

However, those who draw on social care also experience particularly heightened loneliness – most notably people living in care homes (NIHR 2022).

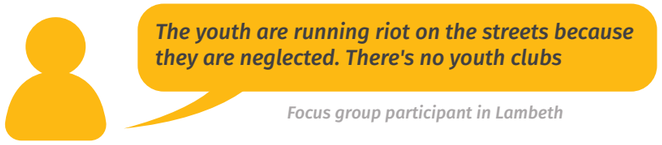
Third spaces and community infrastructure are disappearing

Youth funding has been cut by 70 per cent in the last decade, and informal spaces away from home and school are scarce (YMCA 2020).

In 2019 The UK Civil Society Almanac found that in England, the voluntary sector consisted of 166,854 voluntary organisations, and that although 83 per cent of them had incomes less than £100,000, nine in 10 UK households have accessed a service delivered by one of them.

IPPR has recently shown that young people in wealthier areas are more likely to have extracurricular activities and have a wider curriculum within school (Quilter Pinner et al 2023).

IPPR North estimates that £15 billion worth of local assets have been sold since 2010, including public land, community centres, libraries and swimming pools.



Focus group participant in Lambeth

People feel more disconnected from others and from their community

Despite research showing that social connection to friends, family and community supports health (see text box), people feel more disconnected from others in the 21st century (see Mental Health Foundation 2022).

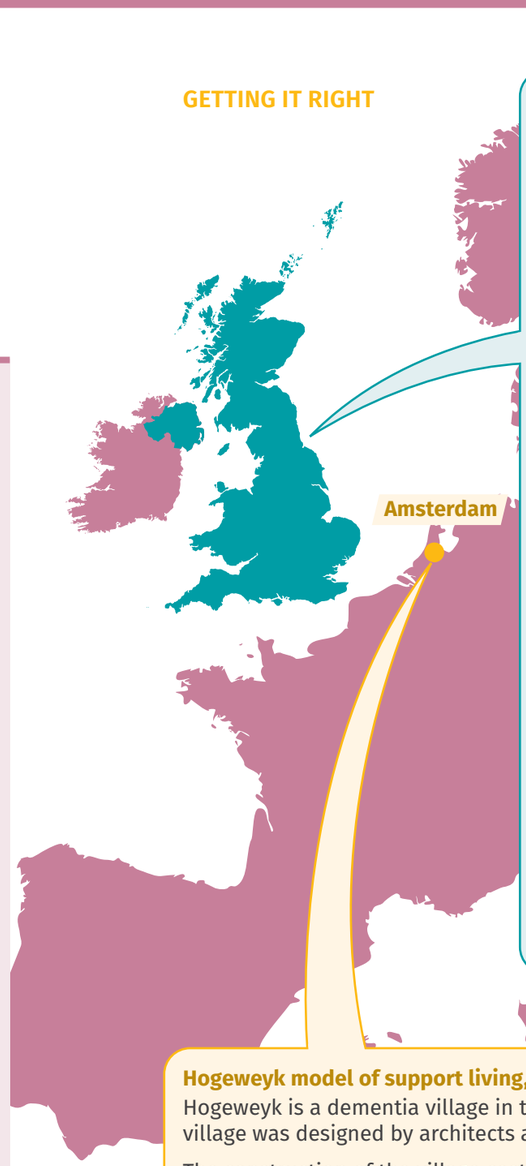
The transition of social engagement and community groups online, notably through social media, has been shown to heighten the experience of weakening friendships, ostracism and heightened loneliness for some (Ryan et al 2017).

HOW DO RELATIONSHIPS AND COMMUNITY RELATE TO HEALTH?

Relationships and community are among the most powerful – and understated – drivers of health through the life course. Studies show:

- Relationships – both number and quality – have been linked with better health outcomes. Strong relationships with parents, spouses, parents, adult children and siblings each have a notable evidence base (Thomas et al 2017).
- Strong community spirit has been linked to better health outcomes. Indeed, strong community has been found to have a protective effect on the impact of poverty and other social disadvantage on health (The Health Foundation 2022b).
- Trade union membership has been linked with reducing mortality when compared to non-union groups (Eisenberg-Guyot 2021).
- Church membership and attendance has been associated with lower stress and lower mortality. Churchgoing has been associated with longevity gains of four years in average in United States studies (Wallace et al 2018).

GETTING IT RIGHT



Mutual aid, Covid-19 pandemic (UK wide)

During the onset of the 2020 Covid-19 pandemic, mutual aid groups were created up and down the country to support people living with additional needs who had to self-isolate due to the heightened clinical risk to their health.

A study was undertaken among 32 organisers of these mutual aid groups, which found several shared factors that not only supported people in their communities, but also proved to be an integral part of strengthening government strategy in tackling the pandemic. For example, mutual aid groups offered to do everyday tasks such as grocery shopping and collecting prescriptions, but also offered translation services, and provided information, advice and emotional support helplines (Fernandes-Jesus 2021).

Covid-19 groups were able to sustain their collective action over time, which may have had positive impacts on their health and wellbeing during the pandemic. There is significant evidence to show the health benefits of volunteering. The value of the VCSE (voluntary, community or social enterprise) sector is important to our economy, with volunteering valued at £23.9 billion (NCVO 2019). Volunteering can create community resilience, create a shared identity and pride around the purpose of volunteers' work, and support the building of new relationships in times of crisis and difficulty. Mutual aid, which often took place in lower socio-economic areas, was able to disrupt and mitigate the disproportionate impact the pandemic was having on these communities.

One of the key findings that determined the success of mutual aid groups was the sustained localised approach, meaning that different groups in smaller local communities were a far more effective mechanism than a much larger scale programme of volunteering. This is because pre-existing charities and foodbanks operating locally had already built relationships with people, understood the local area, and knew how to access funding or additional support from local councils.

Hogeweyk model of support living, near Amsterdam, Netherlands

Hogeweyk is a dementia village in the Netherlands which opened in 2009 across four acres of land. The village was designed by architects and houses elderly people living with the disease (Haeusermann 2017).

The construction of the village cost up to €20 million and was mostly subsidised by the Dutch government. The cost of living in the village can be up to €8,000 per month, but residents are covered by the Dutch government (Dementia Village Associates no date).

The village has all amenities locally, such as a theatre, pubs and restaurants. A key component of this work is prevention and inclusion, incorporating care and consideration into the living environment.

Studies of the village show that residents tend to take fewer medications and live for far longer than most people living with dementia. Since 2009, more dementia villages have opened across Europe, such as those in Rome and Berlin (ibid).

Hogeweyk's model has been associated with a range of positive outcomes: reduced ambulance use, fewer falls, fewer police attendances (Vinick 2019), increased functioning, and reduced need for medication (Pedro et al 2020).

A HEALTHY BODY

Focus group participants in Salford

THE PROBLEM WE FACE

Food poverty undermines our health

Reflecting the recent rise in food insecurity, The Trussell Trust reported the 'highest recorded number of three-day emergency food parcels' in 2022/23 (Trussell Trust 2023), and 7 per cent of people (4.7 million) lived in food insecure homes as of 2021/22 (DWP 2022).

Food insecurity is linked to multiple, negative impacts on health and wellbeing – including malnutrition, dietary conditions, Type 2 Diabetes and obesity.

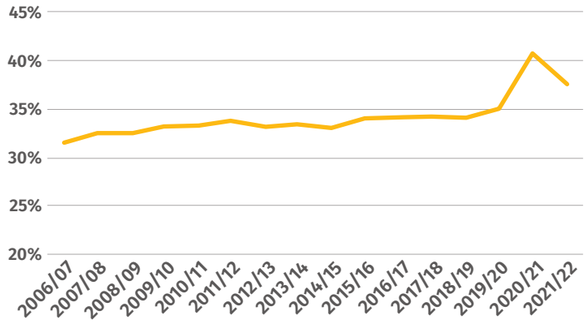
Hunger and obesity are parallel epidemics

Food insecurity is about what we eat, as much as it is about how much we eat. Too many people do not have access to a healthy diet. Healthier foods are nearly three times more expensive, calorie for calorie, than less healthy foods (The Food Foundation 2022).

Obesity levels are high and have risen substantially since the pandemic and it was recorded for the first time and uptick in obesity across every deprivation decile (The Kings Fund 2022).

22 per cent of children growing up in Richmond have overweight or obesity, compared to 44.7 per cent in Barking and Dagenham.

FIGURE 3.1: THERE WAS A SHARP RISE IN OBESITY FOLLOWING THE PANDEMIC



Source: Authors' analysis of NHS Digital 2023

Physical activity and exercise is not accessible for everyone

Physical activity is strongly correlated with obesity levels and can in some cases be a preferred route to decrease disease symptoms than prescribed medicine (Nimero et al 2023).

The number of physically active children fell by 1.5 per cent during the Covid-19 pandemic (Sports England 2021).

Poor health in low-income households is also linked to a low take-up in exercise and poorer children are less active than their wealthier peers (Power 2014).

There is less infrastructure and means for people with a health condition to exercise – with one study showing people with poor physical health were active an hour less – and people with poor mental health 2.5 hours less than those in good health (Barker at al 2019). Prevalence of both major conditions and multiple conditions are projected to rise sharply in the next two decades (Health Foundation 2023).

Physical infrastructure such as access to green spaces, cycle lanes and safety can encourage or dissuade people from being physically active (Kings Fund 2021).

THE PATH FORWARD

Tackling obesity in Amsterdam, the Netherlands and Leeds, England

Amsterdam is seen as a pioneer in addressing childhood obesity. In the 2010s, Amsterdam's new obesity policy targeted the drivers of childhood obesity through a three-pronged approach (Seidell and Halberstadt 2020).

- **Prevention**
- **Cure**
- **Facilitation**

The city reported a 12 per cent drop in childhood overweight and obesity three years after the programme launched (Sheldon 2018).

The embodiment of similar principles in Leeds, England, has also had striking results. In 2018, Leeds was first Yorkshire city to adopt a healthy weight declaration. As in Amsterdam, the programme focuses broadly on nutrition, sleep, and parenting.

Between 2018/19 and 2021/22, levels of obesity and overweight among year 6 children in the city dropped a percentage point, bucking a wider national trend of increasing prevalence. In both Leeds and Amsterdam, the benefits of policies to tackle obesity have been higher in more deprived parts of the cities (Leeds City Council 2021).

Universal free school meals (UFSM), London

In 2023, Mayor of London guaranteed that all children of primary school age would be given free school meals (FSM) across state schools in the capital. The policy removes the measuring of 'eligibility' for those children in families on low-income and/or on universal credit, to reach a wider set of families impacted by cost of living.

- The introduction of FSM for the 2023/24 school year is predicted to save families up to £440 per child across 190 school days.

Previous analysis has shown that UFSM and FSM have a significant impact on fiscal savings. Plus, benefits for children such as reduced absenteeism, educational attainment such as personal, social and emotional development and less childhood obesity (Institute for Social & Economic Research 2020).

A cost-benefit analysis of UFSM by Impact on Urban Health found:

- A £41.3bn total discounted core benefit for all pupils in state-funded schools between 2025-2045.
- Every £1 invested is estimated to bring £1.71 in the core benefits (Impact on Urban Health 2022).

Creating local healthy short food supply chains in Montpellier, France

In 2015 an agroecology and food policy was voted in by Montpellier Méditerranée Métropole in France (Michel and Toussaint-Soulard 2019). The new policy underpinned priorities for tackling food insecurity within the region, including the following.

- Support for small-scale farmers, through a new 'resource farm' and sales guide.
- Awareness building among residents to build demand for sustainable local food.
- Subsidised healthy, school meals, with 70 per cent of households paying under 2 euros for lunch in a school canteen.

The approach led to a 24 per cent reduction in food waste across the region, created more demand for healthy produce, contributed to wider climate goals and created 2 million affordable meals (ibid).

CLEAN AIR

Focus group participants in Salford (left) and Lambeth (right)

THE PROBLEM WE FACE

Toxic air kills tens of thousands in the UK each year

99 per cent of people in Britain breath air that is classified as 'unsafe for human health' (Asthma and Lung UK 2023).

Underneath this, there are significant inequalities in exposure to air pollution. A University of York study recently demonstrated that air pollution was much higher on average in more deprived parts of the country (The University of York 2023).

Official estimates put the annual mortality associated with human-made air pollution at between 28,000 and 36,000 per year (Public Health England 2019) – while other evidence estimates 43,000 premature deaths from toxic air per year (UK Health Security Agency 2022).

As well as the impact of toxic air on lung health, it can also cause cancer, heart disease and dementia (WHO 2023). The British Heart Foundation estimates that there are 11,000 heart and circulatory disease deaths per year caused by air pollution (Blake 2020).

We remain reliant on the most polluting forms of transport

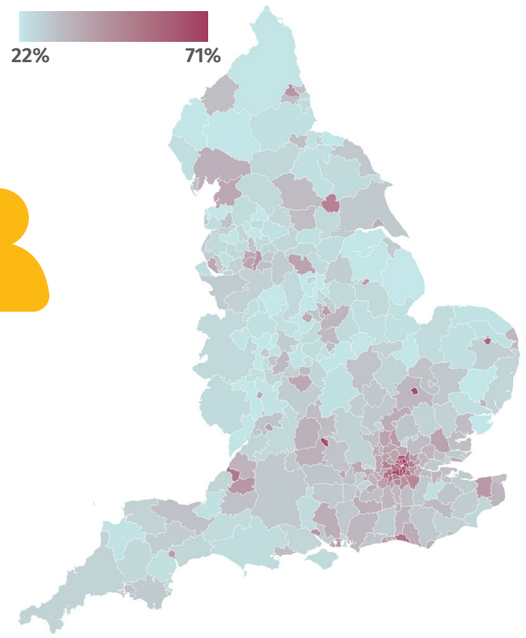
Our deliberative research showed consensus around a desire for better, less polluting forms of transport but there is a lack of infrastructure for active travel, which dissuades people from using it due to causing concerns about safety.

Focus group participant in Salford

Estimates suggest switching car journeys to other forms of public road transport could cut emissions significantly: one study found that if one in every 25 car journeys were switched to bus journeys, it would save two million tonnes of CO2 per year (London Travelwatch 2021). While reduced CO2 emissions are not directly linked to health per se, they are a co-benefit of improving quality, and have significant benefits for tackling climate change.

The World Health Organisation concludes that active travel is possible for all journeys of 16km or less. These are responsible for 40 per cent of all vehicle emissions (WHO 2022). Active commuting, on the other hand, is associated with a 10 per cent decrease in the risk of cardiovascular disease and a 30 per cent decrease in type 2 diabetes risk. Cancer-related mortality is 30 per cent lower among bike commuters.

FIGURE 3.5: THE PROPORTION OF PEOPLE WALKING OR CYCLING FOR TRAVEL BY COUNCIL AREA 2021



Note: 'Travel' refers to cycling or walking (for at least 10 mins) to get from place to place - for example, commuting, visiting a friend or going to the supermarket.

Source: Sport England 2023

ACTIVE TRAVEL IN ENGLAND

There are wide disparities in the use of active transport in England to get to work. Figure 3.5 shows the proportion of people cycling or walking for travel (as opposed to leisure) in 2021.

We see a large variation in the usage of active travel across the UK. A few urban areas stand out for the prevalence of active travel, including London, Oxford and Cambridge, but many urban areas have very little usage.

THE PATH FORWARD

Active travel in The Netherlands

The Netherlands is a global trailblazer when it comes to active travel, particularly cycling. A 2015 study used the Health Economic Assessment Tool to explore the economic and health benefits cycling has created among the Dutch population. It was found that cycling prevents around 6,500 deaths a year, and life expectancy has increased by around six months among cyclists (Fishman et al 2015).

This policy is impactful due to the infrastructural investment in cycling lanes, and road-safety measures that mean cycling is an attractive and affordable mode of travel for most people in the country (ibid).

These health benefits have been linked to more than three per cent of The Netherlands GDP. Indeed, there are high returns on investment, with one study linking a €0.5 billion investment in cycling infrastructure to nearly €19 billion in wider returns (ibid).

London's ultra-low emissions zone (ULEZ)

In May 2019, the Mayor of London introduced restrictions on high emissions vehicles within a specified area of central London. Early analysis found that this generated significant improvements in air quality, with road transport nitrogen oxides emissions reduced by 35 per cent. Nitrogen dioxide levels are 46 per cent lower in central London and 21 per cent lower in inner London compared with estimated levels without the scheme being in place (Mayor of London 2023a).

A 2020 report found that the ULEZ expansion will save the NHS around £5 billion in the next 30 years, with almost 300,000 fewer Londoners suffering from diseases related to air pollution such as heart disease, lung cancer and dementia (Mayor of London 2023b).

In 2023 the zone expanded again to include all London boroughs. Initially, only the lowest income households could access support to purchase a cleaner vehicle, but the scheme is now available to all Londoners, with additional support for disabled people, along with small businesses and charities (Transport for London 2023).

Much of the effort to expand the low emissions zone is supported by research undertaken by experts at Imperial College, who identified a decline in hospital admissions since its introduction (Chamberlain 2023).

A GOOD JOB

> *Have they [council] made any kind of commitment to training local people, hiring local people? Because obviously now with the cost of living and the struggle to provide a visa, imagine your job security*
>
> *Focus group participant in Leith*

THE PROBLEM WE FACE

Health and unemployment have a bidirectional relationship

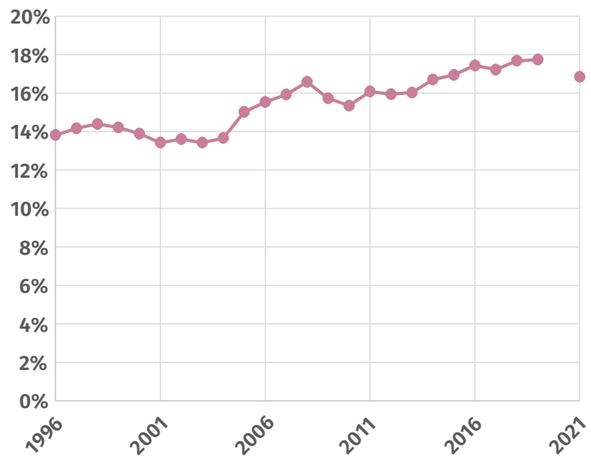
The Whitehall studies showed that having a good job had a significant benefit for wellbeing, and reduced premature mortality (see Marmot et al 1991).

Those in employment have considerably better mental and physical health outcomes than the unemployed (Murphy and Athanasou 1999; Marmot 2005). While unemployment is low by historical standards in the UK, it varies significantly between places.

Poor health, in turn, can undermine job prospects. The first interim report of the Commission on Health and Prosperity found that the onset of sickness not only increased the risk of someone leaving employment, but it also significantly reduced the likelihood of someone already outside the labour market finding employment (Thomas et al 2023).

FIGURE 3.6. AMONG THOSE LIVING IN WORKING HOUSEHOLDS, THE LIKELIHOOD OF BEING IN POVERTY HAS INCREASED

In-work relative poverty after housing costs, percentage, 1996–2021



Source: IPPR analysis of DWP 2022. Data is not available in 2020/21 due to pandemic-related data issues

Poor quality jobs can be just as harmful as having no job at all

While employment tends to lead to better health outcomes, the relationship between work and health is complicated. A low-quality job is just as, if not more, detrimental to health than having no job at all.

Research by the Health Foundation has found that moving from unemployment into low-quality or inappropriate work can significantly worsen mental health outcomes (The Health Foundation 2021).

Other links to worse health outcomes include poor occupational health or workplace hazards, high stress, higher risk of cardiovascular disease and greater rates of premature mortality (Kim and von dem Knesebeck 2016; Chandola and Zhang 2018).

Over one in three employees report being in a low-quality job (The Health Foundation 2020), but rates of low-quality work vary significantly from place to place (see table 3.2).

Work no longer offers a reliable route out of poverty

Poverty remains the central driver of poor health. The healthy life expectancy gap between the most and least deprived parts of the UK is 19 years (The Health Foundation 2018).

As of 2022, 68 per cent of working-age adults in poverty are living in a household where at least one adult is in work (Joseph Rowntree Foundation 2022). 17 per cent of working households are in poverty and even in homes where two people are in full-time work, the risk of falling into poverty has more than doubled in the last 20 years (from 1.4 to 3.9 per cent) (McNeil and Parkes et al 2021).

In-work poverty varies substantially by place. IPPR analysis shows that the highest levels are found in London, Wales, and the North of England (ibid).

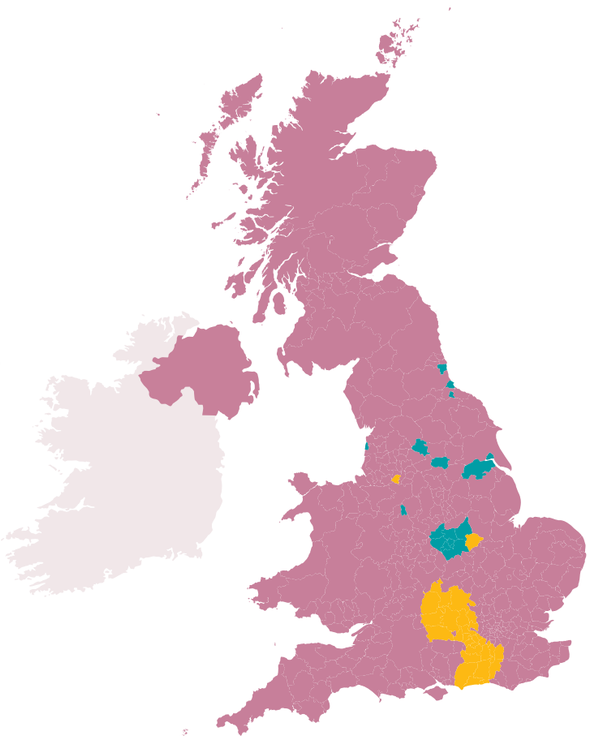
THE PATH FORWARD

Clyde Gateway project, Glasgow and Lanarkshire Scotland

The Clyde Gateway project in the East End of Glasgow and South Lanarkshire is Scotland's largest regeneration project. The project is set to conclude in 2028 with a mission to tackle health and employment challenges that had been a growing problem in this area (What Works Scotland 2018).

The project restored 240 hectares of vacant and contaminated land, and built in new infrastructure, factories and community assets such as the Emirates Arena and Velodrome, the Athletes' Village and Cuningar Loop Woodland Park (Clyde Gateway 2018).

As of 2018, 5,500 jobs have been brought to the area and 2,700 homes have been constructed, with thousands more homes having been refurbished (ibid).



Good and fair work charters – Mayoral Combined Authorities (England)

Five of the 10 MCAs in England have launched region-wide charters on Good and Fair work, to set common standards of decent and fair employment across the country (University of Warwick 2022).

These charters have been deemed successful in their nature to be able to respond to local needs, remain strong across political parties, and therefore stay in place despite a change in leadership. This is largely credited to the local consultation undertaken to determine good and fair work in their respective regions.

For example, the West Yorkshire Combined Authority's Fair Work Charter launched in Autumn 2023 has outlined that it has built on the charters that can support a growing economy across the north of England, taking inspiration from cities such as Liverpool and Manchester (West Yorkshire Combined Authority 2023).

Charters which have more broadly been considered successful have made engagement simple and straightforward, ensuring that accreditation is easy, and co-designed and developed to be accessible. Growing evidence suggests that these charters have supported workers and helped businesses to grow their employee base (University of Warwick 2022).

TABLE 3.2. JOB QUALITY IS LOWER IN PLACES WITH WORSE HEALTH AND HIGHER LEVELS OF DEPRIVATION

Job quality, health and deprivation for select local authorities

Least deprived			Most deprived		
Local authority	Good work monitor score (job quality)	Healthy life expectancy (birth)	Local authority	Good work monitor score (job quality)	Healthy life expectancy (birth)
Wokingham	502	70.63	Sunderland	180.7	57.4
Windsor and Maidenhead	497.4	70.04	Wakefield	179.9	58.7
Oxfordshire	490.5	68.46	Bradford	175.5	61
Trafford	466.4	65.3	Blackpool	174.3	54.51
Bracknell Forest	464.3	67	Leicestershire	169.8	63.6
Surrey	448	68.31	North Lincolnshire	168.1	59.3
West Berkshire	444.1	67.2	Middlesborough	148.4	58.5
West Sussex	431	65.4	Kingston-Upon-Hull	130.7	58
Buckinghamshire	426.7	67.8	Hartlepool	130.4	57.21
Rutland	425.6	67.3	Stoke-on-Trent	123.4	56.68

Note: Higher work monitor scores indicate higher quality of work on average. The score is a composite variable, taking into account access to, and participation in, work; status and autonomy of jobs; and pay and working conditions.

Sources: Author's analysis of ONS (2022a) and Institute for the Future of Work (2023)

A GREAT START TO LIFE

In Croydon, they've opened a new youth club on Whitehorse Road, and it is fantastic as they [young people] are off the streets. They have times for special needs children. This is what Lambeth needs. They can have a meal or breakfast just for £1

Focus group participant in Lambeth

THE PROBLEM WE FACE

Pregnancy defines health through the course of life

Poor mental health and stress during pregnancy has been linked to higher levels of cortisol and a number of maternal problems such as lower birth weight and higher cognitive processing problems (Shriyan 2023).

Poverty presents clinical risks to children – babies born into poverty are more likely to be born early and underweight, which could have future impacts on their life (Dyson et al 2009).

The first three years of life are critical

Evidence shows that children who spend more time in early years provision have better educational outcomes (Ofsted 2023).

The first 1,001 days of a baby's life are critical for brain development. Where babies may fall behind in development in these early stages, these trends can continue and worsen throughout their lives (Parent-Infant Foundation 2013).

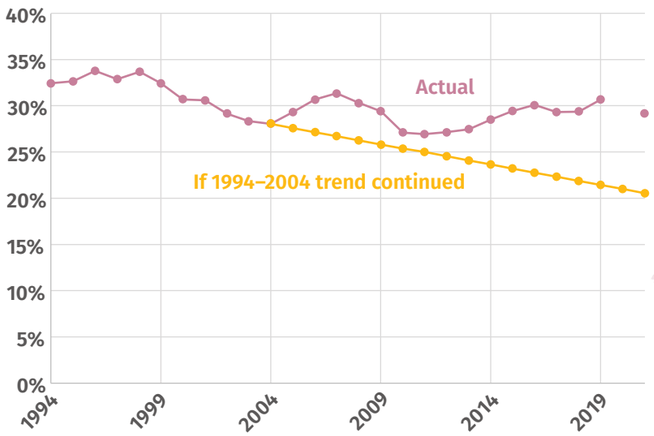
Detrimental and traumatic circumstances during early years can have serious lifelong consequences across child development and capital accumulation (Currie et al 2020).

There should be a place for carers, if you're a carer with autistic children, a place where people can go, and they can have a chat with other people

Focus group participant in Lambeth

FIGURE 3.7: CHILD POVERTY RATES FROM FLATLINED SINCE 2004, THEY ARE 10 PER CENT HIGHER THAN IF THE TREND CONTINUED FROM 2004

Child poverty rates from 1994 to 2021, and outrun versus had 1997–2004 trend continued (%)



Source: Parkes et al (2023)

Support for families and wrap-around care is limited in the UK

As of 2021/22, 4.2 million children are living in poverty in the UK, which is 29 per cent of children, or nine in a classroom of 30 (DWP 2023). This is particularly high when looking at lone-parent households, where 44 per cent of children are living in poverty (DWP 2023).

Larger families face acute challenges, with 42 per cent of children living in families with three or more children living in poverty (DWP 2023).

There are increased risks to health problems such as behavioural problems and wider interpersonal and development issues due to being born in and experiencing child poverty and deprivation (Le Menestrel and Duncan 2019).

IPPR analysis shows that we have made strides in reducing child poverty in the UK, but since 2004 this progress has not been sustained and there have been peaks and troughs.

As of today, child poverty is almost 10 per cent higher than it would have been had we continued the downwards trajectory prior to 2004 (Parkes et al 2023).

THE PATH FORWARD

Coventry 'Marmot City', England

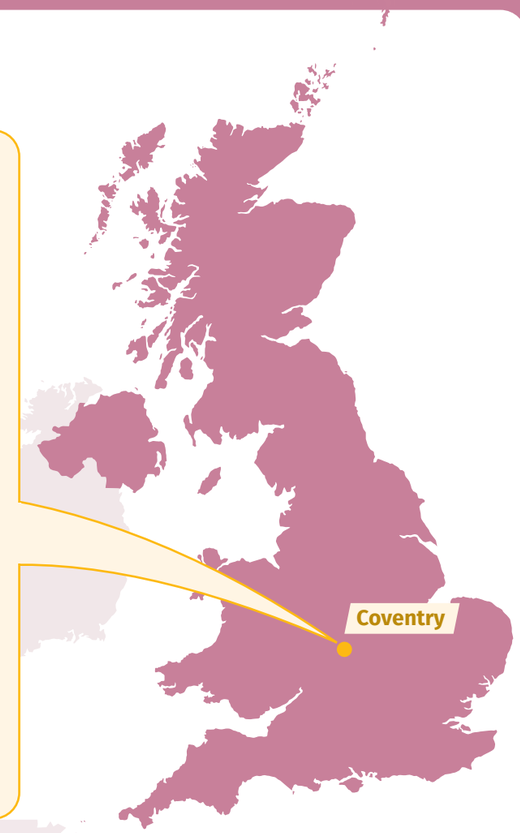
Coventry City council became a Marmot city in 2013 as part of its commitment to make progress across health and outcomes in every part of residents' lives (Institute of Health Equity 2020).

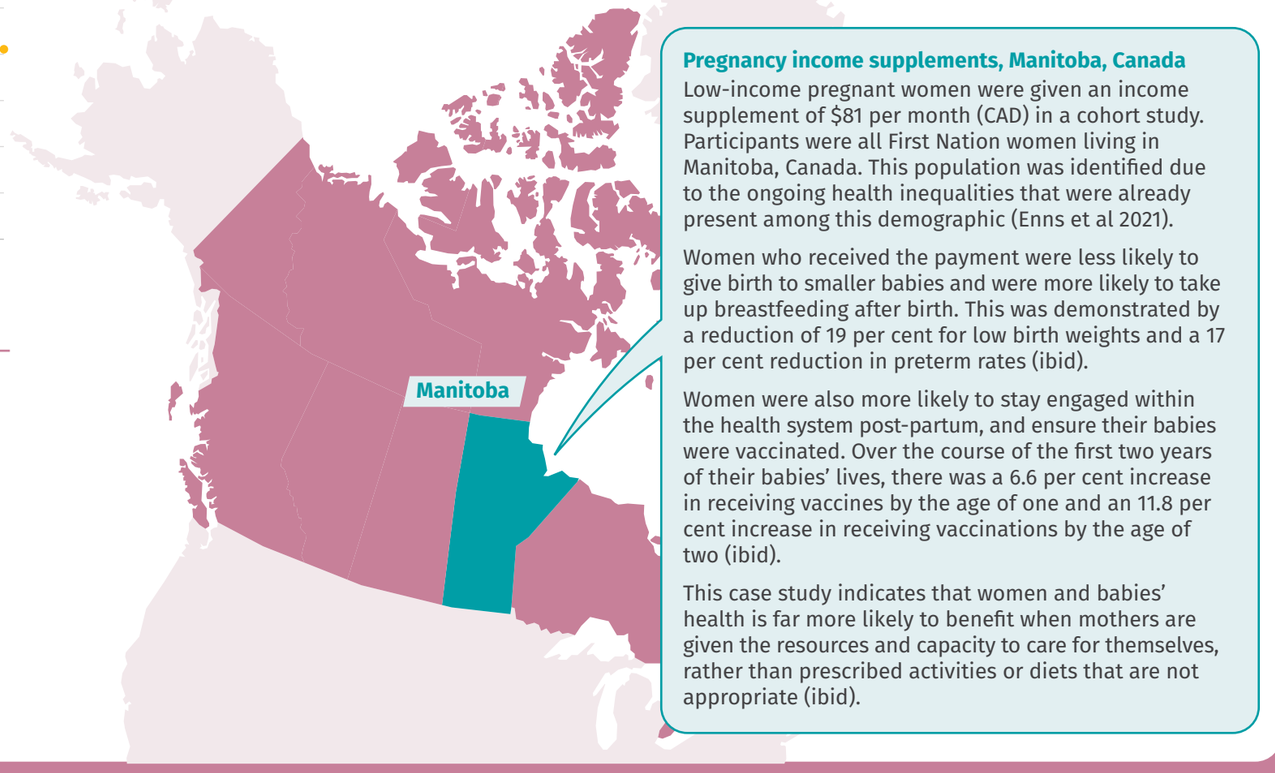
Since 2013, Coventry City Council has opened eight new family centres, available to families with children aged 0-19. The family hubs provide wrap-around support and develop a single plan for each family who use their service. The hubs are accessible to all but are intentionally located in more deprived areas of the city (ibid).

Other interventions included: improving green spaces, creating good jobs (many of which had been lost to previous family centre closures in 2018), and addressing fuel poverty.

The implementation highlighted the importance of cross-sectoral working, as many of the third sector and wider public services had an established understanding of the 'social determinants' of health. This initiative was found to have improved partnership working.

The most recent Indices of Multiple Deprivation showed that there had been a reduction in the number of deprived neighbourhoods (LSOAs) relative to other local authorities, as well as a reduction in life expectancy inequality (Ibid).





Pregnancy income supplements, Manitoba, Canada

Low-income pregnant women were given an income supplement of $81 per month (CAD) in a cohort study. Participants were all First Nation women living in Manitoba, Canada. This population was identified due to the ongoing health inequalities that were already present among this demographic (Enns et al 2021).

Women who received the payment were less likely to give birth to smaller babies and were more likely to take up breastfeeding after birth. This was demonstrated by a reduction of 19 per cent for low birth weights and a 17 per cent reduction in preterm rates (ibid).

Women were also more likely to stay engaged within the health system post-partum, and ensure their babies were vaccinated. Over the course of the first two years of their babies' lives, there was a 6.6 per cent increase in receiving vaccines by the age of one and an 11.8 per cent increase in receiving vaccinations by the age of two (ibid).

This case study indicates that women and babies' health is far more likely to benefit when mothers are given the resources and capacity to care for themselves, rather than prescribed activities or diets that are not appropriate (ibid).

4. HEALTHY, PROSPEROUS PLACES

The final chapter of this report explores why, if we can identify excellent local public health innovations, they are not spreading across the whole country at scale. In consultation with a range of stakeholders and local leaders, we identified seven barriers to innovation diffusion:

1. **The coherence deficit**: there is a lack of common aspiration for local authorities on population health. Where formal aspiration to tackle inequalities does exist, it tends to sit in the NHS – predisposing it to a focus on acute interventions (eg, Core20PlusFive). Outside the NHS, there is significant variation at local authority level, with some places having clear commitments to transforming health at the place level and others having little defined aspiration on the agenda.
2. **The partnership deficit**: there have been efforts to join up sectors within the public sector, including the introduction of Integrated Care Systems (ICS). But strong multi-agency partnerships –between government, but also with business and civil society – have not emerged everywhere. Given how much of health is about what happens outside hospitals, this can make it more difficult to optimise health across society.
3. **The resource deficit**: public health investment and local government funding has been cut substantially over the last decade – particularly in more deprived parts of the country (Thomas 2019). And beyond funding for services, there is little money available to invest in health and health infrastructure (particularly outside healthcare settings).
4. **The capacity deficit**: local government is experiencing a decline in headcount as service pressures grow, creating a large capacity deficit. As this deficit widens, new roles become less attractive to new staff, particularly in a competitive labour market.
5. **The power deficit**: local authorities lack some important powers to influence the social and corporate determinants of health, and in other cases do not always make full use of the powers already available to them.
6. **The accountability deficit**: in contrast to the extensive regulation and inspection regime we have in many public services, notably hospitals and schools, there is little real accountability for public health. This both makes it harder for local leaders to prioritise public health, particularly in contrast to healthcare and hospitals, and for policy makers to understand what is and is not working well.
7. **The prioritisation deficit:** good population health relies on people focused on other policy agendas – from education to the economy, food and climate, and transport planning – to prioritise health. But many do not do this intuitively – and those that do get little reward for their effort. Public health needs a broader coalition within places, where its value is seen and people are rewarded for acting on it.

These are significant barriers to change – and they are unlikely to change on their own. We contend that we need a new approach to overcome these barriers to interventions, with a particular focus on places and populations with the most to

gain. On that basis, we put forward a new proposal for the creation and national rollout of **Health and Prosperity Improvement Zones (HAPIs)** as a route through which the foundations of good health described in chapter 3 are delivered in places that most need additional intervention - first and foremost through the public health initiatives our case studies suggest have demonstrably worked in practice.

INTRODUCING HEALTH AND PROSPERITY IMPROVEMENT ZONES

The idea of Health and Prosperity Improvement Zones (HAPI) is anchored in a simple but aspirational logic: that some parts of the country already demonstrate that much better health outcomes are possible, and that if everywhere in the country was as healthy as places like Wokingham, Maidenhead and Surrey, the UK would be the world's healthiest nation.

Indeed, the biggest strides forward in population health through history have come when national and local intervention is both highly ambitious and coordinated. Henry VIII's moves to build the first formal sewers by legislating new powers for local leaders, the creation of Chief Medical Officers to help answer the Typhoid outbreaks common in Victorian England, and the slum clearance of the 1930s are all examples that we still benefit from today. HAPIs would continue this legacy, through a whole society approach to meeting the biggest health challenges holding places back in the 21st century.

At their simplest, they would work as follows. Local leaders would work with citizens and other stakeholders to designate a new HAPI, at sub-LA level, based on need. They would work together to create aspirational, long-term Health and Prosperity Improvement Mission Delivery Plans, designed around the seven foundations of good health outlined in this report. In turn, they would be backed by resource, staff, expertise, and power from national government (see figure 4.1). They would be the core route through which place contributes to the wider mission of transforming Healthy Life Expectancy already proposed by this commission (Thomas et al 2023).

Effectively, HAPIs would build on the success of local, targeted schemes in providing essential progress against similarly big and complicated challenges. Specifically, the idea is inspired by the role of Clean Air Zones in providing place-led answers to climate emergency – through a multi-agency approach, with local places and people in the lead. Clean Air Zones have been shown to support cleaner air, more innovation in green industries and active travel where implemented – to the benefit of the planet, public health and the wider economy (see CBI 2023).

GETTING THE LOGISTICS RIGHT

As with Clean Air Zones, the ability to designate HAPIs would be a new local authority power. An offer of ringfenced strategic investment, support and capacity from the centre will help incentivise local leaders to enact this power consistently.

The scale of each HAPI footprint should be determined locally. In some parts of the country, such as affluent urban areas, it may be that a relatively small footprint is appropriate, targeted at a smaller area experiencing deprivation, or a particular community or demographic group that experiences more severe health inequalities. Other places – for example, those that are more deprived and rural – might need a bigger footprint, covering a greater number of people. Or it may be that some places benefit from several smaller HAPIs.

In either case, we suggest the designation of HAPIs considers the following criteria:

- **Health outcomes:** first and foremost, HAPIs should target populations that experience the worst health outcomes, as measured through the ONS Health Index.
- **Economic outcomes:** HAPIs should also consider where economic outcomes are worst – looking at wage growth, productivity, overall output, and labour market indicators.
- **Demographics:** beyond deprivation, HAPIs should consider other groups and communities known to experience health inequalities – particularly those protected by the Equality Act. This would align HAPIs with the NHS's Core20PlusFive programme.
- **Funding:** finally, given the unequal cuts in local authority and public health funding over the last decade, we suggest HAPIs consider where funding cuts – or loss of infrastructure like green spaces, leisure centres, libraries, swimming pools or similar - have been most pronounced (see Billingham et al 2023).

We do not suggest that HAPIs take responsibility for either commissioning or delivering targeted interventions directly. That is, our recommendation is not for a new form of 'public health strategic authority'. Instead, we suggest they signal footprints for intensive, additional intervention from multi-agency partnerships of those with the means to make a difference, in which whoever is best placed to lead a bespoke intervention, targeted within the HAPI, does so. That might mean public health teams leading new addiction programmes, combined authorities leading housing programmes, or businesses working with Integrated Care Partnerships on inclusive employment schemes.

As with Integrated Care Systems, we suggest that the relationship between local and national government is defined by the principle of 'subsidiarity'. That is, national government's role should be to empower local leaders to design, develop and fund new ways to guarantee the foundations of good health, rather than to impose a set suite of one-size-fits-all approaches.

That is not to say that strong alignment between local and national priorities is not vital, that national leaders should have no say in the structure and priorities of HAPIs, or that there is no need for mechanisms or forums to oversee, coordinate and evaluate delivery. Indeed, this is important for three reasons.

First, because without some national oversight, there is a risk that HAPIs might be used too widely. A key focus of HAPIs is narrowing health inequalities through targeted, place-based action. This prioritisation and focus of intervention will not be possible if too many zones are designated, and the strategic resource associated with them spread too thinly.

Second, because there must be coordination between what is done nationally and what is done locally. If there is duplication or a mismatch in priorities, progress is likely to be slower.

And last, because at their best, HAPIs would be multi-agency approaches, split between local government, public services, civil society, businesses, and people themselves. It should not be underestimated how much coordination that will entail.

Local Area Agreements (LAAs) give one blueprint for a delivery mechanism through which this coordination - between stakeholders, and between national and local government - might be achieved. Introduced in 2004 and beginning to take widespread form in 2006 (and abolished in 2010), LAAs were a form of social contracting – providing a basis for local and national leaders (among others) to agree priorities, outcome measures, governance relationships and delivery responsibilities. In providing a forum and a formal basis to coordinate

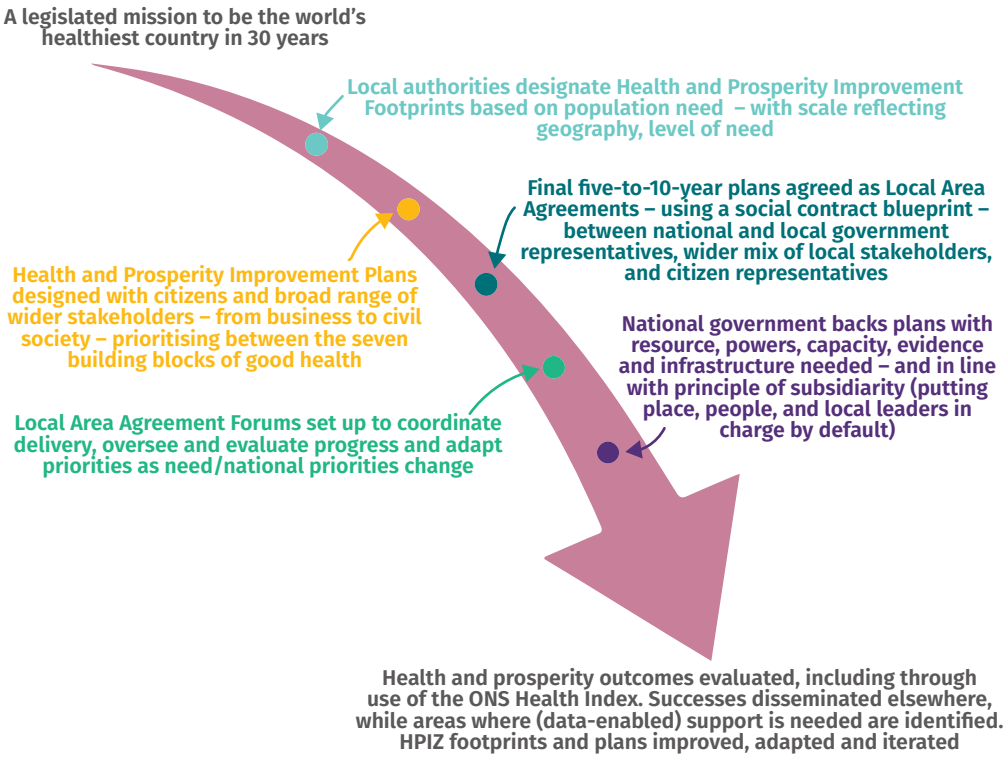
local/national approach, they have been described as 'recasting governance relationships between local agencies' (Gillanders and Ahmad 2008).

More specifically, Local Area Agreements began by negotiating national priorities, local community, and local partners in local strategies (each three years in duration). Each fed into a longer-term Sustainable Communities strategy, covering a 10-year vision for an individual place. Priorities for LAAs included enterprise and economic development, healthier communities, safer communities, and children and young people. Evaluation of LAAs has since been positive (see Andrews et al 2014; Gillanders and Ahmed 2007) while social contract models that have replicated some of the principles of LAAs, including the Wigan Deal and the Walsall for All programme, have since had notable success.

While LAAs were not perfect – the use of a reward grant and the focus on using LAAs to pick from a set of centrally dictated targets are less attractive features of the approach – it is easy to see why the core of a social contracting model might be a useful blueprint for HAPIs. The multi-agency negotiation of priorities into a common plan, the focus on evaluation and outcomes, the use of on-going forums for collaboration and the long-term focus would all support a coherent relationship between national and local government – and between partners.

We suggest that Health and Prosperity Improvement Mission Delivery Plans are finalised in a similar forum – and published as a social contract between relevant partners (including national government). We also recommend that a standing working group provides ongoing oversight, strategy support and coordination capacity across stakeholders. This would mean a process for designing individual place-based approaches (figure 4.1).

FIGURE 4.1. ANATOMY HEALTH AND PROSPERITY IMPROVEMENT ZONES AND MISSION DELIVERY PLANS



Source: Authors' analysis

This gives a broad architecture for HAPIs. But the history of targeted, place-led policy interventions suggests that their success or failure will depend on the specifics of how they are designed and implemented. As we argue in the box on Health Action Zones below, it is not enough to simply implement a targeted scheme: the specifics are also critical, including how they are resourced, what the relationship between local/national looks like, how they are supported and staffed, and how they work with important partners beyond government.

The rest of this report looks at the detail of how HAPIs should be formed, how priorities should be set, how plans should be designed, how partners should be crowded-in, and what institutional support might be needed. Specifically, we set out three further steps in making HAPIs a success:

- **Step One**: the right foundations, including how plans should be designed, what the relationship between local and national should be, and what institutional infrastructure is needed to enable change.
- **Step Two**: back the plans, including what funding is needed from national government, what funding powers should be given to local leaders, and what capacity and expertise would be needed in the local government workforce.
- **Step Three**: crowd-in partners, including businesses, employers, civil society, wider public services, and communities themselves – all of which have a vital role in determining health outcomes at the place level.

LEARNING FROM THE PAST: WHY GOOD DESIGN IS VITAL TO SUCCESS

It is important to recognise that targeted attempts at health creation have been tried before – most notably, through the New Labour policy of Health Action Zones. There is much that this experience can teach us about when place-led approaches work well, and when they work less well.

Evaluation of this approach, implemented in 1998 and expanded through the first Blair government, has been mixed. According to one evaluation, 'many [HAZs]... failed to live up to expectations' (Judge and Bauld 2006). That is, while they were not failures – they did not make people's lives worse - their success was only modest, particularly compared to the size of the challenge they were prescribed to meet.

The design of HAZs was limited in three ways. Firstly, they had an oversimplistic view of why health inequality exists. In focusing on 'behaviours', they did not fully appreciate the complexity and entrenched nature of health inequalities – nor did they reflect the full, economic value of solving them. Secondly, they lacked real investment – HAZs covered millions of people, but only had tens of millions in funding per year. Finally, the top-down, target-led design of HAZs disempowered local leaders – meaning the scheme was often viewed as a tick-box exercise, rather than the main route through which health inequality would be addressed locally (table 4.1).

This means HAZs had only a modest, and quite variable, impact. But that does not mean that targeted, place-led health policy does not or cannot work. Targeted and place-led approaches to big challenges such as health inequalities can work. Indeed, Clean Air Zones have been important in supporting wider progress to net zero, while approaches like the Preston Model and the Wigan Deal have been valuable in improving economic outcomes and public service quality.[12] Rather, the lesson of HAZs is that targeting is not a replacement for high quality, well-resourced and strategically sound implementation. Table 4.1 explores how our proposal of HAPIs learns from, and improves on, the design of HAZs.

12 We explore these in further detail later in this chapter.

TABLE 4.1. DIFFERENTIATING HEALTH AND PROSPERITY IMPROVEMENT ZONES FROM HEALTH ACTION ZONES

Problem	Description
Overly focused on behaviours	Health action zones were overly focused on behaviours – like obesity or smoking – and not the root causes of these problems. They did not address the root cause of health inequalities. By anchoring our approach in the broader building blocks of health, we suggest a scheme designed to be relevant to a broader range of variables that drive people's health outcomes.
Little real engagement from local government, services or people	HAZs had little real engagement from local leaders, who felt they lacked the resources to deliver on the lofty aspirations of the programme and were unconvinced that it was going to work. This generated lip service, and in some cases a focus on low-hanging fruit rather than real change, which was not conductive to long-term progress.
A lack of upward or downward accountability	Evaluations of individual HAZs have concluded that accountability was superficial both upwards, and downwards. There was little incentive for success or identification of failure. In turn, there was no infrastructure to support learning and improvement among laggards.
A lack of meaningful partnership beyond the state	While HAZs were multi-agency, they did not use the full potential of partnership beyond the state. Employers, businesses, social enterprises, communities themselves and individuals all have an important role to play in optimising health. A successful place-led health creation policy needs a strategy for leveraging in these actors.
Top-down guidance and a lack of evidence	Aspirations were lofty, and guidance was often extensive, top-down and lacking in relevance to local decision makers. This accentuated the gap between the hopes of national policy makers and delivery on the ground.
Low investment	Resources for HAZs were modest. Budgets were approximately £4 million in 2004. This was too little to support their aspirations (for example, one zone set itself the target of going from being among the least healthy to one the healthiest parts of Europe within a ten-year period). Indeed, it is a tiny percentage of what is now allocated to local authorities through the public health grant – which itself only funds a basic level of public health service provision.

Source: Authors' analysis

RECOMMENDATIONS

- Powers to implement health and prosperity improvement zones should be devolved to local authorities. As well as footprints for intervention, each HAPI should publish a long-term 'Mission Delivery Plan', anchored in the seven building blocks for healthy life outlined in this report.
- Mission delivery plans should be agreed and published as 'social contracts' between national and local government, people themselves, and a broad range of stakeholders, using a (modernised) version of Local Area Agreements as a blueprint.

STEP ONE: THE RIGHT FOUNDATIONS

1. USE MISSIONS INSTEAD OF IMPOSING TARGETS

In the late 1990s, a great deal of government reforms followed the logic of 'New Public Management': reform focused on the use of financial incentives, targets, extensive central guidance and often, provider competition. In some places this proved effective: National Service Frameworks have been linked to at least short-term improvements in NHS performance, at a time when health services faced profound difficulties around access, quality, experience, and outcomes (Graham et al 2006, Kings Fund 2014).

However, in other cases, the approach had drawbacks, many of which were apparent in the implementation of HAZs. Specifically, evaluation of HAZs has shown that an attempt to set top-down aspiration, with little real local consultation or acknowledgement of the complexity of the challenge, led to:

- Disengaged local leaders
- At worst, gave the impression that the HAZs were unrealistic or unfeasible
- Created conflicting priorities for local leaders, sometimes encouraging them to focus on low-hanging fruit rather than long-lasting change
- Undermined the autonomy and 'intrinsic motivation' of local leaders, making HAZs something of a tick-box exercise

The goal of HAPIs should be to create autonomous, learning, and self-sustaining systems – focused on tackling inequalities at place level, independent of prescription or command from the centre. Given this, avoiding any approach that risks widespread disempowerment and disengagement is clearly important.

There is a growing evidence base and interest in the use of mission-based approaches, as opposed to the imposed top-down targets associated with New Public Management. Put simply, missions work by setting a shared direction from the centre but leaving key actors in the space to create their own solutions (Khan and Quilter-Pinner, forthcoming). Where used, missions have proved to be an increasingly successful approach (ibid).

Missions have several advantages over top-down targets. Most importantly, they are more likely to help create 'intrinsic motivation' by giving those responsible for delivering on their aspirations both a meaningful say in their creation and 'skin in the game' (ibid). They are also more conducive to trial and error: as long-term ambitions, with no fixed answers, they provide space to experiment, learn from what works and what does not, take (good) risk and build a culture of learning.

On the strength of this evidence, we suggest that all HAPIs are organised around a new mission-based approach. This should have three components:

- An overall national mission to be the healthiest country in the world over a 30-year period
- A regional component of that mission, to bring healthy life expectancy to 67 years in every UK nation and English region (as a minimum)
- A local component of that mission, to extend the seven foundations already outlined in this report to everyone in the UK, regardless of who they are, where they come from or where they live

Put another way, HAPIs should be the mechanism to deliver the local component of this mission – in support of an even broader and longer-term aspiration for the country's health.

To suggest that the seven foundations of good health outlined in this report should be at the core of HAPIs is not to recommend a one-size-fits-all approach. Local authorities should be free to outline how they plan to deliver against this overarching aspiration, including how they plan to prioritise, and the order in which they intend to make progress happen. This flexibility is important; not every issue outlined in this report is a priority issue for every part of the country. Indeed, even the least healthy parts of the country normally perform well on at least some indicators, stressing the need for capacity to localise each mission:

- Blackpool has the country's worst health outcomes but still performs well on rough sleeping.
- Nottingham has the country's second worst health outcomes but still performs well on green space and workplace safety.
- Windsor and Maidenhead have among the best health outcomes but still face challenges around early years development (LCP 2021).

Neither do we suggest that Health and Prosperity plans are created by a small number of officials. Rather, plans to deliver on missions should be co-created with the people they will impact rather than by a small number of local officials and representatives.

As well as being a clear priority for participants in our deliberative research, there is a good evidence base on the benefits of co-creation in developing stronger policy. Table 4.1 outlines a range of co-creation methods that could be employed in this process.

TABLE 4.2. EVALUATION OF POTENTIAL PARTICIPATORY METHODS

Method	Description	Pros	Cons
User feedback	Mechanisms for systematically collecting and using the views of citizens such as surveys or consultation	Collects information at scale, allows for representative sampling	No guaranteed findings are used, does not shift power and information can lack nuance
Representation	Representatives are elected (or otherwise appointed) into positions of power	Can ensure citizen voice is in the room where decisions are taken	Can be tokenistic. Power imbalances can mean this form of representation is drowned out or ignored
Advisory	Groups of citizens are selected onto advisory boards	Can enable more nuanced discussion	Can be tokenistic
Citizen's juries	Groups of people are selected to deliberate on specific issues, often with power to make a (binding) decision at the end	Can enable more nuanced discussion; power can be genuinely shifted	Expensive to run, hard to scale, risk that the small group is not representative
Participatory budgeting	People given power to allocate a share of government spending	Hands over real power, and forces consideration of trade-offs	Risk of being skewed by small number of people
Co-design	Groups of citizens work with professionals and experts to co-design services or policies	Hands over real power to people and can enable more nuanced deliberation	Hard to scale, only involves a small share of the population, and more viable for affluent/ time rich people

Source: Authors' analysis

Given that no single co-creation method is perfect, we suggest the expectation is that several are used. This could include a minimum requirement that plans are informed by at least one broad method of consultation (eg, an online portal), and one more specific method of consultation (eg, a citizen's jury) – and that at least 10 per cent of spending from HAPIs is allocated using participatory budgeting methods.

HAMMERSMITH AND FULHAM CO-PRODUCTION APPROACHES WITH DISABLED CITIZENS

Hammersmith and Fulham (H&F) have outlined their mission to co-produce visions for a more inclusive borough for residents. The new approach was catalysed by the council's response to the recommendations set out in the Disabled People's Commission in 2018, and H&F have now committed to making their borough the best place to live for disabled people in England. A key part of their work is getting the consent from all residents and that their work is working when all residents agree that it is.

Across their programme of work, H&F have worked with councillors, organisers and the wider community to co-produce policies. There are several groups which focus on planning, implementation and accessibility, and have successfully co-created the Hammersmith Civic Campus project. This project is a huge refurbishment of the town hall, development of housing, and a new cinema. Disabled residents have worked with the council officers and architects to design a new place that all can access.

RECOMMENDATIONS

- An overarching mission and mission delivery plan for health creation should be set within HAPIs, focusing on what is most needed locally to deliver on the seven foundations outlined in this report.
- Missions should be co-created with people who live within HAPIs. A minimum 10 per cent of each budget should be allocated through participatory budgeting, and other participatory methods should be used to enshrine a 'nothing about us, without us' approach.

2. BUILD CAPACITY TO SCALE WHAT WORKS.

Many public health interventions have a very different evidence base from clinical interventions – often, they use qualitative data, modelling, evaluation and cost-benefit analysis, rather than the Randomised Controlled Trials that have become the clinical 'gold standard'.

This does not necessarily mean that public health innovation has a weaker evidence base than clinical interventions. Indeed, when implemented, such interventions are often highly successful: from bans on smoking in public places, to plain packaging, to the soft drinks industry levy, to the range of case studies outlined in chapter 3 of this report.

However, it does mean that policy makers can be more reluctant to commit to public health measures. Without a commonly understood 'gold standard' of evidence, like an RCT, it can be difficult to create consensus that 'sufficient evidence' exists for whole-hearted implementation. It can also give oxygen to challenge from vested

interests – as demonstrated in the success of the tobacco industry in delaying or undermining regulation of an evidently harmful product over the last 70 years.[13]

We propose that HAPIs are supported by a new 'What Works' institution focused on marshalling the evidence and supporting its translation into practice at scale. In other policy areas, What Works bodies have proved effective in providing policy makers with the practical information they need to commit to new programmes, interventions and investments. For example, in education, the Education Endowment Foundation (EEF)has:

- Funded more RCT evidence than any other organisation globally
- Doubled the amount of trial evidence in education in the country
- Commissioned more than 10 per cent of known trials in the world
- Saved significant money and improved outcomes for children (see Thomas et al 2023)

We reiterate IPPR's proposal to create a National Institute for Excellence in Health Creation (NIEH). The NIEH would fill a slightly different gap to the EEF. Whereas the EEF has effectively addressed a shortage of RCT evidence around schools, education and teaching practice, the NIEH would focus on the translation of well-evidenced and effective schemes from one place to another. That is, the NIEH should be exclusively focused on what works, why it works, and what we need to know to get viable interventions into practice at scale.

To that end, we suggest the NIEH has five formative functions:

- Identifying a pipeline of highly promising public health interventions and approaches from within the country, and around the world – helping provide local leaders with knowledge of what works and avoid any temptation to always begin 'with a blank page'
- Evaluating new schemes, to ensure knowledge is available on whether they are effective, and why – and creating evidence on how to adapt one intervention to the specific context and needs of another place
- Legitimising when evidence has reached a critical mass on interventions through a new Public Health Kitemark scheme, designed to verify what interventions are effective, and to create a repository of best practice[14]
- Sharing evidence between HAPIs, so that they do not develop in siloes – but rather form a network of 'trial, error, adoption and improvement' across the country
- Providing an 'OBR for place-based health' function, whereby it evaluates value for money, wider economic impact, and social value of public health interventions – helping make sure they are as appealing to a wide cross-section of policy makers as possible. While this would not deliver the kind of singular value for money judgements given by NICE, it would help provide a common language for health and economic policy makers, while also ensuring public health innovation is considered on its full merits.

Beyond the distinctly local and non-clinical focus of the NIEH, it would complement existing infrastructure in two ways. It would have an independence that the Office for Health Improvement and Disparities does not – allowing it to operate with more agility and speed. And by taking a pragmatic role in facilitating evidence into practice rather than creating new evidence for its own sake, it would fulfil a different function to NIHR. We estimate that this new body would require a budget of between £140 and £160 million in year one (Thomas et al 2023).

13 As documented by Tobacco Tactics https://tobaccotactics.org/

14 The Social Care Institute for Excellence has a similar function.

RECOMMENDATION

- Government should create a new institution focused on curating and scaling public health interventions – by assessing what works, providing practical evidence on value and economic benefit, and by better understanding how public health innovation can be scaled, with a budget of between £140 and £160 million in year one.

3. GET ACCOUNTABILITY RIGHT, WITH A FOCUS ON LEARNING

Our deliberative research found that people felt mechanisms to involve the community in accountability was tokenistic and often failed to translate into effective real-world action. Making HAPIs viable means getting accountability right.

What public bodies are accountable for has a tangible impact on what government/public bodies prioritise, and how decisions get made. The National Audit Office has had some success with embedding a focus on value for money across government – in 2021, its work was linked to an £874 million financial benefit through improved service delivery (National Audit Office 2022). The OBR, the government's independent economic watchdog, has successfully strengthened the focus on fiscal outcomes in government economic policy (Page 2014) – with HM Treasury under pressure to focus on policies that the OBR scores highly. The Climate Change Committee has been associated with a significantly positive impact on institutionalising climate policy and net zero across government (Graham Institute 2018).

Whether these priorities have an ultimately positive or negative impact on policy is for another paper: what is important is that accountability does effectively steer what is prioritised, and how decisions are made.

There are opportunities to use existing infrastructure to embed accountability in HAPIs. The government has recently launched the Office for Local Government (Oflog) to provide authoritative and accessible data about the performance of local government, with a focus on improvement. However, there has been some scepticism about what value this institution genuinely adds. Giving Oflog a distinct role in driving the success of HAPIs would help clarify its value-add – and would also embody the wider IPPR North argument that better health is the best measure of successful local government (see Billingham et al 2023).

In practice, this would mean giving Oflog four oversight functions (and resourcing it to deliver them fully):

1. Oflog should, first and foremost, provide nuanced data on performance of HAPIs, ensuring transparency and accountability within places.
2. It should assess value for money, with a focus on identifying where local authorities have committed to low value initiatives as well as where they have missed high ROI opportunities.
3. Oflog should have a role in ensuring that participatory health creation strategies within LMNs are best practice, and that initiatives are fully and properly evaluated.
4. Oflog should have a role in holding national government to account on how effectively they are resourcing and enabling HAPIs. We discuss the onus on national government around resource and capacity in the next section.

In delivering on this, Oflog should make extensive use of the ONS Health Index. This provides a 'stock and measure' account of overall population health and allows policy makers to identify key priorities for improvement. It provides a basis for agile

evaluation and reprioritisation that is uniquely suited to this place-based approach to health and prosperity.

RECOMMENDATION

- Oflog should be given a new responsibility for oversight of HAPIs (and health creation more regularly) – embedding the concept that health outcomes are the best possible indicator of successful levelling up. In this function, Oflog should primarily use the new ONS Health Index.

STEP TWO: BACK PLACES WITH RESOURCE

1. RESOURCING HEALTH AND PROSPERITY IMPROVEMENT ZONES

Local government budgets have been cut substantially since 2010. The Institute for Government estimates suggest that local authority spending power has fallen by nearly 20 per cent since 2009/10 (IfG 2023). Given the increase in population need for many of the statutory services provided by local government, this means little capacity exists to deliver new initiatives.

Local public health budgets have also been cut in real terms since 2010. IPPR research shows that the public health grant was almost £1 billion lower in real terms in 2019 than it was in 2014. Moreover, £1 in every £7 cut from the grant came from the most deprived local authorities, compared to just £1 in every £46 in the most affluent parts of the country (Thomas 2019).

Even then, the public health grant is a relatively poor vehicle to deliver on the ambition of HAPIs. As a ringfenced grant, it provides funding for an important but relatively limited number of services: stop smoking clinics, obesity programmes, addiction centres and similar. But it has little to no capacity to invest in the conditions for good public health in a place, and even a well-resourced public health grant would be very unlikely to help deliver the seven foundations outlined in this report meaningfully.

Rather, HAPIs need a more flexible and strategic form of funding. We suggest the government creates a new 'health creation fund' – allocated explicitly for delivery of HAPI missions. This fund would be national funding, invested in HAPIs locally.

The Health Creation Fund should be designed to avoid the unhelpful competition between areas that was associated with the government's Levelling Up Fund.[15] Instead, we recommend it is allocated by formula rather than competitive bidding processes (which are already the basis for NHS funding).

This should draw on the criteria for designating HAPIs outlined at the start of this chapter (deprivation, protected characteristics, economic outcomes, recent funding cuts) – and could also draw on the specialist expertise of the existing Advisory Committee on Resource Allocation (ACRA) in NHS England.

This would not mean that the healthiest areas are excluded from funding. It is important to recognise there are health challenges and deprived populations

15 Namely, that competitive bidding processes can mean funding is not allocated by need, take significant resource to deliver, and can lead to unnecessary expenditure by local authorities on external consultants.

within even the healthiest local authorities. Rather, it would mean an expectation that funding flows in line with the scale of the challenge faced. We would expect funding for Blackpool to be substantially higher than funding for Wokingham.

In resourcing the fund, the government should prioritise revenue raising methods that themselves support better health. Specifically, they should explore expanding on the success of the Soft Drinks Industry Levy and introducing new national levies on other health harming products. Evidence suggests that:

- A salt and sugar levy would drive the reformulation of unhealthy food and beverages and raise an estimated £2.9 - £3.4 billion per year.
- A polluter pays levy on gambling and tobacco companies could raise an estimated £844 million in its first year.
- Reversing the freeze on alcohol duty could increase national income by over £800 million per year and create 17,000 jobs.

This alone would have a revenue-raising power of over £4.7 billion –more than enough to provide the £3 billion of annual, local health investment funding previously recommended by this Commission (see Thomas et al 2023).

However, we also recognise that some places may want or need to raise more revenue than a central pot of funding allows. Given this, we also recommend that the government begins the process of devolving more public health revenue powers to local leaders – to give them an optional ability to supplement the national £3 billion of funding posited by the Health Creation Fund (above). This could include:

- The power to set local levies, such as levies on total yields of gambling outlets in the area, and reformulation-focused levies, such as levies on grams of sugar per kilogram or alcohol content per litre. These would be extensions of the method the government uses to raise its initial £3 billion funding commitment, outlined above – and would be best targeted on issues causing health harms in a local area (eg, increased business rates on takeaways in areas with a high density of takeaways and high levels of childhood obesity).
- More control over business rates, including capacity to discount business rates for health-creating businesses, or to charge additional business rates on health harming businesses (for example, takeaways), particularly where an area already has a high density).

One of the benefits of devolving this method of raising revenue is that it has a stronger incentive for poorer local authorities than richer ones. Research has long showed that alcohol, tobacco, gambling, and fast-food outlets tend to be more likely to locate in poorer parts of the country. Evidence also shows that these outlets tend to cluster within places (Macdonald et al 2018).

PROGRESSIVE OR REGRESSIVE?

There is no denying that some health levies have the potential to raise revenue disproportionately from more deprived people, who are more likely to consume unhealthy products. However, we posit that there are three reasons to consider them progressive. First, many can be targeted at manufacturers rather than consumers – particularly in sectors (processed food or gambling) where demand is relatively elastic. Second, because this commission has shown the income benefit of prevention is so progressive (see Thomas et al 2023) as to outweigh regressive impacts. And finally, because the funding would be ringfenced for the benefit of those who paid for it.

RECOMMENDATIONS

- The government should fund Health and Prosperity plans through a health creation fund worth £3 billion, funded through levies and allocated to local authorities through formula rather than competitive tendering.
- The government should devolve methods of health-positive revenue raising (where wanted and needed), to help increase funding flexibility, while also directly supporting national health outcomes.

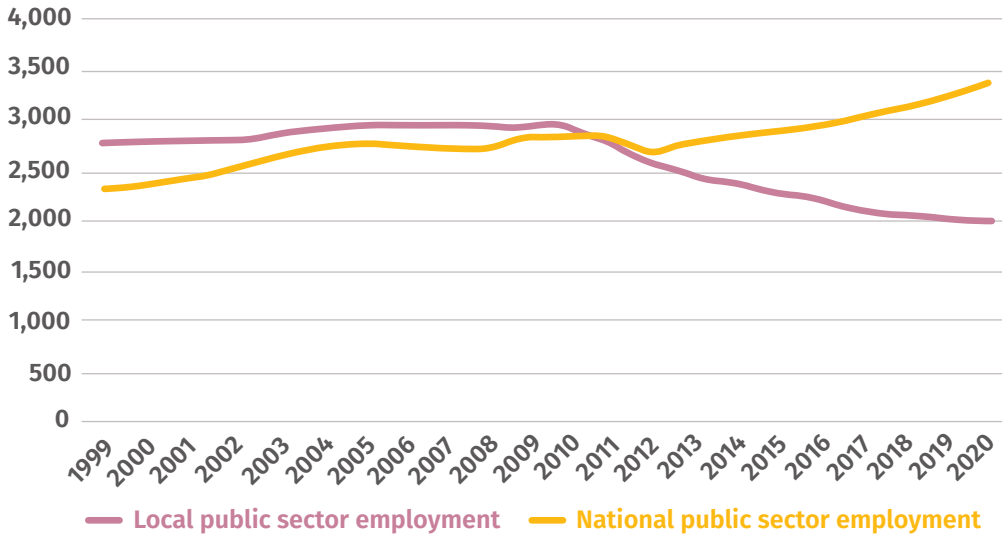
2. BUILD CAPACITY AND EXPERTISE IN LOCAL GOVERNMENT

As well as resource, HAPIs will rely on local authorities having the right capacity and expertise within their workforce to deliver change. Nearly all of the most transformative case studies outlined in this report rely on technically expert local officials, with enough time to design, adapt, implement and evaluate new interventions.

This would be a challenge for local authorities in the UK as it stands. Over the past 10 years, while the local government workforce has decreased by 40 per cent (LGA 2022), the total size of the public sector workforce has grown (Institute for Government 2017).

FIGURE 4.2: THE PUBLIC SECTOR WORKFORCE HAS BEEN CENTRALISED IN THE LAST DECADE

Local (green) and national (purple) public sector employment in millions, 1999–2020



Source: Recreated from Johns (2020), ONS (2021b)

In addition, since 2020 the staff turnover rate has increased. The Local Government Association found that local government turnover increased from 10 per cent in 2009/10 to 13.4 per cent in 2017/18. As well as indicating that local government roles may have become less competitive in the overall labour market, this also suggests a substitution of experienced staff for less experienced staff (Local Government Association 2021).

Even then, increased headcount alone would not guarantee the right workforce to deliver on the extensive ambition of HAPIs. Rather, an increase in staff capacity

must go together with increasing expertise, ensuring that local government is the home of the next generation of public health leaders and innovators.

The decline in headcount in local government has coincided with national government gaining a larger headcount, causing governments to be out of kilter. If we want more place-led policies and to level-up then we need to shift this balance. Removing staff from one place to another is not necessarily the answer. Instead, upskilling is far more likely to support the recruitment and retention of local government staff. To expand localism, we need there to be disproportionately higher local government officials, and to upskill staff to take on new roles and increased responsibilities.

To achieve both greater staff numbers and restore expertise within local government, we recommend that local and combined bodies are given the resources to create new, well-paid public health roles that will lead the implementation and assessment of HAPIs. To do this, we will need a shift in the centralisation of staff from civil service into jobs held within local and combined mayoral authorities and, more importantly, re-training staff with local knowledge and expertise, alongside the recruitment of more local people. The provision of training opportunities such as apprenticeships would ensure that place-based public health knowledge is valued and on par with national public health expertise.

The issues that manifest at local levels are complex and ever-changing. Local governments are aware of the current challenges and are best placed to understand and respond to those challenges but do not have sufficient capability or capacity to respond appropriately. This leads to siloed public health interventions and reactive policies responding to crises, rather than a whole-society preventative approach. To increase headcount, training, pay and job opportunities must be available, but there must also be a shift in how governance is done between the central and the local level. Local government must be seen as specialists in place-based policy who hold a knowledge base that is unique and cannot be replicated at a central level. Local government needs to be seen as equally prestigious and impactful as the civil service.

RECOMMENDATIONS

- HAPIs should be combined with a recruitment drive for expert public health specialists, who can provide the capacity and skills needed to drive forward and deliver on their high level of aspiration.
- HAPIs should create new apprenticeship opportunities for local people to join their local authority and play a role in the delivery of HAPIs. This could be via hybrid roles which exist both in the community and the local government, and/or apprenticeship schemes and training offered to residents to professionalise their local knowledge of their place.

3. CONSIDER NEW POWERS NECESSARY FOR HEALTH CREATION WITHIN DEVOLUTION DEALS

Finally, we recognise that local leaders do not consistently have the powers needed to deliver on the full range of aspirations implied by the seven foundations in this report. Table 4.3 gives an assessment of the devolution which currently exists that could support each one – and opportunities for further devolution.

FIGURE 4.3. EVALUATING PUBLIC HEALTH DEVOLUTION

Further devolution required	There is potential for devolution or further devolution in some places but will require further discussion with local leaders.	Devolution may not be the best mechanism to tackle this problem.

Entitlement	Where power sits	Current extent of devolution	Opportunities for further devolution or different activity
Safe homes	Local government (Local Planning Authorities) and combined mayoral authorities.	Local and combined authorities have powers to build homes in England but face restrictions due to financial constraints and planning legislation. Housing has been included in recent trailblazer deals. For example, the housing quality pathfinders such as in Greater Manchester and access to more housing grants and planning powers in the West of England deal.	Permitted development rights (PDR) limit the ways in which councils can design and create their communities to enable healthier social interactions. PDRs have continued to be extended despite organisations such as the LGA (Local Government Association) and other local authorities explicitly opposing them due to the limitations they put on house building. A case for further devolution should investigate planning reform, particularly the limitations PDRs put on local and combined authorities to exercise their power to build more homes.
Freedom from Addiction	Power is held by central government with some powers within local government.	Public health funding has been strengthened at the local level, including addiction services, and LAs also control premises licenses. However, the scope at which they can reject a license is at a high threshold under the 2005 Gambling Act (set by central government). This legislation includes criminal behaviour and gambling used to target vulnerable demographics such as children.	The UK Misuse of Drugs Act does not give devolved nations or combined authorities the power to take local action on deaths from overdose. Licensing under planning regulation could be extended to limit the number of gambling shops on high streets in places where gambling, substance abuse and deprivation is high. Public health should be promoted in licensing objectives, which could serve as a fifth licensing objective. There are also alternatives to this approach such as local authorities having the power to outline their own licensing objectives on public health overall.
Early years	Local government	Currently hold duties to improve the wellbeing of young children and reduce inequalities. Powers to provide childcare directly or support childcare providers, and duty to assess provision every three years. Requirements to secure free early years provision for relevant groups.	Childcare workforce pay is low, and more than three in five childcare workers (62 per cent) are working below the real living wage (TUC 2023). Childcare affordability could be set accordingly to cost per head or cost per nursery, depending on area and needs of family). New powers could be introduced for local authorities to establish not-for-profit nursery trusts, alongside the establishment of regional care co-operatives to manage supply, and support training and regulation at the regional level. This would be a new role for LAs in maintaining standards and managing local supply (Statham et al 2022). Out of school hours and holidays provision is currently inaccessible for families who cannot take off work or afford school clubs and childminders. This could be addressed by additional funding from local government to support providers to offer wrap-around care, and work charters to ensure local living wages.
Clean air	Central government with some devolution powers (GLA & MCA)	Local authorities have powers to change traffic in their areas, either via changing roads, as seen in the introduction of Low Traffic Neighbourhoods, or creating bus lanes and school streets. There are currently eight clean air zones across the country. However, they have all been implemented (except for London) by enforcement from SoS for Defra (Secretary of State for Department for Environment, Food & Rural Affairs) Further powers include environmental permitting (mostly covering industrial emissions), smoke control (for example, smoke control areas), and Local Air Quality Management (LAQM).	Despite there currently being eight clean air zones across the country, their effectiveness and nature vary significantly. Many of the powers that are used to tackle air pollution are understood to be 'secondary powers' as, while they may benefit air pollution, it is not what they are designed to do (Singer Hobbs et al 2023). There are therefore powers that LAs can currently use to tackle rising air pollution locally and there is also scope for further devolution, but this would be fiscal devolution. LAs currently express that the cost for enforcing environmental permitting and parking fines is greater than the value raised through those fines and fees (Singer Hobbs 2023). As outlined in an IPPR's *Unlocking local action on clean air* report, 'Greater fiscal devolution will support local leadership on improving air quality, and England's local authorities should have the powers seen elsewhere in the world to raise and spend more money locally' (Singer Hobbs et all; Johns 2023). These are the types of powers that could be on the table in creating cleaner, better quality air in places.

Secure and good jobs	Local government and central government	Trailblazer deals in Greater Manchester and the West Midlands give MCAs further powers in technical education post-16 and have been able to expand good work provision into other areas such as bus franchising. Local authorities can also embed decent work in planning, like Manchester's use of Local Labour Agreements through the planning process. They can also highlight to businesses what each party can expect of each other, such as Wigan's Deal for Business which highlights what the council's offer is to business who meet the council's demands (IPPR North 2019). They also have leverage to influence: • Post-16 high needs provision & EHC plans and the tracking and encouraging NEET. • Development of Local Skills Improvement Plans (LSIPs). • Adult education budgets (post-19). Local government can also support the creation of new jobs via new contracts with private contractors. For example, new deals which may create new employment opportunities (Social Value Act 2012). They can also use their direct control over businesses and land to enforce a local living wage. Central government are able to shape job quality through setting the national minimum wage and standards for employers.	Fair and good work agreements could be offered or expanded that have real leverage to intervene where businesses are not complying with duties. IPPR North have previously outlined the role mayors can play in creating good jobs via procurement and new employment charters (IPPR North 2019). This activity may support current powers at the local level and encourage ethical and fair business to support the creation of a healthier local population.
Relationships and Social Isolation.	Local government	Social care's statutory duty lies within local government, but the majority of funding comes from central government. Local authorities do have means to raise funds via a social care precept, but this often puts the burden onto local residents, and still does not match the level of funding from central government.	Social care funding is limited so LAs' ability to meet their statutory duty is difficult. This is a clear example of how powers are available to LAs but the ability to exercise them is limited. This requires better funding to ensure that LAs can fulfil their statutory duties. High streets/green spaces etc are also linked to planning reform and regulation that can enable the creation of better spaces for people to meet and greet. Expansion of these powers could support social relationships within places.
A healthy diet	National and local government	The government sets a national food strategy encompassing commercial relationships with producers of food, and farmers trading within and beyond the UK and EU. Local governmental and combined mayoral authority powers are highly limited in this space. The Food Safety Act 1990 and the Food Hygiene (England) Regulations 2013 hold powers for LAs over food such as licensing, public education on food, and general food safety. Inspections for food standards are done by LAs so they also hold powers and responsibilities to enforce this legislation.	There are limited powers on food advertisement regarding unhealthy foods. However, local leaders and newly created leaders could look at social food provision. Examples of this include Manchester City Council's Healthy Food's Partnership and Greater Manchester Combined Authorities' No Child Should Go Hungry initiative. These initiatives promote access to healthy, affordable, culturally appropriate food for food-insecure people.

Source: Authors' analysis

We recommend that full consideration of which powers can and should be devolved locally in support of health creation and HAPIs is included in every new devolution agreement, to facilitate HAPIs.

To support transparency in this process, we recommend local leaders publish an account of powers they need to deliver on – covering each of the seven building blocks of health outlined in this report. Government should respond to each, either through DLUHC or Oflog, on a 'comply or justify' basis.

RECOMMENDATIONS

- All future devolution agreements should consider the powers needed to achieve on the aspirations of HAPIs. Local leaders should publish accounts of powers they would need to deliver on HAPI aspirations, with an onus on government to justify (in writing) any powers not subsequently devolved.
- Government should review existing devolution deals and open limited negotiations to expand on health powers systematically to ensure that places that have received deals already are not excluded.

STEP THREE: CROWD-IN PARTNERS

HAPIs will not optimise health if they only consider the role of the state. Civil society, community groups, charities, public services beyond healthcare, businesses, employers and industry all have an incredibly important role in our health (and often, a vested interest in supporting a healthier population).

We suggest that HAPIs take a *whole society approach* (as previously outlined in Hochlaf and Thomas 2020), in which health is not solely considered a government or an individual responsibility, but rather everyone's business (and to everyone's benefit). Our deliberative participants saw this as important in creating healthier, more prosperous places – and were clear that they wanted a range of actors with power to use that power more effectively in delivering better health.

TABLE 4.4. THE WHOLE SOCIETY APPROACH

Businesses: are a determinant of jobs and job quality and can create significant wider social value. Business is also the biggest investor in the UK economy.	**Employers:** our work is among the most important drivers of our health, both physical and mental.	**Wider public services:** the NHS is not the only public service that is critical for health: employment services and schools, to name just two, are as important, if not more so.
Communities: as mutual aid during Covid-19 showed, communities can do much for and by themselves – but they need to be empowered and supported to do so at scale.	**Charities:** the NHS's Integrated Care Systems have recognised the importance of charities to health – from their role in service delivery to research, coordinating support, and providing personalised help for people with complicated needs	**Civil society:** from community groups to activists and volunteers, civil society can be a powerful resource in health creation and place shaping

Source: Recreated from (Hochlaf and Thomas 2020)

In some parts of the country, this kind of approach is already being taken. Wigan's Deal for Business, Preston's Community Wealth Building and Lewes' Green Economic Recovery strategy are all examples of a 'whole society approach' – albeit with a varying focus on health as an outcome. These form the inspiration for the recommendations outlined in this chapter.

CASE STUDY: THE PRESTON MODEL

The Preston model sets out to create a 'resilient and inclusive economy for the benefit of the local area'. There are four key pillars in Preston's model:

- Progressive procurement: bigger contracts are broken down into smaller ones, to allow more businesses to work with the council. Procurement processes are simplified, to reduce barriers to access. Contract decisions go beyond cost and consider local benefit, including investment in infrastructure, supply chain benefits and social value.
- Social value: investment, commissioning and procurement have a focus on social value. Suppliers are expected to contribute to job quality and local development – and explain their alignment to the Social Value Act (2012).
- Democratising the economy: Preston supports a diverse range of ownership models, including co-operatives and other models that give people a meaningful voice over their economic future.
- A Real Living Wage: Preston works with businesses to actively promote the Real Living Wage, and considers this in procurement, supply chain and commissioning decisions. Businesses that pay a fair and reasonable wage benefit reputationally from the Preston Real Wage Initiative.

Anchor institutions are also used to lever additional investment, to encourage the development of new businesses, and to support new methods of financial intermediation.

Evaluation has shown a range of benefits. Preston has nearly quadrupled local procurement spend, supporting local supply chains and strengthening local businesses. Growth per head and labour productivity grew faster than the UK average. And unemployment has gone from above to below the UK average, suggesting new job opportunities. Sector-specific evaluation has found benefits of the scheme for creative businesses in Preston, with anchor institutions supporting nine per cent of turnover in those businesses (Whyman et al 2021). And while health creation is not an explicit goal of the Preston model, a recent Lancet paper found that mental health outcomes and life satisfaction scores both improved in in the local area (Rose et al 2023).

Preston and similar models have rarely made health creation a primary goal. However, their approach can be adapted to this end. Table 4.5 outlines three principles inspired by this scheme, which could substantiate a programme of what we call 'Community Health Building'.

TABLE 4.5. PRINCIPLES OF COMMUNITY HEALTH BUILDING

Social Value	Networked public services	Community power
All commissioning and spending decisions should consider health creation and local prosperity explicitly, and include a health impact assessment.	Local health services should be integrated, coordinated, and ideally operate from under one roof at the neighbourhood level.	Communities should be empowered to deliver for themselves, building on the mutual aid they developed during the Covid-19 pandemic.

Source: Authors' analysis

These principles are each designed around the core central aim of this report: policy that facilitates the spread of the kind of transformative case studies we documented in the previous chapter. Here, we cover them in turn.

1. USE SOCIAL VALUE TO SUPPORT HEALTH-CREATING BUSINESSES.

Preston has had significant success with using government money to incentivise social value and support businesses that create large, wider benefits. However, this is meant to be a part of how all local government spending, commissioning and procurement decisions are made.

On 31 January 2013, the Public Services (Social Value) Act came into force. This legislation carried a requirement for 'people who commission public services to think about how they can secure wider social, economic and environmental benefits'. In theory, this is intended to make commissioners think about the ways that the services they buy could secure wider benefits for their area or stakeholders – and to include those, alongside value for money, in making a final commissioning decision.

In practice, the Social Value Act has only had limited impact. For example, research by National Voices and Social Enterprise UK found that just 13 per cent of Clinical Commissioning Groups demonstrate how they are actively pursuing social value in their procurement and commissioning decisions – and that only 13 per cent of Sustainability and Transformation Plans mention the concept. Meanwhile, 43 per cent of surveyed respondents had no policy on the Social Value Act or were not aware of the policy (National Voices & Social Enterprise UK 2017).

This speaks to the core failing of the Social Value Act: there has been little thought on how, from a process perspective, it can be brought to really affect spending decisions - and there is little accountability, data or real transparency when it is not considered fully. We suggest that the use of Social Value is strengthened within HAPIs.

To achieve this, spending decisions worth over £20,000 could be awarded using a points-based system. Half of the points in commissioning or procurement decisions would be allocated on value for money, reflecting that this remains an important consideration for both policy makers and the public. The other half of the points within spending and commissioning decisions would then be allocated across the following social value domains:

- Pay and employment: wherever possible, organisations receiving local funds should pay a fair and reasonable wage. Without very strong justification, this should mean a demonstrable commitment to – or plan to achieve – the real living wage for all employees and contracted staff.

- Quality: the quality of procured goods or commissioned services should be a key consideration. This might mean including a focus on nutritional content as well as cost in the supply of meals to local hospitals and schools. Or it might mean a focus on outcomes in commissioning adult social care services.
- Local impact: preference should be given to organisations that can demonstrate economic and social value to their local communities and are more likely to localise wealth, or to organisations who otherwise offer value to local infrastructure, investment levels or supply chains.
- Transparency: if using state spending to drive health and prosperity, local government should look to increase revenue by only awarding contracts to organisations that can show evidence they pay a fair share of taxation (and ideally, who pay tax locally).
- Direct health benefit: preference should be given to organisations that can demonstrate a benefit against any of the Seven for Seven domains, good workplace health programmes, have supported employment schemes, or similar.

To ensure this is genuinely embedded within commissioning processes across public sector bodies, we recommend that a summary of procurement decisions is published and made available to the public – ideally, before delivery of a new service begins.

The idea here would not be to eliminate value for money as a key consideration for local government. Rather, it would be to ensure that short-term value is not the *only* consideration. To that end, it would have a market shaping role: it would incentivise and reward businesses that create wider benefit, while disincentivising those which provide little value for places and stakeholders (beyond shareholders).

As the Commission has already shown, we expect the benefits of better health to have a significant benefit for businesses – from a labour market, recruitment, and cost perspective. As such, we expect HAPIs to increase the appeal of businesses to invest in areas experiencing poor health and economic impacts (themselves likely to be deindustrialised parts of the country). At first, because of the signalling impact of the policy – and later, because of its tangible benefits.

RECOMMENDATION

- The government should deliver an ethical commissioning charter for HAPIs (with relevance to the country as a whole) – both signalling its intent to support businesses in creating social value, and setting clearer and stronger standards for those that are harming health.

2. THRIVING HEALTH ECO-SYSTEMS

As the move towards Integrated Care Systems has acknowledged, the NHS (as important as it is) cannot deliver good health on its own. If it could, NHS spend would be associated with better (or at least more rapidly improving) health outcomes – whereas it is currently associated with far worse outcomes (see LCP 2021).

The reality is that population health relies on a range of other partners delivering beyond the NHS, on issues such as housing, jobs, welfare, poverty and environment. In other words, public health in places relies on the strength of organisations delivering good health outcomes, above and beyond what can be achieved through healthcare and hospitals.

This creates a problem. Places with worse health, in more deprived parts of the country, tend to have fewer organisations involved in delivering good health outcomes; the NHS forms the whole of their health eco-system, rather than a part of it. Any approach to changing this reality will rely on incentivising – and providing a sustainable funding stream to – charities, voluntary organisations, social enterprises, co-operatives, and small businesses which can support health transformation.

Social Impact Bonds (SIBs) are one promising way to address this. These are a type of social outcomes contract, with either the public sector or governing body, by which the state pays for better social outcomes in specified areas. In most cases, this brings together three partners:

1. The outcome payer, usually a state or public sector body.
2. The service provider, which works to achieve stated outcomes.
3. Investors, who provide upfront funding for the service provider to finance the project, and whose returns are based on the success of achieving the state outcomes.

The outcome payer could also be the investor – indeed, the government has the advantage of access to cheap finance. SIBs can also be opportunities to crowd-in greater levels of private investment.

There is a range of potential advantages of SIBs, including some that are highly pertinent to prevention and public health:

- Public health investments often have a high return, but they take a long time to materialise. This can be a challenge for government, which works on one-year budgets, three-year spending reviews and five-year elections. Impact bonds remove the lag between payment and outcomes.
- SIBs focus organisations on delivering a mission of social value, rather than purely on a profit motive, helping create more 'skin in the game'.
- SIBs also shift risk from commissioners and providers to capital, which allows room for experimentation, innovation and good risk.

There are already some government programmes employing this method, including some that have been evaluated very positively. For example, the Care Leavers Social Impact Bond was designed to engage care leavers who would benefit from dedicated, additional support to get into Education, Employment or Training (EET). A 2023 evaluation found that all projects exceeded their referral and engagement targets, including among care leavers with highly complicated needs (Department for Education 2023).

SIBs need to be well defined, supported by excellent data, and contracts properly managed. But there are indications that they could be used more extensively to support health, particularly where a traditional 'public service' model is less optimal in delivering the best outcomes. Therefore, we recommend that they are more systematically employed within HAPIs – in the first instance, as a pilot of their potential rather than as a 'make or break' part of their strategy.

To enable this, we recommend that every HAPI in England is eligible for a Payment for Outcomes fund. Based on the budget allocated to locally commissioned SIBs in the Social Outcomes Fund, supporting one bond per upper-tier authority (on average) would require an outcomes budget of £270 million. However, the evidence suggests that the taxpayer savings, plus prosperity benefits of the outcomes achieved, would far outstrip this budget. Payment is only made once those outcomes are achieved. As in the case of the Social Outcomes Fund, there should be central government expertise on measurement, financing, and contract management throughout the process.

The specific interventions should be mission-driven and tied to plans to deliver on the seven foundations already described in this report. In each case, the outcome should be defined by specific local priorities, and subject to co-creation and local consultation. And given the focus on developing an eco-system of local partners who can deliver on health, but beyond the NHS, we recommend that providers are limited to not-for-profit organisations, charities, co-operatives, and social enterprises with a demonstrable track record on social impact in the first instance.

RECOMMENDATION

- A health and prosperity Social Impact Fund should be created to support social impact contracts, to explore their viability as a measure of accelerating good public health – and therefore better prosperity – at significant value for money within HAPIs.

3. MUTUAL AID AND COMMUNITY EMPOWERMENT

There is much that communities already and can do themselves. Indeed, our deliberative research showed both a desire within communities to have more agency and a feeling of disempowerment over the health outcomes in their local area.

There are few better case studies of the potential of communities than the Covid-19 pandemic. As a response to public health policies like lockdown, over 4,000 mutual aid groups formed across the UK between 2020 and 2021 – volunteer-led initiatives where groups of people supported each other in the places they live. Nearly one million signed up to the NHS volunteer scheme, and in just the first three weeks of lockdown, a quarter of a million people signed up at local volunteer centres. Indeed, New Local Trust research finds that the government's shielding programme was only possible due to volunteering and mutual aid.

Outside a pandemic, there is a range of community-led or community-owned schemes that have a positive impact on health and prosperity. They include community allotments, schemes to create a cleaner environment, shared living schemes like Shared Lives Plus, and community befriending schemes to tackle loneliness.

However, beyond the context of a pandemic, there are also very real barriers to community-led or community-owned initiatives. Our deliberative research participants suggested four in particular:

1. **Time:** leading new initiatives takes significant time. This can be very difficult to balance against insecure work, as well as family or case commitments.
2. **Resource:** running or owning even a small initiative can require upfront investment and ongoing funding. The funding need is often small – enough to rent or purchase a space or allotment, perhaps combined with a phone and internet connection – but can nonetheless present a significant barrier to entry.
3. **Expertise:** running community programmes requires both management and specific expertise. Many in our deliberative research groups said that they simply wouldn't know where to get started.
4. **Risk:** there is a worry about what happens if things go wrong – including possible financial or legal liability.

This coheres with the wider evidence, which also suggests that these barriers are more significant in more deprived parts of the country. That is, meaningful community power is more difficult to create in the places where it is most needed.

But these barriers are also relatively easy to overcome. To do this, we propose the government introduces a new Healthy Communities Volunteering Service. In the first instance, this service should:

Promote and coordinate

- Connect people interested in volunteering their time with other people, linked to HAPIs (wherever possible).
- Promote volunteering, including through work with job centres, through local engagement, and in partnership with the Royal Voluntary Service.
- Work with the NHS to bring more volunteering outside acute settings.

Break down barriers

- The service should be staffed to provide a consultation service, including hands-on expertise, to help volunteers get initiatives up and running.
- The service should also have a grant making function, providing small payments of up to £10,000 upfront plus on-going funding for costs.

Limit liability

- The new service should limit the liability of small community organisations, mutual aid groups and directly owned infrastructure – helping mitigate against a perception of risk.

This new service should not replace existing national or local volunteering services, but rather provide a focal point for coordinating their efforts.

Given the small amount of funding needed to enable individual initiatives, we suggest a relatively modest budget could still deliver significant impact. We recommend that the service is piloted with a budget of £20 million in the first year, with an ambition of supporting six new community initiatives (on average) per local authority.

RECOMMENDATION

- A new Health Volunteering Service should be created to provide funding, expertise, and to limit liability for community initiatives – while also matching people interested in volunteering with strategic opportunities in places that would benefit the most.

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The Commission on Health and Prosperity

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Lord James Bethell, former health minister

Matthew Taylor, chief executive, NHS Confederation

Professor Donna Hall CBE, chair, New Local

Marie Gabriel CBE, chair, NHS Race and Health Observatory

Kieron Boyle, chief executive, Impact Investing Institute

Jordan Cummins, health director, Confederation of British Industry

Kamran Mallick, chief executive officer, Disability Rights UK

Dr Charmaine Griffiths, chief executive officer, British Heart Foundation

Anna Garrod, policy and influencing director, Impact on Urban Health

Sophie Howe, future generations commissioner, Wales

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Andy Burnham, mayor of Greater Manchester

John Godfrey, executive chairman, Business for Health

Professor Clare Bambra, professor of public health, Newcastle University

Christina McAnea, general secretary, Unison

Dr Jonathan Pearson-Stuttard, chair, RSPH

Dr Halima Begum, chief executive officer, ActionAid UK

Dr Fiona Carragher, director of research, Alzheimer's Society

Carys Roberts, executive director, IPPR

Professor Simon Wren-Lewis, professor of economics, Oxford University

Tom Kibasi, senior vice president of strategy, Flagship Pioneering

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