RSA Inclusive Growth Commission

Response from PHE

December 2016

Final

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RSA Inclusive Growth Commission - Response from PHE

1. Role of Public Health England (PHE)

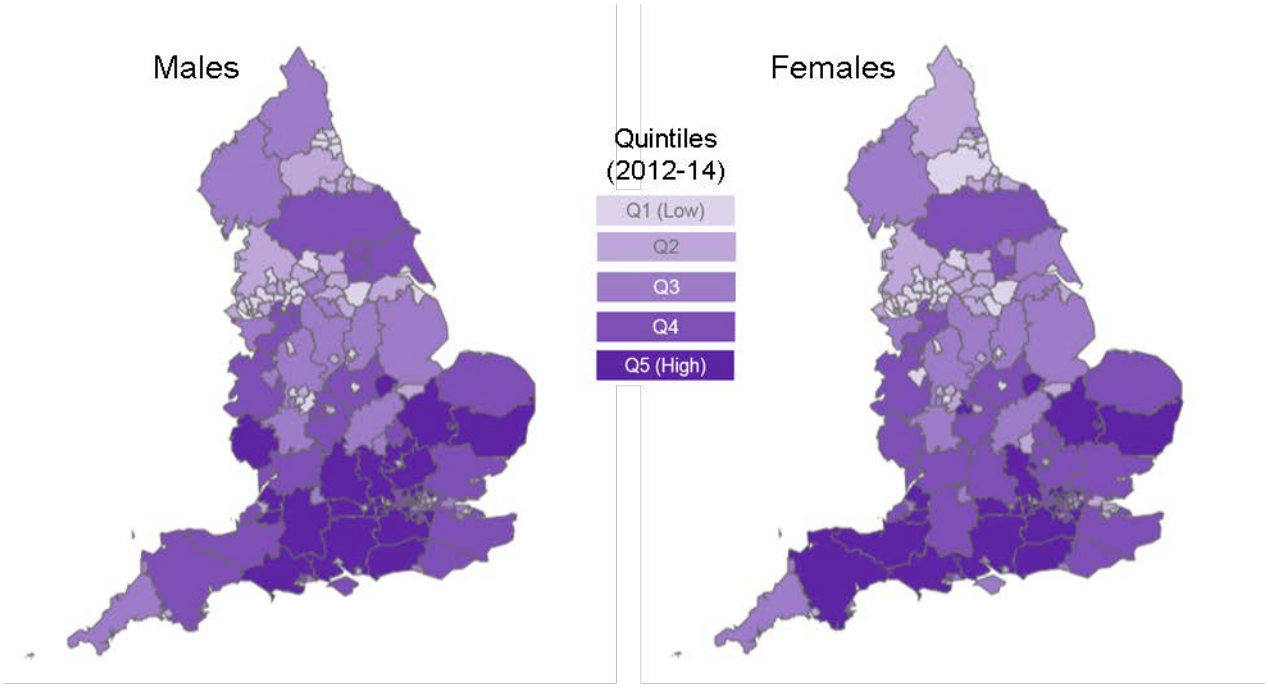
1.1. Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health and works in partnership with national and local government, NHS, community and voluntary sector, businesses and with academia.

1.2. This submission sets out key points of health evidence that are deemed relevant to the themes of enquiry of the RSA commission. In this we show the importance that good early years and childhood play in developing an adult population that is fit for work and has the skills and educational attainment ready for lifelong progression. The paper sets out the bi-directional interconnections between work and health and the dimensions that might be pertinent in considering what makes for inclusive growth and that helps people of all backgrounds to thrive. The physical environment where people live, grow, work and play have an impact on health and wellbeing and so we summarise here some elements of physical places that are important for the creation of dynamic and flourishing people. Our final section covers some thoughts on investment, governance and engagement in supporting growth.

2. Distribution of health across England - Inequalities in health outcomes

2.1 A key international marker for health is life expectancy and in England overall life expectancy for men is 79.5. This varies in association with measures of deprivation with a gap of 9.2 years between those living in the most deprived decile compared with those living in the most affluent. For women the overall figure for life expectancy is 83.2 with a 7 year gap between the bottom and top. These significant inequalities in health experienced by people are distributed unevenly across the nation, with much of the poorer experience of life expectancy being amongst people in northern England. .The following maps show that distribution across the country.

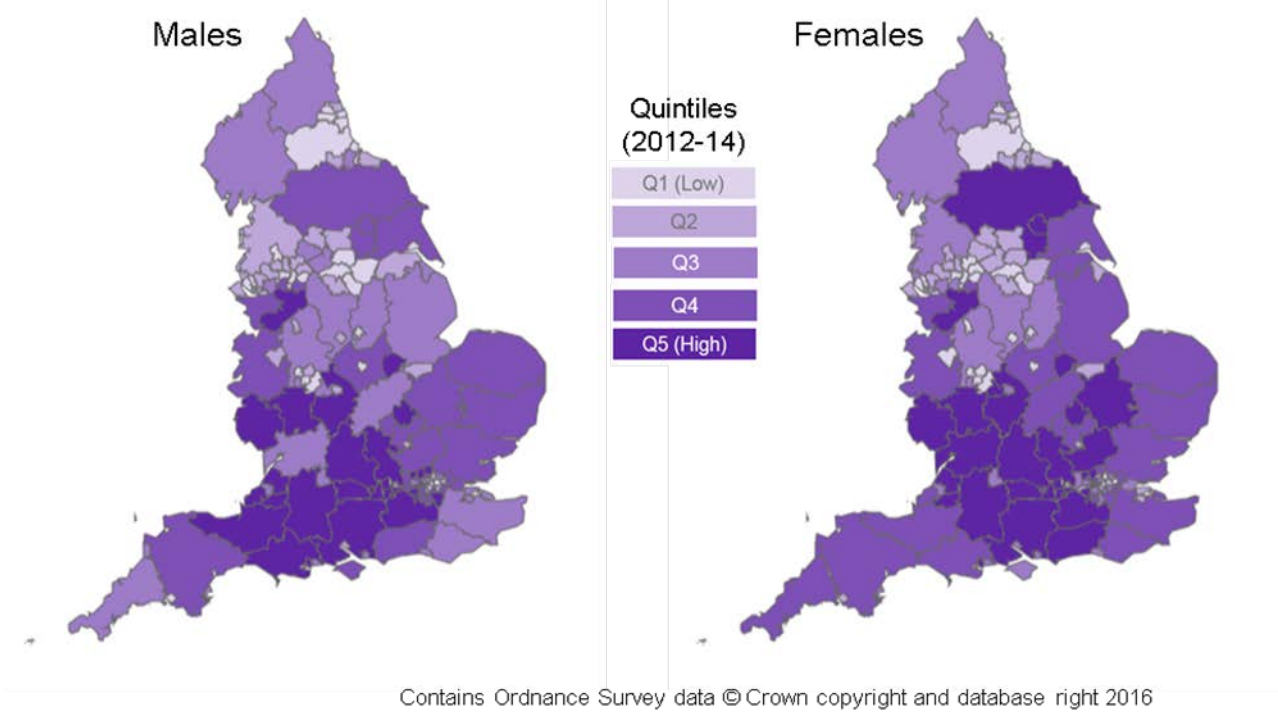
Map 1 Life expectancy for men and women by quintile of deprivation



Source: PHOF 2016

2.2. Map 2 shows the measure of Healthy Life expectancy i.e. of years lived in good health. Across England the gap is 19 years for men and 20.2 years for women.

Map 2. Healthy Life Expectancy at birth 2012-14



Source: PHOF 2016

3. Creating more equal health outcomes for people and places- Findings from commissioned reviews

3.1. There have been a number of examinations of the gaps in life expectancy and health of the nation over the years that have focussed on some of the wider drivers of health inequalities, including the role of work and income. A relatively recent and extensive report for England was the Marmot Review 'Fair Society, Healthy Lives'[1], which examined in detail the evidence on the differences in health experience across the country and what were the key elements or determinants of those outcomes. The review made recommendations based around six policy domains that had the most relevance to reducing inequalities. These are likely to be of relevance also to securing more inclusive growth that leaves fewer behind.

i. Give every child the best start in life
ii. Enable all children, young people and adults to maximise their capabilities and have control over their lives
iii. Create fair employment and good work for all
iv. Ensure healthy standard of living for all
v. Create and develop healthy and sustainable places and communities
vi. Strengthen the role and impact of ill-health prevention.

3.2. The specific problems of health inequalities for the north of England have been explored in detail by the Health Equity North Commission chaired by Prof Margaret Whitehead. In her report 'Due North: Report of the Inquiry on Health Equity for the North ' [2] she sets out the differences in poverty, power and resources needed for health and the differences in exposure to health damaging environments, such as poorer living and working conditions and unemployment. The report set out policy approaches to solutions around four key areas of:

i. Economic development and living conditions;
ii. Early childhood as a critical period;
iii. Devolution: having the power to make a difference at the right spatial scale; and
iv. The vital role of the health sector

3.3. Further findings from the North East of England report, 'Health and Wealth - Closing the Gap in the North East. Report of the North East Commission for Health and Social Care Integration'[3], showed that just a narrow focus by the health and care system would not be enough to change the interconnecting factors leading to poor health and demand on services. Closing the healthy life expectancy gap with the rest of the UK over the next decade would add 400,000 additional years of active, healthy life for the people of the region. The current poor health also reduces productivity and hampers economic growth, entrenching the income inequalities which contribute to poor health.in a commonly described cycle of interconnection

between health and wealth. They have asked CIPFA to undertake the first public sector balance sheet review for any English region.

3.4. What each of these has in common is the understanding that health and local economy are interconnected, that action on reducing health inequalities and reducing demand on health and social care services will not be solved by health sector alone. Health is interconnected with the wider structural and economic conditions in which people grow up and grow old in.

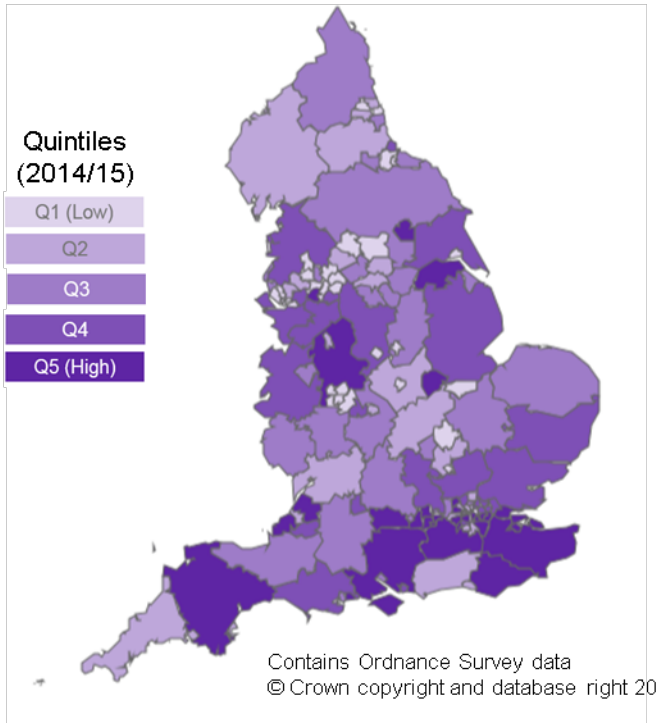
4. Economy: More inclusive, productive labour markets

4.1 Early Years and the Best Start in Life

An extensive body of accepted evidence[4] now points to the important role that early years play in establishing the right conditions for an individual to flourish. This includes healthy pregnancies, safe births, and creating the right environments and support for every child to be ready to learn by 2, and ready for school by age 5. Map 3 shows how the levels of school readiness are highly variable across the country. There is a 15 percentage point gap between the average rate and that for children eligible for free school meals. This in turn will have longer term impact on overall school and learning outcomes for children, attainment of adequate qualifications and the ability to continue to learn throughout adult life.

Map 3

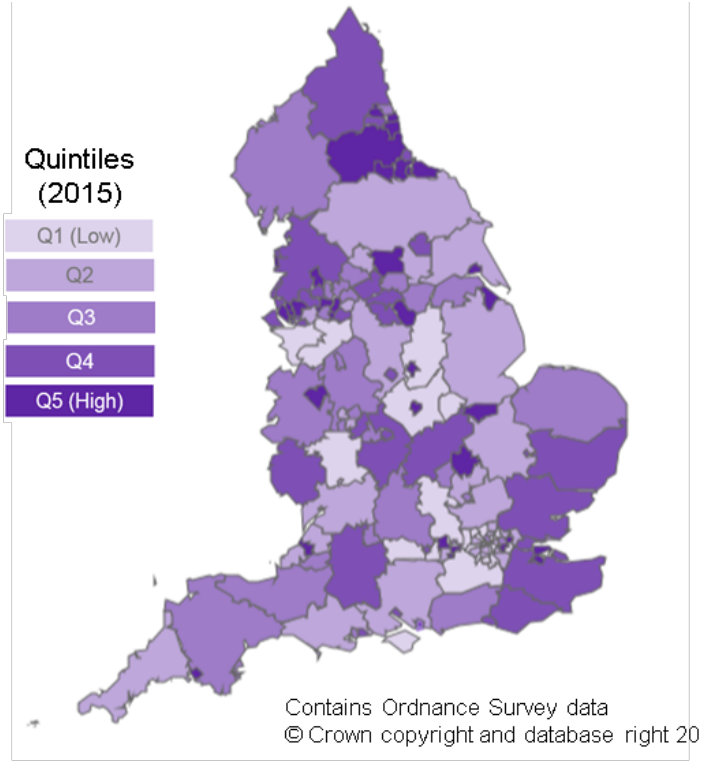
Percentage of children achieving a good level of development by the end of reception (Persons)



Health and wellbeing should be supported across a child and young person's schooling and young adulthood, through a combination of universal services (health visiting and school

nursing particularly targeting CYP), and targeted services to meet the additional needs of those families and children who need extra help and extra protection. Helping children achieve their potential is core to schools, families and wider society and yet we know too many fail to reach that potential by the time they leave school. Levels of people not in employment, education or training (NEET) vary across the country according to Map 4 and reducing levels of NEETs is an important part of ensuring that economic growth works for all.

Map 4. 16-18year olds (%) not in education, employment or training



There is good evidence on what works in order to enable and support young people to enter employment, education and training. Our report[5] on reducing the numbers of NEETs shows that taking action to reduce NEET levels is both possible and necessary –to ensure young people have opportunities, can thrive economically and as an important way to improve health and reduce inequalities.

4.2. Work health and health inequalities

4.2.1. There is a clear relationship between employment and health set out in a range of national reports over the last two decades[6]. The Marmot Review recognised the important role of good employment in improving health and reducing health inequalities: “Being without work is rarely good for one’s health, but while ‘good work’ is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill”. At an individual level, those who are in safe and supportive work environments have better health than those who are unemployed, and the longer an individual is unemployed the greater the negative impacts on their health[7]. Being in employment has the potential for positive impacts both through the activity of work and the workplace social and

physical environment as well as through the economic freedom and choices that being independent of state benefit brings.

4.3.2. At a population and employer level there is a clear logical connection between the health of the local population and the economic viability and productivity of the area, as most businesses draw their workforce from the local community and there is a correlation between employee health, productivity and presenteeism. This relationship becomes even more important when we consider the relationship between local economic viability, business rate income and the future sustainability of public services[8].

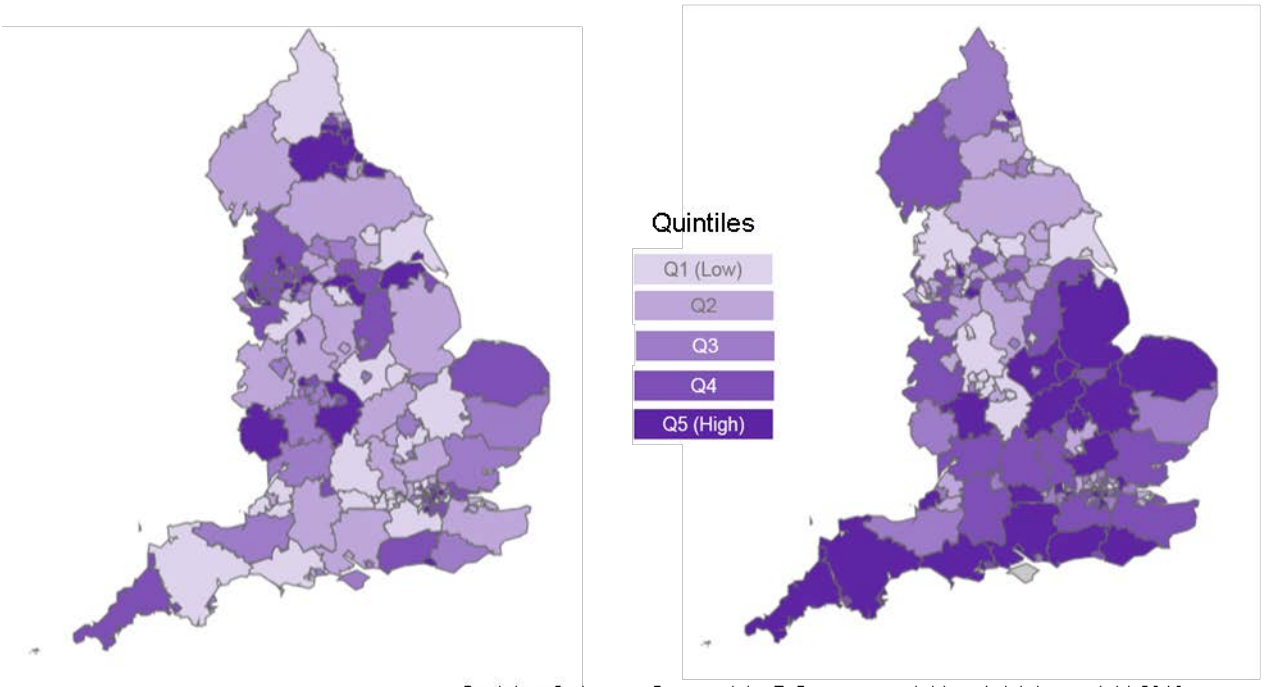
4.3.3. There are inequalities in both health and labour force participation for different protected characteristics[9] (such as ethnicity or disability), as well as stark inequalities in employment rates between individual who live with impairment or long term health conditions including mental health [10]. These inequalities may compound each other and be bi-directional in terms of impact. With an individual who has a health condition or coming from a minority community finding it potentially harder to enter the labour market[11], then once in employment fluctuations or deterioration in their health status or experiences of harassment[12] and discrimination[13] may lead to prolonged sickness absence or leaving their employer prematurely, hence there is a the potential for inequalities in both recruitment and retention.

4.3.4. There are 11.5 million working-age people in Britain with a long-term health condition, with 6.5 million classified as disabled. Around one-quarter of the 28 million workers in Britain have a long-term health condition or impairment but people with a disability or long-term health condition have far lower employment rates than other people with exceptionally low rates of employment among those with mental health problems, which are also leading causes of sickness absence in the UK. The employment rate for all people with mental health problems is 37%, compared with 45% of disabled people, 58% of the population with a long-term health condition and 71% of the working-age population as a whole. The estimated cost of mental health problems to the economy is £30-£40 billion, arising from lost production from people with mental health problems, the costs of informal care, and NHS costs[14]

Maps 5 & 6 show some of the differences in employment outcomes for those with long term illness and those with severe mental illness

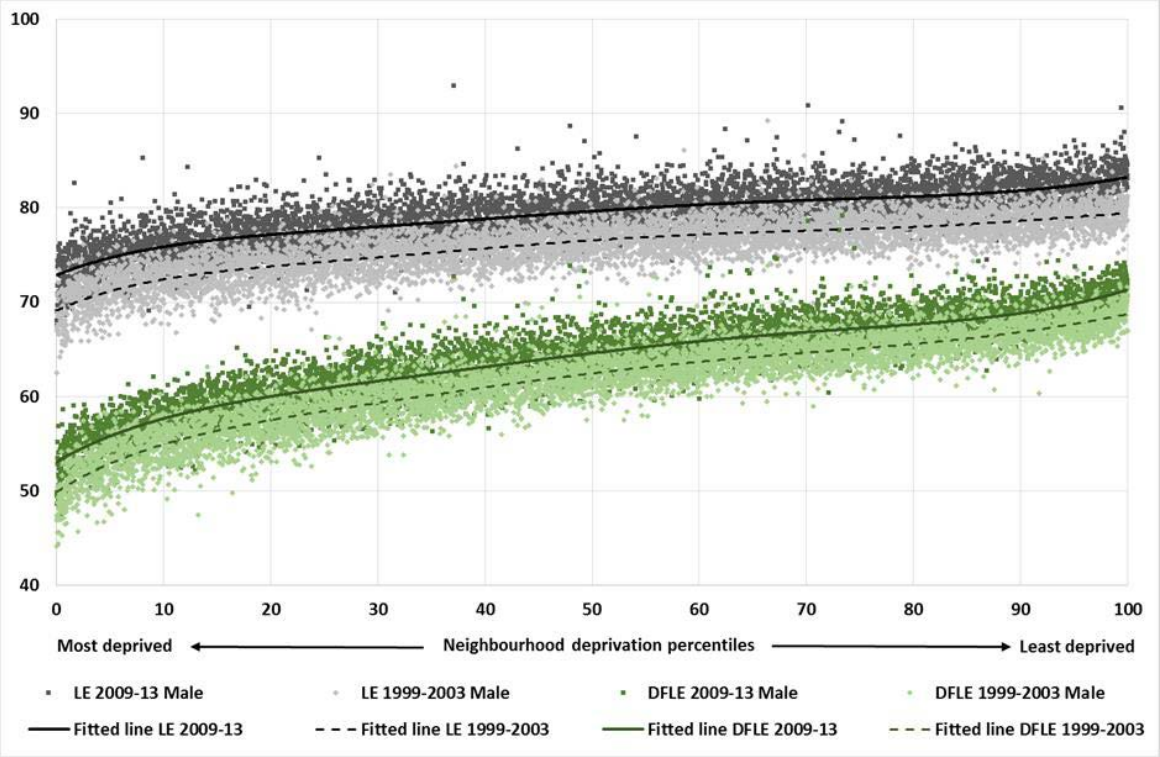
Gap in the employment rate between those with a long-term condition and the overall employment rate. (Percentage point – 2015/16)

Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate. Percentage point – 2014/15)



4.3.5. The challenges of health and employment, particularly in terms of retention, are growing as the average life expectancy has significantly increased[15] but so has the proportion of life spent living with an impairment or long term condition[16]. As the proportion of the workforce remaining in work into older age increases[17] so does the need for employers to be responsive to health issues, particularly those whose prevalence increases with age like cancer and cardiovascular disease. The graph below from Prof Michael Marmot exemplifies that picture for men. Life expectancy increases across two time periods are shown in the grey lines and also showing the gradient across deprivation deciles. The green lines show the gradients in Disability Free life expectancy (DFLE) across those same time periods. So while these have improved there remains a significant proportion of the population, mainly in the more deprived sections of society, who are experiencing disabilities and limitations of function long before their retirement age, which itself is increasing.

- **Fig 1. Life expectancy and disability-free life expectancy (DFLE) at birth, males by neighbourhood deprivation, England, 1999–2003 and 2009-2013**



Source: UCl Institute of Health Equity(IHE) http://www.instituteofhealthequity.org/presentations Dec 2016

4.3.6. In reflecting the paradigm of health and work, it is important to keep in mind the social model of disability[18]. Many people who live with health conditions are able, and want to participate in work of some form[19], however the disablement comes from the lack of job opportunities and workplace which provide flexible and adaptive jobs which enable rather than disable for both physical and mental health.

4.3.7. The way work is organised and the work climate are contributory factors to the social gradient in health. Our publication with Institute of Health Equity (IHE) 'Promoting good quality jobs to reduce health inequalities' shows that lower paid workers with fewer skills or qualifications are more likely to experience poor working conditions and worse health. The nature of work can adversely affect health through:[20]

a. Adverse physical conditions of work. e.g. exposure to physical and chemical hazards, long hours or shift work
b. Adverse psychosocial conditions at work. e.g. conflict, lack of autonomy, lack of control
c. Poor pay or insufficient hours.
d. Temporary work, job insecurity and risk of redundancy.
e. Job satisfaction and wellbeing.

4.3.8. There is evidence that psychosocial working conditions can be improved in a variety of ways, for example by increasing employee control over their work and allowing participation in decision-making, ensuring effective leadership and line management training, adoption of flexible working practices, and with interventions to reduce stress and improve mental health at work – leading causes of sickness absence. Measures to improve the quality of work and working conditions that focus more attention on workers in lower grade occupations may help to reduce inequalities in work-related health problems. Personalised, tailored support has been shown to be effective in supporting people with disabilities and long-term conditions into work or training. Increasing employer awareness of national programmes, guidance and legislation on employment of disabled people and those with long-term or fluctuating health conditions would be positive action.

4.3.9. Poor working conditions are among the determinants of early retirement. Therefore, measures to improve working conditions, including those that aim to make conditions more suitable for older workers, are likely to increase the chances of retaining older staff. Approaches to consider include promotion of fair recruitment practices that encourage applications from older people, flexible working, phased retirement and flexible retirement options and training for managers on issues of age.

4.3.10. PHE's publication with IHE on 'Increasing employment opportunities and improving workplace health' identifies further information and provides a summary of evidence on the effects of unemployment and poor working conditions on health and the unequal distribution of these effects. It outlines the potential actions that can be taken in local areas around four specific topics:

1. Workplace interventions to improve health and wellbeing.
2. Work with local employers to encourage, incentivise and enforce good quality work.
3. Interventions to increase employment opportunities and retention for people with a long-term health condition or disability.
4. Interventions to increase employment opportunities and retention for older people.

4.3.11 There are significant changes taking place in the spectrum of work types. Many of the newly created jobs are at the lower end of the skills and pay level in the social care, leisure and retail industries. These are associated with low pay, lack of guaranteed hours, training and job security; all associated with greater risk of physical and mental health problems. 'Promoting Good Quality Jobs 'looks at how job quality impacts on health, trends in job quality and how work can be health-protective

4.4. **Adult learning**

There is evidence that involvement in adult learning has both direct and indirect links with health, for example because it increases employability. These effects differ according to who is taking part and the type of learning provided. There is also evidence that skill formation (particularly in literacy and numeracy) and qualifications may be important for health. There is some evidence that those who are lower down the social gradient benefit most, in health terms, from adult learning. A PHE paper [21]summarises the evidence on adult learning and health.

4.5. **Health inequalities, living wage and in-work poverty**

.The Marmot Review recognised the important role of achieving a "minimum income for healthy living" in improving health and reducing health inequalities: "An adequate and fair healthy standard of living is critical to reducing health inequalities. Insufficient income is associated with worse outcomes across virtually all domains, including long-term health and life expectancy." THE PHE/IHE paper on this subject [22] builds on that position to show that taking action to increase the number of people earning a living wage is possible and necessary – both to move people off low incomes as a goal in its own right, but also as an important way to improve public health and reduce inequalities. However it is clear from work from the JRF that in-work poverty remains a considerable challenge. In its most recent report on 'Monitoring Poverty and Social Exclusion 2016' it finds that there are 3.8 million workers in poverty[23]and a total of 7.8. million people living in poverty within working households

5. **Place: Dynamic, resilient places need to be good for health**

5.1. Good design for better lives and growth

5.1.1. Dynamic, sustainable and prospering places need good places to live, grow up and grow old in. The quality of the physical environment in homes and neighbourhoods has a direct impact on the mental and physical health of the residents. Considerations of inclusive growth need to take into account wider development objective of those areas that are not prospering.

5.1.2. The key to successful places lies in the communication between services and proximity of amenities, from healthcare facilities to green infrastructure to local transport networks and access to employment[24]. Compact neighbourhoods that feel safe, well connected and provide access to several amenities and destinations, seem to have a positive impact on health and wellbeing[25] [26] [27] [28] [29] . Neighbourhood design can have a profound impact on the physical and mental health of communities as well as on access, growth and inclusion. Good housing, employment and transport also play a major role in the delivery of health and social care. The wider health and societal ambition to keep people as independent as possible is dependent on these dimensions alongside having a vibrant and connected local community.

5.1.3. There is a graded relationship between environmental conditions and levels of area deprivation. Residents of more deprived neighbourhoods tend to experience less favourable living and environmental conditions than people who live in more affluent areas[30] [31] [32].

5.2 Housing, Health and Growth

5.4. Evidence suggests that poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases, depression and anxiety[33] [34] [35] [36]. The greatest risks to health are related to cold and damp homes (including mold and fungus), which affect and exacerbate respiratory conditions, indoor air quality, dust mites and other allergens. House type and overcrowding represent further examples of risk factors[37].

5.5. Children and the elderly, and, are particularly vulnerable to poor housing conditions and are also more likely to suffer ill health in a cold home [34,38]. Evidence also shows that exposure to multiple housing problems increases children's risk of ill-health and disability. A social gradient in fuel poverty exists; those on lower household incomes are more likely to be at risk of fuel poverty, contributing to social and health inequalities. Cold homes are more likely to increase risk of a range of physical health problems such as cardiovascular disease and respiratory disorders. Mental health is also affected by the cold. Our report on cold-home related problems [39] presents the evidence relating to the impact of fuel poverty on health and health inequalities and sets out some areas where action could protect or mitigate the impacts.

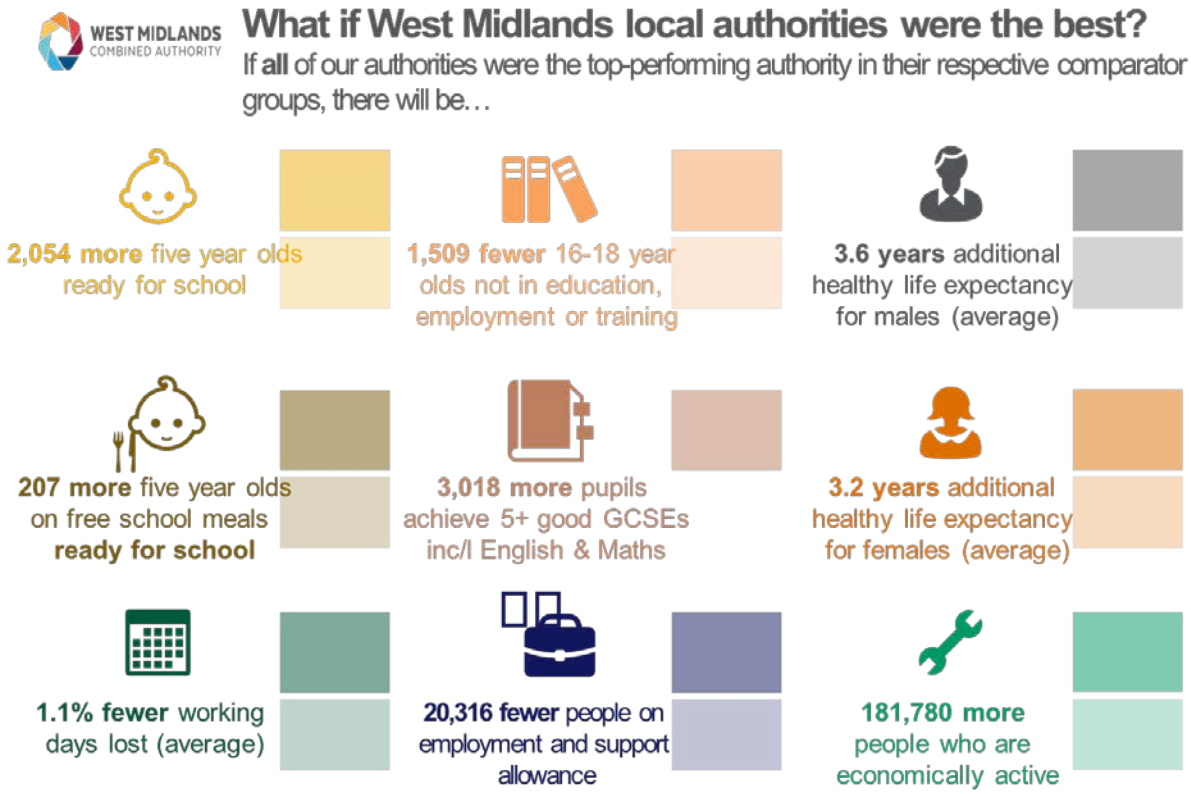
5.6. According to the latest English Housing Survey[40], 4.8m homes in England do not meet decent homes standards, which is equivalent to 21% of England's housing stock. The private rented sector had the highest proportion of non-decent homes (30%) in 2013 while the social rented sector had the lowest (15%). A fifth (19%) of owner occupied homes failed to meet the decent homes standard in 2013. The Building Research Establishment (BRE) recently estimated that the total health cost of poor housing to the NHS is £1.4 – 2.0 billion per year for England[41] . The recent JRF report on monitoring poverty and social exclusion estimated that housing costs are higher as a proportion of income for poorer households, and more so for renters. More than 70% of private renters in the poorest fifth spend at least a third of their income on housing, compared with under 50% in the social rented sector and 28% for those who own their own homes. Experience of the housing market is increasingly determined by tenure and the most common cause of homelessness is the end of a shorthold tenancy or rent arrears.

5.7. Latest research suggests that some 240,000-245,000 additional homes will be required each year to meet newly arising demand with nearly one-third of required at below-market prices and rents . All forms of homelessness, including precarious housing, were estimated to cost the public purse (including health services) £1bn per annum[42] and the latest data indicates that a homeless person is 4 times more likely to be admitted to hospital and visit A&E than the general population[43].

6. Governance: Creating system change

6.1 Interconnected action for growth.

Solutions to Inclusive Growth do not rest with any one sector and are not the responsibility of any single tier of government or society. There is a clear and strong role for national government. There is also one for local government, other statutory sectors as well as the diverse parts of the business community. Actions that support growth operate vertically from national to local to community and vice versa. They also operate laterally across sectors and across investment areas. Devolution offers additional opportunities for greater collaboration on joined up actions as set out in the review from the North East Commission for Health and Social Care Integration shows. Other lessons are emerging from West Midlands on the development of a vision and measureable outcomes that areas might aspire for their region as set out in this example in Fig 2.



6.2. Communities as partners in creating inclusive growth

Discussions on devolution have in the main focussed on devolution from national government to more local control for managing budgets and development. What is not so clear is the potential for devolution down to very local communities and the role that they might play in being more engaged and empowered for action on growth in those areas. Evidence[44] for the positive role that community engagement and empowerment can play in improving health has been emerging and the evidence is strong. Interventions for working with community range across

i) approaches for strengthening communities
ii) volunteer and peer roles
iii) collaborations and partnerships
iv) Access to community resources.

Considerations of creation of inclusive growth might helpfully consider the roles that affected communities might play in helping design and (co)create that growth

6.3. Health, local economy and the Social Value Act

The Social Value Act requires all public sector commissioners to consider how they could improve the economic, environmental and social wellbeing of their population through their procurement activities. This legal requirement creates opportunities to use local and national commissioning to improve health and reduce health inequalities, through action on some of the determinants of health such as training and employment, local reinvestment and targetting of resources. The PHE/IHE report 'Using the Social Value Act to reduce health inequalities in England' makes the case that acting on social value has clear benefits in helping to reduce health inequalities and sets out guidance for local implementation with examples of local action from across the country. This applies to the NHS as a major employer in every area of the country. It is also a major player as commissioner of services and products. With its large budget, 1.5 million staff (approx.) and its consumption of products from energy to food to complex medical equipment and pharmaceuticals, it has extensive reach into all parts of national and local economies.

6.4. Cost effective interventions

PHE is working with CIPFA to develop a framework to advise local government on the best practice for contextualising return on investment analysis for their area. As part of this work, PHE (in partnership with Department of Health) is developing a map of primary and secondary prevention expenditure across the health system, including the NHS and Local Authorities. This analysis will aim to understand how much the system is focused on prevention and provide a baseline for the vision of a "radical upgrade" that might support the NHS plan as set out in 'Five Year Forward View'. Evidence to support action on cost effectiveness of some preventive interventions has been collated for PHE through its Health Economics team, informed by a useful WHO report [45]. PHE is pursuing further evidence on Return on Investment or cost effective interventions through a series of commissions on topics as diverse as i) costs and impacts of air pollution, ii) ROI tool on interventions to reduce health inequalities; iii) cost effectiveness and ROI on interventions associated with best start in life and iv) estimation of the benefits from moving individuals from unemployment into sustainable employment.

6.5. Good governance through the monitoring of outcomes

Achievements towards improving Inclusive growth will need a system of monitoring such as set of metrics. The Public Health Outcomes framework (PHOF) [46] includes a range of metrics that may have relevance. The overarching indicators relate to life expectancy, healthy life expectancy and the gap between upper and lower deciles. These are informed by a suite of indicators across four domains, the first being wider determinants of health from which some of the maps in this report have been created. The PHOF interactive website allows indicators to be examined for different geographical levels and in different formats.

7. Concluding remarks

Good health develops in the context of the wider structural and economic context of where people live. Good growth requires a fit, healthy, well-educated and trained population. Inclusive growth should mean that there is access to good work for all that helps to maintain health and where those who are in work are in a position to be able to live a decent, dignified, participating and healthy life.

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