PRESCRIPTION FOR FAIRNESS

REMEDYING HEALTH INEQUALITIES IN A POST-COVID ERA

Introduction by Jonathan Ashworth MP
Edited by Steve Bradley and Tom Gardiner

The Fabian Society is Britain's oldest political think tank. Since 1884 the society has played a central role in developing political ideas and public policy on the left.

Through a wide range of publications and events the society influences political and public thinking, but also provides a space for broad and open-minded debate, drawing on an unrivalled external network and its own expert research and analysis.

The society is alone among think tanks in being a democratically-constituted membership organisation, with over 7,000 members. During its history the membership has included many of the key thinkers on the British left and every Labour prime minister. Today it counts over 200 parliamentarians in its number. Member-led activity includes 70 local Fabian societies, the Scottish and Welsh Fabians, the Fabian Women's Network and the Young Fabians, which is itself the leading organisation on the left for young people to debate and influence political ideas.

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abpi

Bringing medicines to *life*

Covid-19 has underlined how critical it is that we address the health inequalities that exist across the UK. We have seen the disproportionate impact of Covid-19 on particular communities, and major disruption to programmes such as routine cancer screening and HPV vaccination which particularly impact women. Furthermore, the NHS backlog of care makes the task of addressing health inequalities even more challenging.

The positive news is that thanks to the pace of innovation in life sciences, we have never had such a range of tools at our disposal to succeed in this challenge.

The new era of personalised medicine provides us with an opportunity to shift the dial on health inequalities, putting patients at the heart of their treatment decisions, and providing a wider pool of viable, personalised care options. We need to adopt and deploy these new technologies in combination with cutting edge diagnostics which support more effective interventions earlier in the disease pathway. And we need to ensure all patients have equal opportunity to access these innovations, addressing the existing barriers some patient groups experience.

Alongside this, we must harness the potential of UK health data which can significantly improve our ability

to develop effective interventions for at-risk groups, as we have seen during the pandemic with targeted strategies to improve vaccine uptake amongst groups with higher levels of hesitancy.

Through Covid-19 we've also seen more patients, clinicians, and NHS sites engage in clinical research than ever before. To address health inequalities, we must ensure that clinical trials are more representative of the public at large. All patient groups should be able to take part in clinical research, regardless of where they live, their gender or ethnicity. This needs to be supported by more inclusive trial design, a research-active NHS which embeds clinical research in routine care, and a regulatory system which supports improved diversity in clinical research.

The new Life Sciences Vision sets out the ambition for the NHS to be an innovation partner. Tackling health inequalities can only be achieved through collaboration, and industry is committed to playing our part. The pandemic has shown us, what is possible when the life sciences community and the NHS work in partnership. This is something we must retain as we emerge from the pandemic.

Richard Torbett is chief executive of the Association of the British Pharmaceutical Industry (ABPI).

The ABPI exists to make the UK the best place in the world to research, develop and use new medicines and vaccines. We represent companies of all sizes who invest in discovering the medicines of the future.

LloydsPharmacy

While health professionals and policymakers have known about the need to tackle health inequalities for a long time, the outbreak of Covid-19 brought the issue to public attention as never before. It quickly became clear that people from ethnic minority backgrounds, people who live in disadvantaged communities, and people living with co-morbidities, were suffering worse outcomes from the virus.

There have been warnings since the publication of the Fair Society Healthy Lives report in 2010 that health inequalities are detrimental to people's livelihoods and place a higher cost on society. But it took the pandemic to throw the issue into stark relief. The public outcry means that reducing the prevalence of health inequalities is now a key priority for this government and for governments to come. A great deal of praise is owed to the likes of Sir Michael Marmot who have banged the drum on this issue for so long.

I am delighted that LloydsPharmacy is able to support this report, which goes a step further than other reports and sets out policy recommendations to address the underlying causes of health inequalities.

The publication of this report is particularly timely as the government is working to pass legislation to restructure our healthcare system. The aim of embedding collaboration at a local level is an opportunity

for decision-makers to consider what more bodies and professions can do to reduce the prevalence of health inequalities.

Community pharmacy has a vital role to play in local healthcare systems. We ensure patients have access to medicines, on our high streets and in our communities. We play a role in administering flu and Covid-19 vaccines, and we support many other patients with healthcare advice, either through referrals from NHS 111, or as people walk through our doors seeking our support. As a pharmacist with over 20 years' experience in the profession, I believe that community pharmacy can do more to support action to address and eradicate health inequalities. From administering clinical interventions, to acting as a route for referrals, and supporting with information on healthier lifestyles, community pharmacy is well positioned to deliver the right services across the UK. And importantly, patients and communities trust our ability to do so.

Just as this report brings together different contributors with expertise on health inequalities, so too should the government and local systems as they work to build healthier communities.

Victoria Steele is superintendent pharmacist at LloydsPharmacy.

LloydsPharmacy is a leading community pharmacy and healthcare provider with over 1300 pharmacies across the UK. In addition to dispensing over 150 million prescription items every year, LloydsPharmacy colleagues work to deliver high quality services and support to help people stay healthy in their communities.

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CONTENTS

INTRODUCTION

Jonathan Ashworth MP

"Of all the forms of inequality, injustice in health care is the most shocking and inhuman." – Martin Luther King

Given what we now understand about the factors that influence health outcomes – the so-called social determinants of health – I would humbly remove the word 'care' from that sentence.

If we address the factors that mean some people are bound to live shorter lives, in more pain, and with physical limitations, simply because of socioeconomic circumstances over which they have very little control, we take steps to making this a better world. Tackling these deeply ingrained health inequalities and improving population health is a driving mission of mine and will be a key priority for a Keir Starmer-led Labour government.

I am pleased to introduce this collection of essays from the Fabian Society, as we aim to move the conversation from the many challenges we face, to the solutions we must put in place. The contributors have been drawn from a wide range of backgrounds and all bring valuable expertise and insight. Though the topics they write on are broad, they are all driven

by a set of fundamental beliefs – health inequalities exist, they are unjust, and, crucially, they are mutable.

The backdrop is a devastating pandemic that has brought health inequalities into sharper focus.

In the last year, those who face existing disadvantage experienced the most difficult and tragic consequences. Working-age adults in the poorest areas have been almost four times more likely to die from Covid-19. Between January and November 2020, 60 per cent of all deaths involving the coronavirus were amongst disabled people. Our ethnic minority communities had devastating mortality rates, with men from black African communities at a 3.7 times greater risk of dying than white men in the first wave. Comparing us to other similar countries, only Bulgaria reported a higher rate of excess deaths for people under the age of 65.

A decade of austerity with poor housing, food poverty, and income insecurity has given us deteriorating population health, increasing health inequalities, and, in some parts of the United Kingdom, falling life expectancy. It left us exposed when the pandemic hit. Our poorest communities paid for years of austerity with their lives and livelihoods.

The population health of the UK is amongst the worst in Europe. People living in England's most deprived areas are likely to develop a significant long-term health condition 19 years earlier than those in the wealthiest areas. This means being forced out of paid work earlier in life and, tragically, dying earlier. Michael Marmot's analysis has shown people living in the poorest areas in England will on average die seven years earlier than those in the richest.

The prevalence of some mental health conditions is higher in deprived areas, alongside higher rates of suicide, addiction, and overdose deaths. In the most deprived fifth of the population there are 29.1 deaths for every 100,000 men due to alcohol specific causes, compared to 7.6 deaths for every 100,000 men in the least deprived fifth. And it is well

evidenced that some places have unique challenges, like coastal areas.

Certain groups in society face unique inequalities that have not been reversed as other health indicators have improved. Women with learning disabilities live on average 27 fewer years than the rest of the population. Black women are four times more likely to die in pregnancy or childbirth. People from South Asian backgrounds are more likely to develop type 2 diabetes.

These inequalities have disfigured Britain for years. But the pandemic has lent urgency to a problem our government had been ignoring for more than a decade. Since Labour's health inequalities strategy for England was scrapped by the Conservative-Liberal Democrat coalition in 2010, inequality has been allowed to progress relatively unchecked by ministers.

Tackling health inequalities is about social justice, the core of what the Labour party stands for. It makes economic sense as well. Health inequalities are preventable, yet the annual cost of inequality is around £40bn in lost taxes, lost productivity, welfare payments, and NHS costs.

Improving population health is not just about treating illness, but also preventing illness and creating health. That demands widespread action across all drivers of health, from housing quality to income security, social engagement, air quality, nutrition, and education. Tackling health inequalities calls for action from every government department and local authority beyond just the NHS. Creating the conditions to tackle stalling life expectancy and help people enjoy healthier, happier, and longer lives is vital. Measuring overall health should become as central to our national debate as GDP.

First, we know from a recent report by the chief medical officer that we could prevent 75 per cent of new cases of heart disease, stroke, and type 2 diabetes, 40 per cent of cancer

incidence, and reduce dementia levels by tackling smoking, alcohol consumption, unhealthy diets, and lack of physical activity.

In this introductory essay I want to focus on the narrower contribution of health policy to tackling inequalities.

Championing public health services is a priority of mine. The pandemic has reminded us of the value of local authority public health services and directors of public health. But for years, rather than enabling public health staff to successfully prevent people getting ill in the first place, the Tories have devastated public health infrastructure with deep cuts. For example, we know smoking leads to over 50 serious health conditions, and that 21.2 per cent of those on low incomes smoke, compared to 9.9 per cent of those on high incomes. Yet smoking cessation services have been cut by 17 per cent since 2016. Similarly, more and more are losing their lives to alcohol and drug addiction. Yet specialist services have been cut by 15 per cent since 2016. The pandemic should have reminded ministers of the value of local authority public health services and directors of public health. They deserve the tools and resources to target inequalities.

Second, we need to confront the social and commercial determinants of ill health. Government must use the tools at its disposal to drive down smoking, drinking, consumption of high energy foods and unhealthy diets high in salt, sugar, and starch. Tackling advertising of unhealthy products and action to reduce sugar and salt content is vital.

Of equal challenge is food poverty. Food bank usage has exploded – the Trussell Trust distributed 61,000 emergency food parcels in 2010/11, and 1.9 million in 2019/20. Many of those who are affected are children, with 320,000 children referred to a Trussell Trust food bank in 2019/20. These numbers should shame ministers. If the very poorest were to

follow healthy eating advice they would spend 74 per cent of their income on food.

Third, action on health inequalities must ensure every child matters again. Health inequalities, observable at birth between deprived communities and wealthy communities, continue and compound throughout a child's life. By the time they leave primary school, 27.5 per cent of children living in the most deprived areas are obese, almost three times as many as in the least deprived areas. This metric has worsened by around 50 per cent over the last 15 years. Today we see long-term conditions such as type 2 diabetes in children as young as seven. These inequalities often continue into adulthood, with evidence showing those who were overweight, had lower birth weights, or suffered mental ill health in childhood are at increased risk of ill health in midlife.

What's more, although children may not have been the face of this pandemic, they have been amongst its biggest victims with limited schooling, restrictions on play and social interaction. Child health and wellbeing has been a longstanding priority of mine. From a focus on early years, to valuing health visitors and improving mental health provision, ministers must provide children with the support they deserve. It is my personal ambition as a potential health secretary to put in place the largest children's health and wellbeing programme ever seen, with the voices of children, parents and experts at the heart of developing it.

Fourth, just as we need to address inequality in health outcomes, so too must we tackle inequality in access to health services. Ministers should be appalled by the fact that in primary care, practices in poorer areas receive around 7 per cent less funding per patient than richer areas once greater health needs are accounted for. They also have four

fewer GPs for every 100,000 patients and less time to spend with those patients in appointments.

Access to healthcare was further blighted by inequality throughout the pandemic – the number of completed treatment pathways in the most deprived areas fell by 31 per cent in 2020, compared to a fall of 26 per cent in the wealthiest areas. I have recently published analysis from the House of Commons Library that shows in the first three months of 2021, patients in poorer areas faced greater difficulties making a GP appointment than those in wealthier areas.

When the Labour government introduced health checks for everyone over 40 to reduce heart disease in 2009 we were looking to improve the health of everyone, rich or poor, but it was a crucial intervention for tackling inequalities given the prevalence of cardiovascular disease in poorer communities.

However, pre-pandemic, under the Tories, only half the people invited were actually receiving those checks. These checks were paused during Covid-19. It is now vital they are relaunched and as we know people with heart and kidney conditions were more likely to die from Covid-19, it is even more important that ministers put in place a plan to ensure people attend these checks.

And, finally, we face the challenge of scaling up technological innovation in a way that benefits us all whilst also reducing inequalities. Throughout the history of the NHS, technology has transformed healthcare. The pandemic has shown the remarkable achievements of our scientific community in developing vaccines. Emerging advances in genetic sequencing, machine learning and artificial intelligence will provide patients with greater precision in managing their long-term conditions, which we know cluster in poorer communities. Continuing to champion and expand our research and science base should be a priority for ministers. These assets can be deployed to tackle health inequali-

ties, alongside developing the diagnostic tools, therapeutics, and lifesaving drugs of the future.

This pandemic can and should be a watershed moment for health inequalities. We must all dedicate ourselves to finding the solutions and making them real. Labour is more than ready to do so.

1. GREENER AND HEALTHIER

Mala Rao

Devastating as the pandemic has been, its effects are likely to be overshadowed by the impact of climate change in the years to come. Now is the time to act to ensure global warming does not exacerbate health inequalities.

History will remember 2020 as the year when the Covid-19 pandemic, the greatest public health disaster in a century, struck, and the world woke up to the fact that the disproportionate impact of the virus on disadvantaged communities was substantially explained by pre-existing socioeconomic inequalities which have defined their lives.

The Marmot Review 10 Years On[1] highlighted that UK population health has deteriorated and health inequalities have widened in the decade since the team's 2010 report.[2] Inequalities in life expectancy have increased, and the life expectancy of men and women in some of the most deprived areas outside London has dropped. Life expectancy gradients follow social gradients and in 2020, the healthy life expectancy gradient was steeper than that of life expectancy. Addressing these inequalities and their structural causes is imperative. In this chapter I argue, however, that we are at a moment in history when the impact of the pandemic, devastating as it has been, may appear historically transient

in magnitude and scale, dwarfed as it is by the threat posed by climate change and its impact on health and wellbeing.

Health is shaped not only by the social but also the environmental conditions in which people live and work[3]. For example, areas with poorer air quality are also characterised by social deprivation. A 2006 study[4] commissioned by the UK government, which confirmed the link between environmental and social inequalities, demonstrated that health inequalities are best addressed if social and environmental justice are considered together. Against this background, the recently published sixth report of the Intergovernmental Panel on Climate Change[5] is stark and unequivocal. Improving health and addressing health inequalities will require the climate to be recognised as the core underpinning of health, as it is key to how the social determinants of health will be shaped and how health and social equity can be realised.

How climate change risks increasing health inequalities

Climate change harms health and exacerbates health inequalities in the UK[6] as it does globally. Strategies to tackle these inequalities will need to take account of the differences in vulnerability due to differential exposure, sensitivity and the adaptive capacity of individuals and groups. The pathways and mechanisms by which the climate impacts on health and increases health inequalities are complex and interwoven. Extreme heat and air pollution, as well as malnutrition, population displacements due to extreme weather and further pandemics, are some of the risks we face if global warming increases beyond 1.5C.

Heat-related mortality is projected to increase in the UK by 45 per cent by the 2020s and by 167 per cent by the 2050s, when projected population growth and demographic change are taken into account[6]. Exposure to heat may be greater in urban areas, densely built neighbourhoods with limited

green spaces, poorly ventilated buildings and top floor flats, with many of these features coming together in deprived urban neighbourhoods. A warmer climate may benefit health by reducing cold-related mortality in vulnerable older people facing fuel poverty and poor housing, although rising energy prices may be a significant barrier to indoor heating even during occasional cold spells. Warming is also increasing the risk of food-borne diseases, especially among older people and households with young children with lower adaptive capacity due to factors such as low incomes and isolation. Air pollution is high in cities, and especially in areas near major transport corridors, which are associated with an over-representation of socioeconomically disadvantaged and ethnic minority residents. Air pollution increases the risk of all-cause, cardiovascular and respiratory mortality and morbidity, and is worsened by warmer weather, more frequent heat waves and changes in rainfall. The frequency and intensity of flooding is also set to increase, with a range of impacts from irrecoverable losses due to damage to homes and assets to lack of access to health and other services. The burden of these will fall disproportionately on deprived and vulnerable households lacking the resilience to withstand climate disasters.

Addressing climate change and health inequalities

Scope for hope and optimism

Solving the climate crisis requires the whole of society to come together in ways we have never done before. The scale of change will require every individual to be involved. The public already recognises this, as societal awareness of climate change has grown. In a UK study in 2019[7] it was found to be the most important issue for young people and among the top five for the whole population, ranking more

important than terrorism and housing. Also of concern is the level of eco-anxiety in children who, according to a BBC survey[8], are worried, do not trust adults to tackle the challenges and do not believe leaders are listening to their views. Leaders will need to be cognisant of this, because building the resilience of individuals and communities will be core to successful climate mitigation and adaptation. Challenging as this is, there is great scope to build hope and optimism as environmental justice is key to health and social equity, and harnessing public interest and commitment towards the common environmental good is likely to benefit mental health and wellbeing and to build the resilience necessary to address the agenda collectively.

The health benefits of climate action

There is a substantial body of evidence demonstrating the wide spectrum of health co-benefits from climate action[9]. Decarbonising the transport sector has the potential to significantly reduce air pollution – and the wide range of diseases associated with it. Children are likely to be major beneficiaries as their health is particularly at risk from air pollution. Adopting active forms of travel has the multiplier effect of reducing the risk of other health conditions, such as obesity and diabetes. Improving the energy efficiency of UK housing has the direct health benefit of reducing winter deaths in older people. In children, it also helps to reduce NHS hospital admissions due to respiratory illness, with the longer term impacts of reducing school absences due to illness, and improving educational attainment, employability, and health and social mobility. Energy efficiency also has a knock-on effect on nutrition, given that low-income households may face a choice between 'heating and eating'. A reduction in red meat consumption reduces the carbon footprint of food and

reduces the incidence of cardiovascular diseases and cancer, while the benefits to mental health of green spaces are also well recognised.

Overall, benefits of climate change mitigation for health and wellbeing in the UK include improvements not only in public health and reduced NHS costs, but also the indirect impacts in terms of greater energy security, growth in the low-carbon jobs market and a reduction in poverty and inequality.

The need for collective action across sectors and across government

In the UK, rapid and significant strategies are being agreed in some sectors as a means to achieving net zero CO_2 emissions by 2050. For example, transport is now the highest emitting sector of the UK economy, accounting for 22 per cent of total greenhouse gas emissions[10], and the full transition to electric vehicles will be an important contribution towards the UK's target. However, this is not enough. Every aspect of transport will need to be considered, uncomfortable questions asked, impacts on other sectors recognised, compromise agreed and decisions taken. More broadly, siloed thinking, and the differing and competing interests and priorities of government departments and sectors need to give way to a collaborative unified approach towards one outcome – limiting global warming to 1.5C.

There are of course, legitimate concerns about the adverse effects of climate action; for example, the impact on communities and employees as the fossil fuel industry is replaced with renewable sources of energy. The 'just transition' is a methodology which anticipates and plans for these changes, minimising the adverse impacts and ensuring equitable forward planning[11].

Reimagining the economy

Concerns regarding economic growth have shifted from being a marginalised academic view to occupying centre stage, as the link between the climate crisis and the relentless pursuit of financial profit and consumerism, with scant regard for environmental and social costs, has become clear. This is against a background of nine planetary boundaries which have been described by scientists as "the safe operating space for humanity with respect to the Earth system and are associated with the planet's biophysical subsystems or processes"[12]. Transgressing these boundaries would put human survival at risk.

Given the scale of the climate threat, green growth is beginning to gain much ground and published reviews[13] have described examples of UK businesses which have been successful in achieving economic impacts, like increased employment and productivity as well as decarbonisation. One analysis of the co-benefits of climate action also highlighted the advantages of a shift towards a more circular economy as a way to improving the efficiency of resource use and improve productivity. The Green Alliance and the waste and resources action programme[10] define the circular economy as "an alternative to a traditional linear economy (make, use, dispose) in which we keep resources in use for as long as possible, extract the maximum value from them whilst in use, then recover and regenerate products and materials at the end of each service life", thus ensuring that decarbonisation is at the heart of economic strategies which in the future will provide a means to achieve health and social equity within ecological limits.

Science and innovation

The pandemic illustrated the importance of heeding scientific evidence and advice. It also illustrated the role

of scientific and technological innovation in identifying solutions to address seemingly intractable and challenging issues. Science and technology are already making an enormous contribution to the armoury of climate solutions and investment in science and technology needs to remain a high priority into the future.

The UK has world-leading expertise in low-carbon technologies and in every sector with a link to the climate crisis, ranging from transport to food production, world-class research and innovation is ongoing. Technological solutions will not 'fix' global warming and indeed, in relation to many carbon-intensive sectors such as aviation, they are a long way off. In these areas in particular, rapid decarbonisation may be fully reliant on behaviour change. The conclusion is evident – behaviour and system change, as well as science and innovation, will be required on a massive global scale.

Partnering with the public

Fridays For Future is a youth-led and organised climate strike movement launched by Greta Thunberg and her fellow strikers in 2018. Their call for action inspired a global awakening, and an invitation to join the worldwide campaign to "put moral pressure on policymakers, to make them listen to the scientists and to take forceful action to limit global warming". Climate change has mobilised people across the whole spectrum of society to come together to protest against inaction as well as to contribute to collective action. This benefits the health inequalities agenda, too, and is our best chance of ensuring that global warming is limited to 1.5C and there is a levelling up in terms of socioeconomic and health status.

For change to be mobilised at such a monumental scale, citizen participation needs to be at the centre of climate change action. Changes need to be planned and delivered with the people, ensuring those who are most marginalised and have the least voice are included, listened to and

supported. Public engagement needs to be built on the best citizen involvement theory and practice so that the public is well informed, actions have their full support and input, and they are the main actors determining how their communities will respond to the challenges of both mitigation and adaptation to climate change.

Children and young people stand to face the worst effects of climate change. They are impressively knowledgeable and clear about the action needed. This is the first time in world history where children are leading the adults towards a just transformation and there is a moral imperative for policy leaders to ensure that their futures are not gambled away.

Conclusion

The year 2020 will be remembered for the Covid-19 pandemic. But in the decades and generations to come it will be overshadowed by the impact of climate change and its concomitant effect on health and social inequalities. In the UK, 2020 may also be remembered for another milestone: the year when temperatures, rainfall and sunshine were all in the top 10 highest on record – the first time this had happened in a single year[14].

The urgent need to focus on climate action is undeniable, and the pandemic demonstrated that rapid change is possible. John Kenneth Galbraith, the distinguished American economist, said: "All of the great leaders have had one characteristic in common: it was the willingness to confront unequivocally the major anxiety of their people in their time. This, and not much else, is the essence of leadership." We must hope that our leaders recognise the challenges ahead, the need to act now and the commitment necessary to create a path to a healthy future, leaving no one behind.

2. A TRANSFORMATIVE VISION

Parth Patel

The policies we need to dismantle structural racism are the same solutions required to reduce economic and health inequalities, to tackle the climate emergency and enhance democracy. Politicians must forge a new political vision.

At the start of May 2020, it was clear that Covid-19 was exposing racial cleavages in Britain and the United States. At the end of May 2020, anti-racism protests swept across both countries. The murder of George Floyd ignited, or re-ignited, a guilt that has long simmered in civic consciousness. From buses to boardrooms, the phrase 'Black lives matter' was everywhere.

As the number of people describing racism as a structural phenomenon (rather than something simply perpetuated by racist individuals) rose, the proportion proposing structural solutions shrank. In Britain, the anti-racism reckoning transpired into calls to 'educate' people (particularly those who are white) and put more ethnic people into boardrooms ('EDI' – equality, diversity and inclusion – in corporate jargon). Such initiatives have value, but they "deal not with the politics of discrimination", as Ambalavaner Sivanandan once put it "but its arithmetic – rearranging the distribution of inequality as not to alter the structures of inequalities themselves". They are straw man solutions to the problems

that mean people from several minority ethnic backgrounds are more likely to die from Covid-19, develop schizophrenia, die at childbirth, be stabbed, incarcerated or deported than those who are white British.

Shared structures, shared solutions?

The social and economic determinants of health are irrefutable. Michael Marmot has led the way, and many have followed, in providing robust evidence for the causal and graded relationship between relative deprivation and health. Socioeconomic inequalities, Julia Lynch convincingly argues, have been actively reframed as health inequalities. She suggests this was the consequence of post-war welfare states clashing with the neoliberal taboos of redistribution, regulation and state spending. Centre-left political parties, who by definition are interested in creating a more equal society, responded by reframing inequality from a problem of maldistribution of economic resource and power to a problem of unequal distribution of human capital such as health. A former New Labour advisor Lynch interviews in her book, Regimes of Inequality, says: "[Labour party leaders] are keen to talk about health inequalities providing they don't have to talk about income and wealth inequalities." Lynch's insight is important. Reframing inequality as a health problem restricts the range of policies considered appropriate. Why would a reasonable policymaker think of using fiscal, monetary and labour market policy (a reasonable toolbox to tackle economic inequality) to address a health problem? Calls for a 'cross-government' or 'health in all policies' approach to health inequalities will fall on deaf ears for as long as health inequalities are viewed independently from wealth and income inequality.

Racism shapes health through two main pathways.[15] The dominant pathway is through socioeconomic inequalities:

the differences between ethnic groups in where people live, what jobs they do, their income and wealth. Academic analysis often statistically strips out these differences as 'confounding variables', removing the effects of racism with it, when investigating ethnic health disparities. Sometimes this is for good reason, for example to estimate the explanatory power of socioeconomic factors in the effect racism has on health. The problem arises when such analysis moves from the academic world to the real world and is misappropriated to explain away racism. It leads to comments like: "It's not race, it's class", perpetuating the absurdity that race and class are entirely independent – as if Black people cannot be working class, and vice versa. In modern Britain, there can be no understanding of race without class and no understanding of class without race.

The second empirical pathway through which race determines health is a result of actual or perceived discrimination. This refers to both the experiences of racial discrimination and the implicit effects of racialised culture, as Stuart Hall described in his theory of representation. It is thought that discrimination, implicit or explicit, is pathologised into poor health through psychosocial stress pathways. The biological mechanisms are still being unearthed but the epidemiological presence of this second pathway between race and health is clear.

Structural racism and health inequalities are not the same problem but have a common base: both stem from the unequal distribution of resource and opportunity. They are structural economic, cultural and democratic problems calling for structural economic, cultural and democratic solutions.

The capability to be healthy

Decoupling race from health means severing the socio-economic and cultural discrimination pathways that link them. Unequal distribution of resources between ethnic groups – such as wealth, income, work, welfare, education and housing – leads to an unequal capability to be healthy, to borrow Amartya Sen and Martha Nussbaum's approach. The pandemic is a good example of this. Insecure and public facing work, lack of savings, welfare chauvinism and overcrowded households – all of which disproportionately affect minority ethnic people – are reflected in racialised pattern of deaths from Covid-19. Structural solutions that would have reduced ethnic health inequalities during the pandemic included raising statutory sick pay and providing community isolation facilities, for example by reappropriating empty hotels. Instead we saw a strong bias toward policy that focused on individual agency rather than capability, such as translating public health advice and personalised risk assessments.

The bias towards individual-level policy solutions to tackle inequalities is widespread in Britain. The leading edge of prevention today is personalised medicine and genomics. These are indeed important advances in public health. But individual-level biomedical solutions cannot, by definition, repair health inequalities that are social and economic in origin. These technologies may even widen ethnic health disparities as their benefits may accrue more rapidly in better-off sections of the population (sometimes called the 'Matthew effect').

Population-wide prevention interventions, Geoffrey Rose described in 1985, tend to be more effective than interventions targeting certain individuals. It is a lesson the US appears to be learning. Embedded within President Biden's

spending plans are structural solutions to structural racism and resulting health inequalities. Plans to replace poisonous lead water pipes will disproportionately benefit Black communities. As will plans to build more affordable housing, increase remuneration and rights of low-wage workers, reduce air pollution and improve internet and public transport access in deprived neighbourhoods. Each of these policy initiatives, if implemented, will reduce racial disparities in health outcomes.

British political parties should take note: some of the most effective tools to dismantle structural racism and health inequalities are population-wide not group-specific. Greater protections for the underclass of taxi drivers and cleaners – and gig workers more generally- is low-hanging fruit in the fight against racism. So is creating more social housing and a less hostile environment for asylum seekers. More challenging policy asks why the biggest predictor of home ownership in young adults is home ownership of their parents (around 30 per cent of households with Black ethnic backgrounds own their house compared to 68 per cent of white British households, ensuring racial hierarchies transmit across generations). A sovereign wealth fund that pays a 'universal minimum inheritance' to all young adults, as Thomas Piketty and the IPPR think tank have argued, is a policy that deserves more airtime.

Economic structures are not all that matter. The second pathway linking race to health – discrimination – is the consequence of living in a racialised society. Severing this link is even harder than the first: it means discarding the social invention of 'race' altogether. Race, Paul Gilroy has written, is a "virtual reality given meaning only by the fact that racism endures". Indeed, racism endures and its deleterious consequences on health are clear. But progress is being made. Racist attitudes among the British public fade with

every new generation. Culture-shaping institutions, particularly the media, will need reforming to keep up. If they do, racism, and its impact on health, will fall with it.

Transforming political economy and culture to stop producing racial inequalities is a tall order. If those with power will not prescribe the bigger-than-the-individuals solutions required, then we should consider where power lies and ask, should it lie elsewhere?

Democracy against ethnic minorities

Political representation of ethnic minorities is often equated to ethnic minority political representatives. The underlying assumption – that minority ethnic people in power will enact policies that better serve minority ethnic people's interests – is rarely made explicit. It is a poor assumption. Does anyone believe the most diverse cabinet in history is committed to the fight against racism? While there is epistemic value in diversity, it can only ever be a contingent approach to racial justice.

British democracy, it is not said enough, suppresses the voice of minority ethnic citizens. The first-past-the-post system means a white British vote is worth more than a British Bangladeshi vote[16]. Many suspect plans to check voter ID at ballot boxes will make it yet harder for minority ethnic and migrant voters, who are less likely to hold photo ID and more fearful of deportation checks, to take part in our democracy. Elections in Britain may be free but are they fair? Reforming outdated democratic institutions, starting with a move to a proportional voting system, could exert greater electoral pressure to enact policies that reduce racial health disparities.

Electoral reform is only one aspect of making democracy work against racism (instead of working against ethnic minorities). Stopping race shaping health requires bold

policy – and bold policy requires better democracy. That means sharing more power with councils, communities and citizens – rather than hoarding it in Westminster. As Maureen Macintosh and Hilary Wainwright note, County Hall in 1984, under the Greater London Council, was open to "punks and Rastas at one end to parties of Bangladeshi old-age pensioners at the other"[17]. Citizens' assemblies can make transformative or radical policy, such as those required to dismantle structural racism or stop the climate and nature crisis, appear more feasible.

Connecting the dots

No government has ever sought to enact meaningful policy against structural racism. Some politicians believe it is a divisive or risky policy agenda. All too often one crucial fact is ignored: the most effective policies to dismantle structural racism are the same policy prescriptions required to reduce economic inequalities, health inequalities, tackle the climate emergency and enhance democracy. It is a political vision waiting to be forged.

3. PRIMARY CONCERNS

Anne Longfield

A government committed to reducing health inequalities in society should start with an offer to children. At present, our early years system is fragile and progress has been piecemeal. We need an ambitious national framework that works with families to ensure every child gets the best start in life.

The pandemic has exposed how health inequalities can take hold from a child's earliest days. Many children have suffered with poor mental health and for some, physical and cognitive development has regressed. Families with lockdown babies struggled for weeks without health visitor support and health conditions have often gone unidentified and, in some cases, untreated. Children with special educational needs or disabilities have often felt particularly isolated.

These consequences are felt most starkly by disadvantaged young children. We know a child's experience in the early years impacts on so many aspects of their life to come – from critical thinking, social skills, and the ability to form relationships to the development of physical skills, movement, and co-ordination. Without help to recover, the impact of the crisis will last for years.

The pandemic has also shown the fragility of an early years system that is too inconsistent, fragmented and often inac-

cessible. As Sir Michael Marmot has argued, the imperative is not just to build back but to build back fairer. There is no more important place to start than with the early years.

While we invest more than we did in early years support, it remains the poor relative in health and education. Early years policy has developed incrementally, initiative by initiative. The lack of coherent vision means that policies are both baffling parents and neglecting too many children. To create a thriving society that offers the best start in life to all, we need to redesign our early years system, so all children have the health and wellbeing support they need to flourish.

There is a growing consensus to draw on. The NHS 10-year plan set out planned improvements for the health of children from pregnancy, birth, and the early years. In 2020, as children's commissioner for England, I set out a blueprint of what I believe is needed. Earlier this year, Dame Andrea Leadsom MP published her Healthy Development Review of the Early Years, followed by the Duchess of Cambridge's Early Childhood Centre's recommendations and the cross-party Early Years Commission co-chaired by Sharon Hodgson MP and Edward Timpson MP and jointly run by the Fabian Society and the Centre for Social Justice.

There are common threads throughout: the need for a national framework that works with families and is accessible for all, better maternity care in pregnancy and post-natal support, a system that ensures good early identification and recognises and responds to the individual needs of children in a holistic and co-ordinated way – particularly the most disadvantaged children, and a system that is proactive and reaches out to families to offer help and support.

A new integrated framework to reduce health inequalities

At the heart of this approach must be a relentless focus on reducing inequalities. We know poverty increases the likeli-

hood of health problems with poor nutrition, severe health conditions and poor mental and physical health leading to diminished life chances and shortening life expectancy. The statistics are shocking. Over two million families with children under five live in poverty and in 2019 there were 560,000 children under five living in households where a parent or carer was experiencing severe mental ill health, substance misuse or domestic abuse. In the same year, 29 per cent of five-year-olds in England were not at the expected level of development by the time they started school, including 45 per cent of children receiving free school meals. Tackling these problems head on is essential.

I want to see an expansion and refocusing of the supporting families programme (which replaced the troubled families programme) towards health and wellbeing in the early years. Embedded in every area, and well recognised as the primary route to deliver early intervention for children and families, the programme has the potential to work much more dynamically with midwives, children's services, and health visitors to identify the families who need support and deliver co-ordinated practical help in response.

The work of charities such as Oasis also shows how long-term community support can work, helping families negotiate better social housing, providing access to good food through community kitchens, and food banks, getting help with addiction, debt, employment, mental health and tackling domestic violence. This practical support can make the difference between a child surviving and thriving, and it should be the foundation of a new commitment to ensuring children have a healthy start in life.

Whilst the scale of such an ambition might be new, this is already the core business of many Sure Start children's centres and family hubs. Despite a reduction in services over recent years, there remains a significant network to build upon, the majority of which are situated in disadvantaged

areas. The case for putting this local, accessible, trusted support hub back at the heart of disadvantaged communities remains overwhelming. With a renewed national policy focus, these centres could be revitalised to provide highly effective local gateways to multiple services and support in disadvantaged areas.

Children's centres have been shown to enhance the outcomes of wider services – bringing together health, family support and early years care and education into a co-ordinated approach that can work with children and families in a more holistic way with long term trusted relationships, and have proven success in achieving positive social emotional outcomes for children and parents, reducing the reliance of accident and emergency services, and reducing costs as a result. In some areas, these centres have also driven reductions in obesity. From family support to health visiting teams, assessment and support services, a revitalised network of these centres would be united in a core mission to reduce health inequalities. Children's centres allow parents to meet other parents or get additional advice about breastfeeding, strains on their relationship, or on their mental health. But these hubs should also offer more targeted services – including perinatal and infant mental health teams, speech and language therapists and housing teams – co-located within the service. For children with particular needs, hubs could operate as a base for targeted interventions, and support parents as they navigate their way through specialist health teams.

This is not a call for 'one size fits all' centres and local areas should develop their own focus in response to local need. Creative responses will also be important, maximising the potential of online support, proactively engaging families in a network of support that does not wait to be asked. The groundswell of enthusiasm for volunteering over the last

year should also be harnessed to create local neighbourhood buddies – part of the community and there when needed.

A backbone of support

These centres would need to be complemented by national intervention and leadership in some key areas of priority:

- A commitment to improve support and care during pregnancy is particularly important with the persistently high levels of infant mortality we are seeing compared to other European countries. There are clear links and correlation with deprivation.
- Enhanced mental health support for mothers during the perinatal and early years period – essential in building nurturing environments with strong bonds and attachment.
- A health and wellbeing focused supporting families programme to deliver the in depth, practical, long-term support to tackle the social determinants of health inequalities.
- An enhanced healthy child programme to drive a preventative approach to child health in the early years through a strengthened health visitor workforce to improve health and wellbeing; reduce hospital admissions for preventable illness; and build healthy habits and promote specific outcomes such as immunisation and good oral health.
- New healthy start obesity prevention programmes working through children's centres to encourage confidence and motivation to support families to develop and sustain healthy habits. This approach has achieved real success in Leeds where it has reduced school entry obesity by 6.4 per cent while levels in comparator cities remained unchanged.

● An enhanced focus on the two-and-a-half-year-old development check that too often misses out on the children who need support and fails to respond strategically with consistent support. Checks should have a new rigour to assess the needs of the most vulnerable children with a guarantee of support services in response – including speech and language support which we know is so important for healthy development and for children to succeed in school.

There must be more agency information sharing, including clinical commissioning groups, hospitals and GPs, supporting families teams, schools, local authorities, housing and the Department for Work and Pensions, the Department for Education and local directors of public health. Many children's centres, nurseries, health visitors and social workers are striving to keep in touch with families, but they need enough information to monitor whether babies and young children are progressing.

Poor data gathering and an unwillingness to share data is highlighted consistently as a problem, including in regular submissions and evidence sessions to the current Lords public services committee inquiry on public services and vulnerable children. Government needs to lead a revolution in intelligent data sharing both nationally and locally to help understand and monitor, in real time, the needs of disadvantaged children and determine whether enough resources are in place.

A revitalised infrastructure of children's centres and family hubs would also sit alongside a renewed early years offer for children from the age of two – reviewing national funding and redesigning a system to provide universal support but with free access for disadvantaged families. When combined with enhanced parental leave periods and the in-depth family support for disadvantaged families, this

would provide a new support guarantee to help all children thrive. An ambitious programme of training and development for all of those working with children in the early years, within a new framework of progress and enhanced status will be essential.

Two pieces of this newly integrated jigsaw remain: how to measure progress, which would require a common outcomes framework linked to child health and wellbeing and readiness to start school; and a new financial settlement, which would share outcome funding for early years, children's centres and hubs, early health and wellbeing with wider public health, supporting families, and local authority support.

These strategies will only succeed if we make child health and wellbeing a national priority, backed by the best minds and the engine of government. That means putting early years at the heart of strategies to level up, with a national framework to build and support improvements. It requires health and wellbeing to be prioritised in every department from welfare, housing and communities to education and employment. It requires understanding what it means to be a country where all children grow up well and being prepared to take the steps necessary to make that happen. That will include actions such as banning junk food adverts and promoting of parks and other outdoor environments for sports and play.

Around the country there are already examples of excellent practice achieving remarkable results. We have academics working on research with the potential to transform our understanding of health inequalities and our ability to respond. There is a workforce, keen and committed and eager to work together to bring about real change. There are local authorities and health providers who see the consequence of poor health every day without the day-to-day capacity to bring about the urgent change needed on their own.

The health and wellbeing of our young children deserves an intense national effort to bring about lasting change. Our future success as a nation depends on it.

4. CREATING HEALTH

Nigel Crisp

For communities to flourish, we must provide the conditions for people to be healthy and help people to be so. This means looking at every part of society, from our homes and workplaces to our schools, planning and architecture, with community groups, local authorities and national government all having a key part to play.

A new platform created by Bradford-based Yeme Architects allows us to run a cursor across a map of a town or city and reveal as we do so all the facilities and services available in the different areas. We can set it to pick out everything within a 15-minute walking radius so that it shows us all community assets and activities that could lead to opportunities for human interaction, such as shops, green spaces, schools, evening classes, places of worship, gardening groups, choirs, food banks, social clubs, and community groups of all kinds. We can overlay this with data on employment, educational attainment, income, health status and much more, so that it can begin to reveal a whole living, breathing picture of real communities – of what is there and what is not.

The platform shows us what we already know – that, for example, areas of lower income have fewer facilities, fewer activities and less green space. But it also shows us things

we did not know – levels of social activity, hidden from our normal view of the world. Above all, it reveals opportunities.

Let us imagine that NHS and local authority planners want to understand how and where to target their interventions. They can see where people meet and identify potential allies who can help promote health literacy and support programmes to tackle isolation, poverty and inequalities more generally. They can see where new facilities could be best sited and how to join up green spaces to create green pathways through the city. And local people, of course, can use the platform to find out what is going on and join in.

It shows us, in other words, how we can help create health in communities, bottom up and community led.

This approach helps us to think about health in new and broader ways. I argue elsewhere that we need to see health in three parts[18]. The first is about health services, treatment and care and is led by the NHS and health professionals.

The second is about tackling the causes of ill health through disease prevention and health protection where government and official bodies play the most important role in legislation, regulation, standard setting and investing in everything from air quality and food processing to vaccines and educating school children.

The third is about the causes of health (not the causes of diseases and ill health) and creating health. Everyone has an important role here. I define health creation as being about providing the conditions to be healthy and helping people to be so. It is what parents do, and good teachers, good schools and good employers. And it is what good architecture, design and planning can help do too. It is about enabling people to develop as resilient, social, competent, confident and healthy individuals. It is about all these qualities and more because health is not an add-on to normal life. I think of it as being about human flourishing.

And health creation is vital in the fight against inequality.

I first thought about health creation while working in several countries in Sub-Saharan Africa where I learned the expression 'health is made at home, hospitals are for repairs' from professor Francis Omaswa, former head of the Ugandan health service. And, one might add, health is made at home, in the workplace, school, community and every part of society.

Health is made at home, hospitals are for repairs

The science behind this approach is becoming clearer, with Sir Michael Marmot and others demonstrating how the social and political determinants of health affect life expectancy and life chances across whole populations. There are also many studies which show how environmental factors – being in a green environment, for example – and social factors, such as relationships and stress, affect individuals and alter their chances of illness and recovery.

There are thousands of groups in the UK who I call 'health creators', such as the Sewing Rooms, a social enterprise which creates jobs and brings socially isolated women together in Skelmersdale; Salford Dadz, a group of unemployed men improving life in their neighbourhood; The Black Health Network based in Leeds which provides services for local people and helps the NHS develop policy; the Growing Health Together group, a network of community members and service providers in East Surrey set up by a GP; the City Mental Health Alliance in London, where big employers are changing working practices to create workplaces where people can flourish; and the TR14ers in Camborne, Cornwall, a dance club set up 15 years ago by a policeman who was fed up with chasing young people for minor offences and started to work with them.

This impressive list does not include housing associations, religious, conservation and arts groups, and to it should be added Wellnorth Enterprises who are bringing communities together by running summer science schools in Skelmersdale and East London. These examples show that health creation is something that can be led by local community groups and businesses, employers and professionals of all backgrounds. Ideally, all these and other parts of a community will be involved and work together to create a thriving community.

This diverse range of groups have many features in common. They all start by building relationships, they experiment and learn by doing and are purpose-led and vision-led, they all deal with mental as well as physical health and they all understand how health is intimately linked with the natural and built environment. Most importantly, however, they are all about people and organisations gaining control for themselves, taking the initiative and changing their own and other peoples' lives.

These examples are not about the NHS or local authorities engaging with communities and civil society. They are not about social prescribing – valuable as that is – where local activities are co-opted by the NHS. This is not business as usual. The people running them are not responding to other people's plans but doing things for their own reasons.

People within public bodies sometimes talk about the difficulty in engaging people. The issue is really the other way round – how to get the NHS and other authorities to engage with them. People in local communities very often know what needs to be done but no one listens.

There are now several organisations leading this change in the UK including C2 Connecting Communities, the Health Creation Alliance, as well as Wellnorth Enterprises and the Health Creation Academic Network.

Practical action to create healthy communities

National government, local authorities and planners need to think about communities and health in this wider way, recognising the value of health creation and supporting it alongside service provision, disease prevention and health protection.

This framework will enable them to agree practical steps to support local action as well as undertaking action themselves both nationally and locally.

Support for local action and health creation should include:

- Providing direct support for local initiatives through grants and help in kind as appropriate – listening to what local people and communities believe needs to be done. Some authorities already provide grants for local initiatives, but these are mostly short term. If successful, these should be carried through into formal commissioning alongside other activities – as is now happening in Salford.
- Finding better ways for local groups to engage directly in local authority and NHS decision making and activity. This covers everything from membership of committees and consultation processes to direct service provision.
- Supporting local communities' own assessment of what their needs are and planning for improvement.
- Bringing cross-sectoral groups together including businesses, public bodies and voluntary and community groups to identify and act on local priorities.

Action taken by local authorities should include:

- Adopting the healthy homes principles published by the Town and Country Planning Association which include

the recognition that all new developments and conversions should promote health, safety and wellbeing and adhere to defined standards in areas such as size, access to daylight and green space, noise insulation as well as heat insulation.

- Linking green spaces throughout towns and cities, providing scope for path and cycle ways using the sort of methods adopted in Bicester eco-town which encourages physical exercise and promotes social interchange.
- Working with schools to reduce exclusion rates. Exclusion from schools is linked to major problems and disadvantage in later life.
- Encouraging employers to support initiatives like MIND's blue light programme, which provides mental health training to employees in the emergency services.
- Restoring or replacing Sure Start programmes locally.

At the national level the biggest gains in terms of healthy communities can be achieved through:

- Developing education policy which reduces exclusion, increasing the opportunity for technical and vocational education and reforming Ofsted – giving children a better start in life.
- Reforming social care policy – for the benefit of disabled, chronically ill and older people.
- Ensuring that people employed on zero-hours contracts and in the gig economy have access to better conditions, pay and support.
- Supporting the Healthy Homes Act.

The first step in building healthy communities is to recognise the importance of health creation, and to build a health creating society where all groups and organisations

can play their part. Without it, all new initiatives are likely to be unsustainable. I have watched too many fail over the years since I worked as a youth and community worker in Merseyside in the 1970s. More than 50 years later, we should be able to do better.

5. REAL GAINS

Frances O'Grady

Meaningful work goes to the heart of what Labour stands for and is key to good mental and physical health. And since policies, regulations and laws wield the greatest influence on the way we all work, there is much a future progressive government could do to foster more dignity and decency in the workplace. Crucial to its success is giving a strong voice to working people.

"Labour wants pride and joy in doing good work, a sense of making or doing something beautiful or useful – to be treated with dignity and respect as brother and sister." – Thorstein Veblen

The pandemic has thrust how, and why, we work into the spotlight as never before. Many of us have seen our working lives turned upside down as offices have been closed. But others have had no choice but to put themselves in harm's way in the service of others. And many of these key workers have received the minimum wage for their troubles, doing the most important work for the least reward.

Covid-19 has also underlined the importance of safe, healthy working. And it has exposed how the UK's preponderance of low-paid, insecure work lies at the heart of profound inequalities in society – with women, Black, Asian and minority ethnic workers and disabled workers on the frontline. This poor-quality work is a root cause of the UK's

shocking health inequalities. As Michael Marmot and others have noted, it is no coincidence that the places with the lowest life expectancy are also those with the lowest wages, weakest skills and poorest-quality jobs.

Even before the pandemic struck, the world of work was failing millions of workers. With our labour market still one of the least regulated in the developed world, working people have been left to face the consequences. One in nine UK workers is employed precariously. One in five does not earn enough to live on. And one in three children are growing up in poverty, often with at least one parent in work. Shockingly, these include a million children in key worker households.

The trade union movement has always existed to win dignity, decency and voice for working people. And that imperative is even more urgent now, amidst the disruption of the pandemic, Brexit, tech change and the climate emergency. Representing what the late, great leader of the Transport and General Workers' Union, Jack Jones, called the 'human face of labour' remains our defining purpose.

Throughout the pandemic, the TUC and trade unions won real gains for working people, including the furlough scheme that has protected the livelihoods of so many workers. But while we will keep organising, bargaining and campaigning for change, ultimately it is the government which wields the greatest influence on the way we all work.

And through new policies, regulations and laws, there is much a future progressive government could do over a 10-year timespan to transform our working lives and promote health and wellbeing. That is why the TUC is calling for a bold vision to improve work, boost productivity and reduce inequality. Decent, meaningful work goes to the heart of what – and who – Labour is for, and it is key to good mental and physical health.

Creating good jobs for the future

One of our key priorities is to create good new jobs in the communities that need them most, notably those hit hard by deindustrialisation and austerity. With interest rates at historic lows, the TUC is calling for an £85bn investment to create 1.25 million jobs in green transport, infrastructure, tech and housing. New jobs need to be healthy jobs that promote physical and mental wellbeing. That means fair pay, positive flexibility, secure contracts and satisfying work. And it means the dignity of having a voice at work, not least through stronger rights to join a union.

As well as delivering employment and growth, this would help us decarbonise our economy, meet our climate change commitments and facilitate a just transition to net zero. But where President Biden's America is investing almost £3,000 per head in the good, green jobs of the future, the UK government is spending a pitiful £180. A proper state investment bank would provide the funding we need, while a smart, active industrial strategy could deliver growth and opportunities to the regions most in need. Levelling up will not happen by accident.

Trade unions are also campaigning for 600,000 additional jobs to bring our public services back up to strength after a decade of austerity. As well as creating good, skilled jobs, investing in our schools, hospitals and social infrastructure would also combat many of the inequalities that bedevil modern Britain.

And looking to the long term, unions are keen to exploit the job-creating potential of new tech. The TUC's AI manifesto argues that with the right choices, artificial intelligence could improve working lives, boost productivity and deliver highly-skilled new jobs. But we have reached a crucial moment in the AI revolution. If left unchecked, AI could become a profoundly dehumanising force, entrenching

existing inequalities. Stress is a major cause of work related ill-health and for too many workers there is nothing more stressful than being managed by an algorithm with no right of appeal to a human being. A central challenge for future progressive government is to ensure tech change benefits all, reasserting the importance of human agency in our working lives.

Making work better for all

Since the summer, the TUC has stepped up our campaign for decent work for all. We are lobbying for the much-delayed employment bill to include a raft of measures to combat workplace injustice. We are demanding a ban on zero-hours contracts, action to curb the disgusting practice of fire and rehire, stronger rights for mums and dads, and a £10-an-hour minimum wage. And we are campaigning for greater investment in workforce skills, vocational education and lifelong learning.

Better work is also fundamental to our broader struggle for equality. The pandemic has exposed the injustices facing women, Black workers, disabled and LGBT+ people, and working-class communities. For millions, precarious, poorly-paid work is a daily reality. And that is why we must strengthen our anti-discrimination laws, reinstate the gender pay gap reporting requirements without delay, and introduce mandatory ethnicity and disability pay gap monitoring. The hard reality today is that low-paid workers work longer into old age and enjoy fewer years of healthy retirement on incomes well below the European average.

And rather than the culture of blame and sanctions that characterises our current approach to welfare, we need to better support those who are currently unable to work. As well as decent sick pay and social security – including root-

and-branch reform of universal credit – we must enable greater labour market participation for the most marginalised groups of workers.

Despite a government pledge to halve it in 2015, the employment gap for disabled workers is currently almost 30 percentage points. Properly funded access to work schemes, a new approach to reasonable adjustments and state-funded occupational health initiatives could all make a difference. Self evidently, empowering disabled workers is vital to addressing health inequalities.

Giving workers a collective voice

Trade unions know instinctively that you cannot have dignity and decency in the workplace without a strong voice for working people. As Marmot recognises, a lack of control at work undermines workers' health and wellbeing, with long-term social consequences.

Stronger trade unions and more collective bargaining are essential to boosting worker voice – and to delivering decent work. Rather than wrapping unions up in more costly red tape, a future government must follow the lead of President Biden's administration by levelling the playing field for labour with new organising and bargaining rights. After decades of neoliberal ideology, it is time to rebalance the relationship between workers and their unions on the one hand, and businesses and employers on the other.

For the past decade, the TUC has stepped up our campaign for a stronger collective voice for workers. We have been making the case for greater worker representation – including workers on boards. Commonplace throughout Europe, and a feature of many of its most admired companies, this would empower workers, curb managerial power and put a brake on obscene rewards at the top. Former prime minister

Theresa May promised to put workers onto boards – but backed down at the first hint of opposition from business. Yet the case for change remains sound.

As we reform the way companies are run, we must also improve worker voice in the growing gig and platform economies, where workers are often managed by an app rather than by a real human. In recent months, trade unions have made significant inroads, negotiating recognition agreements with Hermes and Uber. As we engage our growing army of gig workers, unions must also exploit the organising and bargaining potential of digital.

Wellbeing as well as wealth

The pandemic, changing world of work and rising health inequalities all underline the need to protect and enhance workers' health and wellbeing. Naturally, this must start with proper funding for the Health and Safety Executive, inspection and enforcement. And it must extend to stronger trade union recognition rights, because unionised workplaces are strongly correlated with lower absence, illness and accident rates.

But workers' wellbeing also demands a change of mindset in how we think about work, the economy and society. While measuring growth will always be important – for funding our public services and our pensions – other metrics must be given greater prominence. Among them must be measures of inequality, pay differentials, employee happiness and workplace health. General wellbeing (GWB) matters just as much as GDP.

All of this is even more important given the flexible working revolution unleashed by the pandemic. With the borders between home and working life increasingly blurred, it is time the UK followed other European countries and intro-

duced a new right to disconnect. And as we address the issues raised by the growth of homeworking, we must also strive to deliver greater flexibility and choice for all working people, regardless of where they work. We cannot allow a class divide between those with "Zoomable" jobs, and everybody else, to take hold.

The spectacular rise of homeworking could permanently change the way many of us work – with profound implications. Workers in transport, hospitality and other sectors could find their jobs are at risk. The workforce may become even more atomised and fragmented. And it could become harder for unions recruit and organise dispersed workers. Progressives must address these questions now, not in five years' time.

Decent work must be a political priority

The pandemic has raised fundamental questions about how we live, how we work and the things we value most – both individually and collectively. It has exposed, and exacerbated, inequalities of race, class, gender and disability. And as we have seen so graphically, these inequalities can literally be a matter of life or death.

Decent work for all can help us heal these fractures in our society. Meaningful, fairly-rewarded jobs can make Britain fairer, healthier and more equal. That is why a compelling vision of good work, in an age of change, must be a central priority for future progressive governments. Naturally, trade unions have a huge contribution to make to that conversation. For us, decent work goes hand in hand with a strong society and a fairer, greener economy.

6. DISRUPTING THE CYCLE

Liz Sayce

Redressing disability-specific health inequalities requires targeted action, including more inclusive education and stronger employment laws. But any vision must be codesigned with disabled communities, giving people who are often made to feel powerless more control over their lives.

Health policy and practice often separate the topic of 'health inequalities' (with its frequent focus on geographically differentiated socioeconomic disadvantage) from the 'equalities' agenda (addressing disparities of race, gender and other protected characteristics). Each tends to be led by different sets of people, drawing on different evidence and deploying different narratives.

They need to be integrated. Nowhere is this more evident than in the health inequalities experienced by disabled people, including those living with mental health challenges.

Poverty is a disability issue: about half of people living in poverty in the UK are either disabled or live with someone who is[19]. This is the result of a vicious cycle, in which relative poverty brings risks of mental ill-health and physical health conditions; and once people have these conditions, their risk of poverty escalates. People with serious mental health problems, for instance, have an employment rate of just 28 per

cent[20] and are more than 3.5 times more likely than others to be in problem debt[21].

Policy approaches are needed to disrupt this vicious cycle. With 59 per cent of Covid-19 deaths being of disabled people[22] and people with serious mental health challenges dying 15 to 20 years earlier than other citizens[23], this is a central agenda for health improvement.

Multi-factorial inequalities

Disabled people have challenged purely individual and behavioural interpretations of the health inequalities that affect them. Early in the pandemic, the common public explanation that Covid-19 deaths arose from underlying health conditions was experienced as 'a reassurance to the majority that left disabled people feeling frightened'[24] and othered. Whilst some impairments did carry increased risk – for instance, respiratory conditions – so too did living in congregate settings like care homes, or having essential social care visits at home[25]. Other risks included, for those disabled people in work, being more likely to work in low-paid roles[26] with little choice to self-isolate.

People have also challenged periodic overstatements of the contribution of lifestyle factors to health inequalities.

We know that social isolation is at least as important as smoking, excessive drinking and obesity in determining health and wellbeing, and disabled people are more likely than other citizens to have only one or two people they feel close to and to have seen only one or two people in the previous week.

Other factors relevant to the premature mortality of disabled people include health service response. People with serious mental health challenges are more likely than other citizens to get some common 'killer' diseases like heart disease and stroke; more likely to get them young; likely

to die of them faster once diagnosed; and less likely to get some of the standard tests and treatments[27]. And, compared to the general population, people with learning disabilities are more than three times as likely to die from an avoidable medical cause of death[28].

There are also subtler impacts of inequality that have particular significance to disabled people. Richard Wilkinson and Kate Pickett argue that high socioeconomic inequality leaves those in 'inferior' positions internalising shame and failure: for many disabled people this is compounded by feeling 'shamed' for not being able 'to cope', not fulfilling others' or their own expectations of their lives. Michael Marmot argues relative poverty leads to loss of control in life, which contributes to worsening health: and for people who become disabled, loss of control is often particularly acute, as relationships with family and the state shift. Hence 'choice and control' as a rallying cry of the disabled people's movement.

What should be done?

Whilst further work to quantify the respective contributions of different factors to these health inequalities can always be helpful, we know enough to shape a multilayered approach. It should aim to restore disabled people's status and control and disrupt the vicious cycle of inequality.

First, overarching policies to constrain inequalities of income and wealth – and the status and control that go with them – could disproportionately benefit disabled people. However, the devil of how well overarching approaches serve disabled people is in the detail. Some approaches to universal basic income, for instance, risk trading the vital benefit coverage of extra costs of disability for the simplicity of universalism.

To redress disability-specific inequalities – those that compound the impacts of wider inequalities – requires targeted action. Targeted, however, does not mean separate. History is littered with examples of separate initiatives that have embedded inequality: sheltered workshops, for instance, did not increase the employment or pay of disabled people, but separated people from the full range of economic opportunities. To move the dial requires targeted, inclusive action.

Co-design and co-production

Policymakers and system leaders achieve better outcomes if they work with the people they aim to benefit.

The commission for equality in mental health identified numerous examples where people at the sharp end of inequality participated in solutions: from street-based young peer workers successfully engaging people who had lost all trust in state services, to system change like Black Thrive, led by the community in partnership with major public agencies. This shifts services from managing need to creating capability, restoring control to people who often feel powerless[29].

As integrated services develop, with a renewed focus on 'place', there is a major opportunity to shift resources to co-produced, sustainable solutions to inequalities: ensuring organisations led by disabled people and those with mental health challenges are part of wider solutions.

Equal participation

Article 19 of the UN Convention on Persons with Disabilities states that disabled people should have the right to enjoy full participation in the community. For disabled people of all ages this lies at the heart of living an autonomous and connected life, avoiding isolation, shame and powerlessness.

Policies across government can help realise this right, from strong requirements for inclusive transport to tightened planning regulation to promote life-time homes and accessible housing. Social security design and levels are critical and need to recognise both extra costs of disability and the 'real world' barriers to employment.

There are two other major policy examples around education and employment worth noting.

Inclusive early years and education

Investment in early years and school age education are core general strategies to reduce inequality. Angela Morgan's review of support for learning in Scotland found 30.9 per cent of school-age children had additional support needs, ranging from language to emotional and behavioural challenges. As she put it, this 'cannot continue to be viewed as a minority area of interest, to be considered in a separate silo'[30].

Making early years support inclusive is essential to preventing disabled children from falling behind developmentally and socially. Learning from the (geographically varied) experiences of Sure Start and children's centres, promising strategies involve universal hubs that link families into tailored support, from speech and language therapy to parent peer support; backed by inclusive design of play facilities and active outreach to families facing disadvantage.

Around the world, the Sustainable Development Goals and UN Convention on the Rights of Persons with Disabilities are driving momentum towards inclusive education. In 2020, the Zero Project identified good policies and practices from around the globe, ranging from making the practice of inclusion core to teacher training, to innovative use of technology.[31] The UK is not listed amongst the eight countries demonstrating the most good practice. In England, the trend

is for more and more disabled children to be educated in separate 'special schools' rather than with their non-disabled peers[32].

A policy realignment towards inclusive education, addressing training, investment, measurement and regulation, could bring the UK closer to global good practice, with benefits both for disabled children's wellbeing and long-term reductions in prejudice, as children learn together on equal terms.

Employment and pay

The OECD recently noted that despite policies to reduce the disability employment gap in OECD countries – like work incentives in social security and early intervention – the gap has barely moved in 20 years[33]. In the UK the gap remains stubbornly at 28.8 per cent[34]. In addition the disability pay gap 'means that disabled people effectively work for free for the last 60 days of the year'[35].

Most policy to close these gaps has focused on disabled individuals – incentivising people through benefit conditionality or supporting them to work. Outcomes have been generally weak[36]. More promising is tripartite responsibility between employer, government and individual. Widely supported proposals for change include mandatory reporting by larger employers of the employment, progression and pay of disabled people; strengthening the right to 'good work' and 'flexible work' where both have inclusion embedded in their definition; and fully inclusive government employment and skills support.

What should health and social care leaders do?

At least 70 per cent of NHS and social care resources are spent on people living with long-term impairments or health conditions[37]. It is a fundamental responsibility of leaders to be explicit about the purpose of services to those not experi-

encing 'cure': supporting people to enjoy full participation, pursuing activities and contributions that give life meaning. Both health and care services are a means to this end and can support people to have more agency and connection.

Measures of success should concern how far, for instance, children with complex conditions are developing socially and educationally, or how far people with dementia are connected and thriving.

Health and social care leaders should:

- Agree a purpose of service with people using services long-term and set a cultural expectation of full participation.
- Take the opportunity of integration, 'place' and potential social care reform to invest in a human infrastructure of community and civil society organisations to enable and support people.
- Tackle discrimination robustly – for instance, the application of 'do not resuscitate' notices on disabled people's records without their freely informed consent[38].
- Be proactive in ensuring outreach to disabled people at health risk, ensuring through monitoring that they receive all recommended tests and treatments and that health promotion options are fully inclusive[39].
- Aim for exemplary accessibility, implementing the NHS accessible communications policy and ensuring users of services can secure reasonable adjustments easily.
- Systematically reduce coercion within services: there has been an 'inexorable rise of detentions under the Mental Health Act'[40] and repeated findings from regulators of restrictive practices that potentially breach human rights[41]. Boards should commit to year-on-year reductions of compulsory detention, restraint, seclusion and long-term segregation.

● Set an example as 'anchor organisations', paying the real living wage, using a 'dashboard' to understand employment and pay across different groups, acting to redress inequalities and modelling 'good work' standards (as developed by some city regions). Aim for an inclusive work culture, with in-built learning.

Regulators need, in collaboration, to support local systems by measuring year-on-year progress in reducing interconnected health inequalities; and stimulating accountability, learning and transparency by sharing with the public. Year-on-year improvements may lend themselves more readily to complex change than targets, which can distort activity.

Priorities, building support and messages

In July 2021, the government published a disability strategy, with a welcome commitment to cross-government accountability for progress. Amongst many ongoing and planned actions are a promised review to reduce the disability gap in educational outcomes (though no commitment to inclusive education); a consultation on mandatory reporting by large employers of disability employment (but not pay); and action on health inequalities, specifically in relation to autistic people and those with learning disabilities (through training).

To create a sustained, cohesive policy shift towards the linked goals of greater socioeconomic and 'protected characteristic' equality requires public and political support. What would make this agenda relevant?

British Social Attitudes Surveys over the last decade show a shift away from the view that benefits are too generous and deter job seeking. Public and policy appetite to leave austerity behind and increase support to some groups – including

disabled people – is apparent and could potentially influence policy decisions. The public may be getting closer to John Hills' evidence based comment that "there is no them and us – just us", as we all pay in to the welfare state and often 'get out' close to our contributions[42].

Research for Social Care Future found that reframing the social care issue from a 'crisis' in the 'sector' to human experience garnered increased public support: for instance, 'communities where everyone belongs' and 'leading the lives we want to live'. The purpose proposed in this chapter is congruent with this finding.

For health and care leaders, improvements for people living with long-term impairments is core business, with potential large scale rewards. There are calls from staff teams – and from increasingly active disabled professionals – for fairness at work; a commitment to inclusion potentially boosts morale and benefits both colleagues and the public. People with lived experience are increasingly involved in research and professional training; some now expect co-production.

Finally, integrating inequalities – across socioeconomic and protected characteristics – potentially creates an agenda for the whole community and a message that can be mobilised to build united support over time, across different governments. And a revitalised public sector equality duty could help turn that integrated approach into policy and practice.

All this shows that, with a multilayered approach which combines the health inequalities and equality agenda, we can vastly improve outcomes for disabled people, ending the vicious cycle between disability and poverty. The key – for policymakers – is to remember that inclusion can be a win-win.

7. PEOPLE POWER

Patrick Vernon

Black and minority ethnic communities have been hit particularly hard by the pandemic. But the health inequalities they face have deeper roots. To tackle them, we need a people-centred approach.

I n the wake of the murder of George Floyd, the work of Black Lives Matter activists has shone a light on the myriad of injustices and inequalities faced by Black people not just in the United States but here in the UK too. As a country, we have been having long-overdue conversations about how race and racism structure our society.

The pandemic has hit Black, Asian and minority ethnic communities particularly hard. A Public Health England review[43] found that people of Bangladeshi heritage were dying at twice the rate of their white peers, while other minority groups had between 10 per cent and 50 per cent higher risk of death. However, polling has suggested that people from Black and minority ethnic backgrounds are less likely to be willing to get the vaccine. As the Runnymede Trust has highlighted[44], many BAME groups do not trust the vaccine because of historical institutional racism.

Now, figures show that white people in England over the age of 80 are being vaccinated at twice the rate of their Black peers – and the gap is widening. Researchers suggest that both vaccine hesitancy and structural barriers to health-

care could be contributing to this. It is vital that this gap is urgently tackled to prevent the appalling inequalities we have seen throughout the pandemic from persisting through unequal access to the vaccine.

Of course, Covid-19 did not create these ethnic inequalities – and they will not go away when the pandemic is over. So we also need to work hard to tackle the root causes. At the Centre for Ageing Better, we have long had an interest in the inequalities faced by people in later life, and how they affect the experience of ageing. But like many organisations, we have often focused more on issues like class and gender than on race. Part of the reason for this is that while the data available on many aspects of later life is extremely rich, this is not the case when it comes to racial inequalities and the experiences of Black and minority ethnic communities.

In 2020, we set out to find out more about the experiences of BAME people in later life[45] and the inequalities they face. The findings were stark. We found that Black people in this age group have a weekly income of, on average, £100 less than their white peers – and are more likely to be in the poorest fifth of people in England. Despite this, Black people in their 50s and 60s are more likely to be working, with white people three times more likely to have retired. This suggests that these groups are more likely to be in low-paid jobs or have less access to other sources of income like pension savings and assets.

These inequalities also extend to the homes people live in. Nearly half of white people in their 50s and 60s own their home outright, with no mortgage – but for Black people in this age group it is just 13 per cent. Black people are also more likely to live in deprived areas: nearly a third of Black people in this age group live in these areas, compared to just 16 per cent of white people. We know that poor and over-crowded housing has been linked to Covid risk: of all the

councils in England and Wales, Newham in east London had both the highest Covid-19 death rate and greatest proportion of homes classed as overcrowded (25.2 per cent). A report by the Runnymede Trust[46] found that Black and minority ethnic households are more likely than white British households to be multi-generational, have more occupants and to be overcrowded.

The coronavirus pandemic brutally highlighted the health inequalities faced by Black and minority ethnic communities. The Public Health England review which found that BAME people faced higher death rates, cited structural racism and socioeconomic inequalities, as well as the prevalence of conditions like obesity and diabetes, as possible factors. Our research investigated the factors that affect our health in later life and found that Black people in their 50s and 60s are more likely to be physically inactive and to eat fewer than two portions of fruit and veg a day – but are less likely to smoke, or drink heavily. We know that our ability to stay physically active and to eat healthily depend to a great extent on our environment – our access to green spaces, whether we can afford to buy fresh fruit and vegetables and have the time to prepare healthy meals.

Sir Simon Stevens, the former head of NHS England, made it clear this summer that tackling these inequalities must be central to the government's 'levelling up' agenda and it is vital that the pandemic is a spur to action for the government. The tragedies that Black and minority ethnic communities have faced during this crisis must never be allowed to happen again – so through the vaccination programme and beyond, those communities must be front and centre of the government's response. With Amanda Pritchard taking over the helm of NHS England, a greater commitment is now required to tackle health inequalities and structural racism in healthcare delivery.

We need a dedicated public health strategy which recognises the impact of structural racism. Sadly the report of the Commission on Race and Ethnic Disparities led by Tony Sewell failed to acknowledge this and the section on health was one of the weakest links in its analysis. The work of the NHS Race and Health Observatory[47] will have a crucial role in gathering data and influencing health policy in the months ahead. Its latest report in partnership with the Kings Fund makes a series of recommendations which could form the basis of a race and health inequalities strategy to tackle structural racism. In particular, it highlights:

- National policy and strategy.
- Accountability and improvement support.
- Funding.
- Leadership.
- Workforce.
- Data and Evidence.
- Community Engagement.

Working as a senior NHS leader, campaigner, and activist over the years, I have seen the historical failure to harness people power to cut through the muddled thinking around patient involvement, public engagement and participation. We have not learned the lessons about empowering communities to take control of health budgets and strategies while giving NHS managers working with local government and voluntary sector the leadership skills and the permission to make radical changes around commissioning and service development. Ironically it has taken the pandemic for organisations to be creative and take risks after the disinvestment in public health funding and leadership over the last decade.

The voices of communities were ignored for many years. When we did speak out, we were too often gaslit by a government that accused us of being perpetrators of

increasing rates of Covid-19 transmissions, and told us that structural racism was a figment of our imagination. The Windrush scandal showed the horrifying consequences of failing to listen to community voices and of forgetting our history. All too often, the experiences of Black Britons in their 50s, 60s and beyond are left out – both from conversations about race and discussions of later life. Many still experience PTSD because of the hostile environment and both the NHS and local government have failed to address their mental health and wellbeing needs.

People power now needs to be at the heart of tackling health inequalities and structural racism. This will require a new approach to leadership, risk-taking, collaboration, a shared narrative of social change and a process of reconciliation and mediation to build trust and confidence with all stakeholders.

One of the positive things that has come out of the pandemic is how philanthropy and the work around antiracism and race equality acknowledge the historical failure to address the power dynamics between them and Black and minority ethnic communities. In a series of conversations and meetings led by the National Lottery Community Fund, the Ubele Initiative and Global Fund for Children, a set of principles were established which has influenced National Lottery funders' approach to tackling structural racism and funding. These principles are called the Phoenix Way. They set out how:

- People are not hard to reach … organisations are.
- All work must be based on inclusive co-design.
- All work is participatory at its core.
- All work is relational as opposed to transactional.
- You do not need to over-facilitate or over-engineer.
- Develop shared language. Ask more, tell less.
- Do not start by filling the space.

The success of developing these principles and constructive dialogue has led to the establishment of a £50m Phoenix grant scheme to fund and develop the Black and minority ethnic grassroots and voluntary sector and to change the relationship with philanthropists[48].

I believe these principles can also be applied to develop a people powered approach for system change and to tackle health inequality and structural racism in the delivery of healthcare.

Integrated care systems could provide the leadership to adopt the Phoenix Way approach subject to having the right governance and accountability frameworks in place when they go live in April 2022. However, it requires a fundamentally new approach from a future government to learn the lessons of the pandemic and Black Lives Matter to liberate public services for transformational change and anti-racism. Accountability needs to be determined by local communities with the right support around resources and leadership.

8. RECOVERY PLANS

Anita Charlesworth

A strong National Health Service must put reducing inequalities in access to care and improving health outcomes at the heart of its aims. But if a commitment to tackling inequalities post-pandemic is to be meaningful, it needs to be reflected in decisions about resources and priorities, with transparency and accountability too.

Healthcare free at the point of use, based on need rather than the ability to pay, is the founding principle of the NHS. The quality of care is the top reason the public cite for being satisfied with the NHS, followed by the fact it is free at the point of use and has a good range of services[49]. Public satisfaction with the NHS was high even before Covid-19.

The UK is not alone in recognising the significance of universal access to comprehensive healthcare. It is a principle endorsed globally through the Sustainable Development Goals adopted by all United Nation's member states in 2015, which include the ambition to achieve universal health coverage. The global importance of this goal has been brought into sharp relief through the pandemic, as countries have seen fragile health systems overwhelmed and huge inequalities in access to vaccines.

A recent LSE-Lancet commission confirmed that one of the key strengths of the NHS is that it provides a very high level of protection against catastrophic care costs, with the UK having fewer than 2 per cent of the population facing out-of-pocket payments of 10 per cent or more of household income – one of the lowest rates in the world[50].

Although the NHS has major strengths, over the decades evidence has mounted showing that deep health inequalities remain. The Commonwealth Fund survey of 11 industrialised countries found that the UK ranked 10th for health outcomes among comparable countries[51]. Vaccination rates, screening, early diagnosis of cancer – all critical to improving health outcomes – are all lower in more deprived communities in England than in affluent ones.[52] [53] [54]

Why might this be the case if cost is not a barrier to accessing healthcare? In 1971, the Welsh GP and academic Julian Tudor Hart identified that "the availability of good medical care tends to vary inversely with the need for it in the population served."[55] Since the 1970s, the NHS has been trying to reduce inequalities in access, but 50 years on from Tudor Hart's groundbreaking description of the inverse care law, mortality amenable to healthcare is still 3.2 times higher for men and 2.5 times higher for women in the most deprived tenth of areas in England when compared to those in the most affluent areas.[56]

One obvious conclusion is that we need to look beyond the healthcare system if inequalities are to be reduced. It is undoubtedly the case that social and economic determinants of health play a vital role in improving health outcomes and reducing inequality.[57] [58]

Back in 1971, Tudor Hart also concluded that: "Medical services are not the main determinant of mortality or morbidity; these depend most upon standards of nutrition, housing, working environment, education and the presence

or absence of war." Research in the intervening 50 years strengthens the case for a much greater focus on the contribution of economic and social factors to improving health and reducing inequalities.[59] [60] But research also suggests this is not a zero-sum game and access to healthcare is also associated with improved health outcomes.[61] [62] Societies that seek to reduce health inequalities need to ensure access to high quality healthcare alongside lower levels of economic inequality.[63] The strategy needs to be one of 'both, and' not 'either, or' between wider determinants of health and healthcare services.

While inequalities in access have been a stubbornly persistent weakness in UK healthcare, it is not the case that nothing can be done. Research by Benjamin Barr and colleagues in 2014[64] explored the impact of adding a health inequalities component into the resource allocation formula for the NHS in 2002 on avoidable mortality. They found that, between 2001 and 2011, funding per head of population increased by 81 per cent in the most deprived areas, more than the 70 per cent increase in the more affluent areas. Over the same decade researchers found that in deprived communities, mortality amenable to healthcare fell faster than in other areas. Overall, they concluded that: "Each additional £10m of resources allocated to deprived areas was associated with a reduction in four deaths in males per 100,000 and 1.8 deaths in females per 100,000." Targeting additional funding at deprived communities did appear to reduce inequalities.

It is also worth considering that the pandemic has had a profound effect on the NHS, with services reorganised to free up capacity and allow more social distancing and enhanced infection control. Care needs and care-seeking behaviour have both been affected. The result is that the use of hospitals and primary care has changed dramatically. The pandemic has been a major live experiment in the rapid adoption of

new technology and service models. It is essential that these innovations are tracked and monitored to understand how they are affecting inequalities in access to care.

Recent research by Samantha Burn and colleagues found those living in more deprived areas have experienced the biggest falls in hospital care through the pandemic. The pandemic has highlighted other stark inequalities in health need: patients living in poorer areas are much more likely to experience multiple chronic illnesses that lead to much higher levels of demand for primary care. Despite these higher levels in primary care access, we have observed larger falls in urgent cancer referrals and new cancer first treatments in poorer areas.[65]

As the rollout of the vaccine completes, the government is introducing new legislation to restructure the NHS, shifting from a market-based approach to a focus on collaboration and population health through new integrated care systems (ICSs). And autumn 2022 will see a spending review to set out the funding envelopes for all public services for the rest of this government's term of office. At the same time, the government and NHS leadership need to produce a plan for recovery.

As the government and NHS leaders formulate the NHS recovery plan, they need to put reducing inequalities in access to care and improving health outcomes at the heart of post pandemic health policy. But if a commitment to tackling inequalities is to be meaningful it needs to be reflected in decisions about resources and priorities. There also needs to be action to ensure transparency and accountability.

As the work of Barr and colleagues shows, money talks. How well the needs of people from socioeconomically deprived backgrounds and more marginalised groups are reflected in the formula to allocate NHS funding to local areas really matters.

Yet it is not just funds available for the day-to-day provision of health services that make a difference. Where the NHS invests to build hospitals and GP services is also very important. The patchwork of hospital provision for very specialist care has grown over many decades. The result is that major cities tend to have good access and their populations use these services more. For remote areas with lower population density, access is much more limited. For people in places such as Cornwall and Cumbria, major health needs for conditions that are rare or highly complex are likely to require a lot of travel and for some that is simply not feasible.

And it is not only specialised care: there are fewer GPs in socioeconomically deprived areas once adjusted for need, as well as higher rates of staff turnover.[66][67] Funding to improve population health is allocated to local authorities via the £3bn public health grant. A new funding formula that sought to account for differences in need between local authorities was first introduced in 2013/14. But there was never any meaningful progress to shift resources to those areas below target as spending per person fell by almost a quarter between 2015/16 and 2021/22; a £1bn real-terms reduction in the public health grant[68].

Making sure that funding and facilities are distributed in a way that puts more weight on the needs of more deprived areas and marginalised groups is essential. Given that the NHS and social care bill creates new organisations – ICSs – that will oversee healthcare in a given place, the approach to deciding how much funding each of these bodies get and the system for sharing out new capital investment budgets, must have tackling inequalities at their heart.

Getting the money to the people who need it most is necessary but not sufficient to tackling inequalities as the NHS recovers from Covid-19. The barriers to accessing services are multi-layered. Progress is likely to depend on a combination

of a national pull to hold those leading the NHS organisations to account for their progress on inequalities and a local push from organisations, led by people who understand and are committed to reducing inequality.

The NHS has a long way to go to reflect the communities it serves in leadership roles: 22.1 per cent of NHS staff are from a minority ethnic background but occupy just 7.4 per cent of senior management posts. The accountability framework between NHS England and the new ICSs needs to have a clear focus on reducing inequalities. But who is at the leadership table matters. The new NHS Race and Health Observatory has argued "The appointment of new leaders for integrated care systems is an opportunity for the NHS to deliver on its long-standing aim to diversify the system's senior leadership and make it more representative of the communities it serves." [69]

The NHS needs to be part of the solution, not just the system that mops up the consequences of economic and social inequality. The idea of health service organisations as 'anchor institutions' in their community is gaining hold. In the 2019 Long Term Plan, the NHS recognised that through its role as an employer of over a million people, combined with its huge spending power, the health service has the potential to create social value in local communities. But that this is particularly important for those living in more deprived areas. The Long Term Plan recognised that "nearly one in five people employed in Blackpool work for the NHS and the gross value added from health spending is significantly higher than in areas in the south (over 17 per cent vs 4 per cent in London." Employment practices and procurement can play an important role in extending economic and social opportunity.

'What's measured is what matters'. For at least 40 years targets and performance management have been central

planks of the NHS's approach to improving care. Targets and performance management depend critically on measurement. It might be argued that the one reason inequalities in access to NHS care have persisted for so many decades is that they are often hidden. Many health-related datasets do not routinely include ethnicity and in the main hospital data set in 2019/20, 13 per cent of inpatients and 17 per cent of outpatients did not have a known, stated ethnicity recorded[70].

Data and data-driven technologies are playing an increasing role in the NHS. Those using data – whether to understand population health, to improve services, or develop data science tools – also have a role. They need to be aware of data quality issues, and to use this data in an equitable way, ensuring questions asked will help those with greatest need, and involving a diverse group of people[71].

The NHS's role in reducing inequalities is foremost about providing access to high quality healthcare and organising the delivery of care so that it recognises the barriers faced by different groups in the community. But this is not the limit of the contribution NHS organisations can make to improving health. With the shift away from competition and market mechanisms in healthcare, the NHS needs to have a deep and rounded focus on its contribution to the health of local communities. The pandemic has shown how central health is to our economic and social infrastructure. That flows both ways; political leaders need to invest in the health of populations, but NHS leaders need to recognise and champion the wider role the health service can and should play in local communities.

As the NHS recovers from Covid-19 and moves to a more population-health focus, placing inequalities centre stage is vital. But the strategies to do this need to be wide ranging, recognising that the health system is not an island standing

apart from communities and services. To be effective, health services need to be rooted in a place and its people.

9. A MAGIC BULLET?

Christina Pagel

Science and innovation can play an important role in reducing health inequalities, but to harness their power requires us to go back to the fundamental causes of these inequalities. In doing so, we can understand, implement and research in new and more impactful ways.

Health inequalities are a symptom of wider inequalities and so targeting science and innovation policy at health inequalities specifically is a mistake and will not work if their root causes are not addressed.

The fundamental issues are well known and cover[72]:

- Low income (financial strain causing stress, poverty, adverse behavioural exposures such as smoking).
- Housing (affordability, poor quality, frequent moves, homelessness).
- Work (unemployment, job security, quality of work environments).
- Transport (air and noise pollution, road safety, and access to public services and active transport such as walking and cycling).
- Neighbourhoods and surroundings (access to green spaces and factors that enable thriving communities).

● And family, friends and community (safe home environment, positive role models, peer support, loneliness).

It is not just that each of these can profoundly affect health, but often they interact and combine to compound health impacts and perpetuate health inequalities. Ultimately, comprehensive local and national policies across the range of these areas are needed to address these issues.

There is already plenty of evidence of what is needed across all of the six aforementioned domains and how improvement can be achieved. What is needed is the money, the will, the coordination and the competence to implement policy. Science and innovation are thus not the most important levers to reduce health inequalities. That said, there are important contributions to be made and here are six suggestions on how science and innovation can contribute.

1. Do not focus on technological solutions

There is a temptation to look for 'magic bullet' solutions to difficult problems, particularly when considering science policy. However, as discussed above, the problems underlying health inequalities are so broad and deep that there is no magic bullet. Concentrating resources on research promising such solutions is likely to be a distraction and not represent value for money.

2. Measure, understand and evaluate

To address inequalities, and the causes of inequalities, you have to know they exist, in which demographics, and how large differences are. The UK already has world leading national datasets covering health, employment, income, transport and housing. But these can be improved. All

public sector data collection sets should be comprehensively reviewed to ensure they are capturing statistics on inequalities. Technology and data science could play a crucial role in routinely linking across datasets to help:

- Add to the type of data already routinely collected such as mobility data and some health outcome data (eg blood pressure monitoring).
- Generate a comprehensive, up-to-date dataset describing the contexts of people's lives across the six domains listed at the start of this chapter at the level of individuals.
- Use cutting edge data science to understand better how different aspects of disadvantage combine to impact health inequalities (and indeed other inequalities). Identifying which ones are most influential would help inform where resources and policy should be targeted.
- Evaluate new policies across the six domains to understand how and if they impact health inequalities and use that learning to continually improve policy and its implementation.

3. Invest in multidisciplinary and multisector research

Research councils and government departments are naturally siloed. There have been moves to integrate further through joint funding or policy integration (eg integrating policy across education, health and social care departments). This must be accelerated. The six main domains generating health inequalities are so intertwined, that research or policy that considers only one domain in the absence of the others risks being ineffective. Similarly, policymakers and funders should encourage collaboration across sectors: involving industry and third sector organisations from the beginning

will help ensure that new findings can be put into practice more quickly and effectively.

Funders and policymakers also need to recognise the underlying domains and prioritise research or industry incentives that address the fundamental issues. So for instance, developing cleaner transport, more effective ventilation or safer housing materials should all be considered as important interventions to improve health inequalities.

4. Include communities in commissioning, implementation and evaluation

Many disadvantaged communities, which are also often the communities with the worst health are less likely to be included in discussions on what policy and research priorities should be, on how to design and implement new policies and in evaluations on whether new policies are working. They are also underrepresented in health data – and indeed, other forms of data.

Research teams need to consider and demonstrate how they are including relevant communities in their work. An example here is in the case of artificial intelligence: any use of AI needs to consider what biases can emerge in resulting algorithms due to imbalances in input data or data reflecting existing inequalities, including the over or under representation of ethnic groups in crucial areas. Any data collected should collate enough demographic information to allow measurement of inequalities across participants and outcomes.

When commissioning or prioritising research, funding councils and policymakers should ensure that communities have a voice in what research matters, how it should be conducted and how it could be implemented.

Researchers and national data organisations should demonstrate and explain how they have worked with communities
81

to ensure that disadvantaged groups are as fully represented in the data as possible. This could include rethinking ownership of data and how access to data is managed and negotiated with communities.

5. Build representation of disadvantaged communities in science and policymaking

While involving communities is crucial, it is also vital to ensure that people from disadvantaged communities are enabled to become research and policy leaders.

First, by not addressing educational attainment in disadvantaged communities, we are wasting the potential of our children and young adults to be brilliant scientists, entrepreneurs or public sector leaders. Second, too many important research questions or policy options are never explored or even conceived of simply because too few people designing them have lived experience of poverty, poor housing, food insecurity, employment insecurity or poor working environments. Scientists and policymakers are just people, and the research we prioritise and pursue is influenced by our own experiences and values and those of our peers. This is illustrated by the relatively low investment into research and policy addressing homelessness or addiction. It has been seen historically in the lack of research and investment into significant health issues that primarily affect women such as menstrual disorders, menopause or urinary incontinence compared to erectile dysfunction. This is only just changing, and changing slowly, as more and more women participate and lead in health research and policy.

There will be immensely impactful research and policy proposals that the existing communities of praxis (scientists, industry leaders, civil servants and MPs) never consider because they simply do not occur to them. The more we diversify these communities of praxis, the better we can

address the underlying domain problems causing health inequalities. A corollary of this is the regional 'levelling up' agenda: we know that geographical patterns of poverty and disadvantage have persisted for well over a hundred years with higher deprivation and worse health outcomes, such as in the North of England compared to the South. In this respect, the dominance of funding in the 'golden triangle' defined by Oxford, Cambridge and London of universities, businesses and policy experts, exacerbates these problems. Concerted efforts to allocate funding outside this traditional triangle are important.

6. The climate emergency

Policy and research funding must be forward thinking. Climate change represents the greatest challenge to human health over the coming century. As the climate changes and warms, it will affect the spaces in which we live, the food we can grow and eat, the water we drink, the air we breathe, the types of buildings we will need, how we build resilience to extreme weather events, the diseases that affect us, and the communities we live in as people are forced to migrate.

All research and policy that aims to impact health inequalities must take into account our changing climate and funders and policy leaders should incorporate this into prioritisation and evaluation exercises. Fundamental research into mitigating the impacts of climate change will also be crucial in mitigating worsening health inequalities and this should be recognised by funders and policymakers.

There can be a tendency in science and innovation policy to reach for the most exciting or ground-breaking fundamental research or the newest technological advances. Of course

these remain important, but if we want to genuinely reduce health inequalities we have to go back to the fundamental causes of these inequalities and be thoughtful about how science policy can impact these. The six suggestions in this chapter are all intended to achieve research and policy that will have enduring positive impact on health inequalities.

10. THE INSIDE STORY

Kate Stanley and Emilie L'Hôte

There are huge gaps between how people in the health sector and the public understand health – which results in lower support for solutions to health inequalities. By framing and communicating health-related issues in a different way, we can increase the public's backing for action.

Is it possible to strengthen public demand for government action to reduce health inequalities? At FrameWorks we have been conducting research to identify communications strategies capable of meeting this challenge.[73]

The Covid-19 pandemic has happened since some of this research took place and future research will need to be attentive to any changes in public mindsets[74]. However, while the impact of the pandemic has been dramatic, mindsets are enduring and shift gradually over time. We therefore expect many patterns of thinking we have identified to persist.

Public and sector understandings of the social drivers of health inequalities

Understanding how members of the public think is a crucial first step in constructing a new story about health inequalities that taps into more productive ideas and avoids reinforcing ones that sidetrack the conversation.

Our research has identified important overlaps and gaps between how those working to address health inequalities and the public understand health.[75] The overlaps represent the common ground on which to build support for action. They include the following ideas:

- Health includes both mental and physical health.
- Chronic, non-communicable illnesses have become a key health issue.
- Stress plays an important role in determining health outcomes (although experts and the public are only partially aligned on the health effects of stress).
- Social and environmental factors can have a direct effect on health. For instance, poor housing conditions can cause respiratory issues for people, or workplaces can create risks for accidents.
- There is a causal link between wealth and health outcomes, and people who are poor are likely to have worse health than people who are wealthy.
- There are geographical disparities in health, both within the country and globally.
- Central and local government have a role to play in improving health.

There are also significant gaps between how people in the health sector and the public understand health that must be addressed if we are to increase support for action – including government action. We will briefly take a look at these gaps:

Societal issue vs individual issue

For the sector, health is primarily a product of societal systems. Solutions must, in turn, be designed at the level of society. For the public, health is understood at the individual

level: individual behaviour and choices are seen as the main source of health issues and the main site for solutions. This gap is at the root of all the other gaps between the sector and the public on this issue.

Good health: Integrated wellbeing vs absence of illness

The sector defines good health broadly; having a healthy society means people can experience physical and mental wellbeing, make meaning of their lives and have the sense of control needed to pursue life goals.

In contrast, members of the public understand good health as simply the absence of illness. This deep gap around the definition of health is critical as it produces differences in thinking about what our goals should be and about what are appropriate and effective solutions.

Individual behaviour: Driven by context vs source of problems

According to the sector, individual behaviour is strongly constrained and shaped by social and environmental factors – so, for example, living in a poor area can reduce a person's access to nutritious food resulting in a poor diet. The sector sees social and environmental factors as critical factors which often interact with one another in ways that 'stack the odds' against people. The sector also argues that traditional awareness campaigns can be counterproductive and strengthen the sense that individuals are to blame for their own health issues.

In contrast, members of the public understand individual behaviours and lack of willpower as the source of most health issues. And while the public recognises that these factors play a role in shaping health outcomes, people tend to underestimate the power of social drivers in favour of a focus on individual behaviour.

Power, wealth and resource inequalities: Key determinants vs off the radar

The sector explains that inequalities in power, wealth and resources lie at the root of health disparities. The public, by contrast, is largely unaware of how discrimination, racism and other power imbalances shape health. They understand the link between wealth and health only in terms of individual purchasing power and fail to see how economic inequality is bound up with other forms of inequality.

Genetics: Minor influence vs powerful explanation

The sector insists that genetics only play a minor role in shaping health outcomes. By contrast, the public see genetics as the main factor – other than individual behaviour – that explains health outcomes. And because people also see genetics as immutable, they see few opportunities to influence and improve health outcomes.

The NHS: Limited Influence vs paramount role

The sector argues that the way to a healthy society is through increased investment in public services that protect and improve the health of the population over the long term. In this view, while the NHS is important, the prioritisation of the NHS budget at the expense of other health-creating services puts the wellbeing of the population at risk. By contrast, health care and the NHS are at the forefront of public thinking about health. The public assumes that medical treatment is critical to improving health. This gap must be addressed to boost public support for a shift in policy focus and government funding towards health creation.

Role of government: Expansive vs limited

The sector argues that government has a varied and expansive role to play in the reduction of health inequalities. They argue government should include policy to create health across departments and empower communities to play a significant role in decision-making around this.

While the public recognises that government has a responsibility to protect individuals from unhealthy environments, people mostly see the government's role as funding and managing the NHS, with some limited regulation of commercial practices. And the public has a blind spot about the ways that good health can be created through policy and community actions.

These gaps between sector and public understandings of health need to be addressed to shift thinking and open up space for a different public conversation – a conversation capable of boosting support for new solutions and government action.

Media and health sector discourse

Public understandings are, of course, informed by media and health sector discourse. We analysed dominant health narratives in news media and in health advocacy, policy and research organisations' communications – and assessed how these practices may be affecting public thinking[76].

This research was carried out in 2018. If we were to repeat the work now, it is likely that – as a result of the pandemic – we would see greater discussion of health inequalities than we did in this research. However, there are aspects of the discourse which are less likely to have shifted in this time; in brief, these are:

- Media coverage tends to reinforce public thinking that individual behaviours are what matters.
- There is a disproportionate focus on health care in media and sector communications which encourage a medicalised understanding of health and obscure the importance of other social factors. This limits understanding of how health can best be created.
- Current media and sector discourse supports recognition of how social drivers harm health, but not how they create health. The sector is also not presenting a consistent, coherent narrative about how shifts in policy and practice could create a healthy society.

The public primarily hears two stories from the media and the sector. One is focused entirely on the challenges faced by the NHS. This narrative often uses crisis language, coupled with vague solutions. The other focuses on how the government has not effectively addressed health issues. Each of these narratives casts doubt on whether the public sector can affect meaningful change and are likely to trigger fatalism about the efficacy of large-scale government interventions in health.

On the basis of this 2018 snapshot, we can see how sector and media discourse is more likely to reinforce the gaps in understanding between the sector and the wider public. A new approach is needed when talking about health inequalities in order to bridge these gaps and boost public support for the kinds of actions the sector advocates including government action. In the final section, we identify three such approaches.

Strategies to strengthen support for action

Tell a complete story – with explanation and solutions

Before the pandemic people underplayed the role of social drivers in shaping health outcomes – and therefore did not see addressing them as a policy priority. While the pandemic might have shone a light on these issues, there is still significant work to do.

Often, we simply describe issues rather than explaining why and how they occur – moving too quickly from cause (say, 'poor education') to consequence (say, 'poor health') without the necessary links to explain how and why one impacts the other. In the absence of a complete story, people are liable to 'fill in the blanks' with default, and potentially unproductive, ways of thinking – in this case that a lack of education means people make bad health choices. This leads people to reason that 'more education' or 'better decisions' are the only solutions.

Explaining the causal links between different social and environmental factors and health outcomes is critical to this effort. For example, communicators might explain how lack of access to a good education leads to limited employment options; how this in turn affects people's housing conditions; how all of these things conspire to decrease individual power; leading to specific effects on physical and mental health. When we tell complete stories with fuller explanation, people are effective reasoners about appropriate action. In this case, reasoning that there are opportunities to improve access to education, but also employment opportunities, housing conditions and community decision making – in order to improve health outcomes.

Make it about inequalities in life expectancy

An issue frame establishes what something is about. For example, when we talk about climate change, the issue frame could be: climate change is about nature, or is about human health, or is about the economy. Framing research shows that the choice of issue frame can dramatically affect public thinking and policy support[77].

Evidence emerging from FrameWorks research to be published in late 2021 suggests that a productive issue frame for health inequality is to make it about life expectancy going down in some parts of the country. Put simply: health inequalities are about some people living shorter lives than others based on where they live.

This issue frame had similar effects on people holding different political beliefs, and in our study was particularly effective with participants who identified as conservative. This is consistent with findings in the political science literature arguing that conservatives are usually more willing to devote attention to negative information. Or it may be effective because focusing on death conveys a stronger sense of urgency and importance than talk of poor health in general.

Avoid backfiring frames

There are at least three communications strategies that FrameWorks research suggests may backfire and should be avoided: 'meeting people where they are', appealing to 'common sense' and 'emergency' frames.

It is often assumed that it is wise to open a discussion by 'meeting people where they are', acknowledging their concerns before pivoting and making a point. For example, we might be tempted to say something like: 'Individuals certainly need to do their part – try to eat well and exercise regularly' or 'This is not about a nanny state'. This strategy

aims to defuse sources of resistance, but instead it actually reminds people of – and reinforces – existing unproductive ways of thinking and should be avoided.

The value of 'common sense' is often used by politicians on the right to frame messages about why individuals should take action on health. The same value has also been used by the sector to make the case for government action to address the social drivers of health. In our research, this frame reduced support for government action. This may be because co-opting a familiar frame to make a different point, triggered disbelief.

Rising rates of diabetes, cancer and obesity tend to be framed as 'epidemics', and 'emergencies' and depicted as a strain on an NHS 'in crisis'. However, research has found that crisis messages typically backfire by reinforcing people's sense of fatalism[78]. This results in lower support for solutions and disengagement from the issue.

Conclusion

By consistently telling a story that focuses on how environments, resources, and power shape health outcomes, it is possible to push public thinking about health away from individualism and towards a more holistic, structural understanding. Further research is needed to identify communications strategies capable of overcoming the deepest and most challenging gaps we have identified, however, these initial strategies offer promise in boosting support for government action to address health inequalities.

CONCLUSION AND RECOMMENDATIONS

Steve Bradley and Tom Gardiner

Tackling health inequalities will require a relentless sense of mission from the next Labour government. Proposals in this pamphlet provide a starting point.

Of all the injustices in our society, none is more fundamental than the way material and social circumstances dictate how long we live and the proportion of our lives spent in good health. The pandemic has exposed shockingly unequal burdens of ill health. As clinicians, we have observed this first-hand. But the underlying factors responsible for these inequalities have been well understood for decades. As the World Health Organization explained back in 2008: "Social injustice is killing on a grand scale." Among those who are committed to tackling this prodigious injustice, there is little serious disagreement about the kinds of solutions required. Yet in its response to the inequalities exposed by the pandemic, the present government has maintained a tradition of ignoring comprehensive policy reports produced on its behalf, preferring to cling to the dogma that individuals simply need to make healthier choices.

Since health inequalities are largely a manifestation of income inequality, a Labour government is naturally better placed to address these problems. Many suitable remedies also go with the grain of Labour's other priorities, from

taking real action on climate change to ending child poverty and homelessness, creating jobs and improving our taxation and benefits systems. Since health is only influenced to a limited degree by healthcare alone, ensuring a progressive policy programme adequately corrects entrenched inequalities will require a relentless sense of mission across virtually all portfolios. We will also need to recalibrate the public's understanding of the underlying causes of these inequalities and engender an expectation that a core responsibility of government is to improve societal health that outlives any one administration. The urgency of this endeavour requires us to prepare an integrated framework of bold but plausible policies. The purpose of this collection of essays is to help catalyse this process and to consider how such a vision might be delivered across some key policy areas.

If Labour is to have the opportunity to deliver change, it will need to articulate a coherent vision of a healthier, fairer society that fits seamlessly within its broader message. The vision which emerges from these essays is of a future in which all individuals and communities obtain the control to create good health. This is the authentic counterpart to the senseless injunction that all adversity must be overcome through 'individual responsibility', which continues to hobble health policy, despite its manifest ineffectiveness. Taken together, the essays also offer a number of strategic priorities to inform policy development. These priorities include:

- Creating the conditions in which everyone, not just the wealthy, can exercise autonomy to pursue better health.
- Transforming services into health creators embedded within communities and support staff to proactively seek out and serve those who need the most support.
- Eliminating discrimination by enforcing existing mechanisms and mandating additional responsibilities on

organisations, including new integrated care systems, to tackle discrimination and report differentials in appointments and outcomes.

- Harnessing data to improve monitoring of, and performance in mitigating, health inequalities, and enhance communication by establishing secure data flows between organisations.
- Ensuring that those who suffer poorer health outcomes have a role in co-producing the solutions to health inequalities.
- Altering the composition and leadership of services to better reflect those they serve and grant service users and communities greater say in how these organisations are run.
- Allowing communities to set their own priorities for how inequalities are tackled and permit divergent solutions to emerge in order to meet local circumstances.
- Telling a better story about the causes of health inequalities and learn how to explain why societal approaches are needed, so that individuals can overcome barriers to create better health.

Some of the actions and aims that have been discussed in this collection are summarised at the end of this chapter. It is striking that relatively few of these proposals are primarily health policies. Instead, several of those listed address other policy goals which are worthy in their own right and are not usually promoted with reference to improved health outcomes. That we can present policies that already have currency within the Labour party as being likely to create collateral benefits by reducing health inequalities should help copper-fasten the case for proposals that already make sense in their own terms. But, taken in isolation, it will not be possible to demonstrate that many of these individual

actions will improve health on their own. Therefore it is vital to avoid a 'shopping list' approach in favour of a coherent architecture of priorities which are framed by Labour's vision of a fairer and healthier society. That this collection has barely referenced many important areas like justice, housing, drugs and education reflects the daunting scope of that task. We sincerely thank all of the contributors who have helped us make a start.

Table: Some actions and aims suggested for consideration in this collection.

Proposals which may be considered to fall within the conventional remit of public health and/or health and social care are high-lighted in red. The table is presented to convey the breadth of responses and perspectives included, it does not constitute a cohesive policy programme and inclusion does not connote agreement of all contributors/editors. Readers should turn to the respective chapters to understand the context and arguments with which specific ideas are framed.

Policy Area	Proposals suggested for consideration by contributors	Chapter
Early Years	Revitalise Sure Start children's centres and family hubs, particularly in disadvantaged areas	3, 4, 6
	Expand and refocus the Supporting Families Programme towards health and wellbeing in the early years	3
	An enhanced Healthy Child Programme to consolidate a preventative approach to child health	3
	Increase health visitor numbers	3
	Deliver 'Healthy Start' obesity prevention programmes through children's centres	3
	Enhance the 2 ½ year-old development check	3
	Free childcare from age two for disadvantaged families	3
	Measure progress with a common outcomes framework linked to child health and wellbeing and readiness to start school	3
	Introduce a financial settlement with shared funding for early years including children's centres and hubs, along with wider public health measures pertaining to early years health and wellbeing	3
	Establish a national framework for children's health and well-being that supports improvements delivered locally	3

Prescription for fairness

Policy Area	Proposals suggested for consideration by contributors	Chapter
Employment, Industrial Strategy	Concentrate creation of high quality jobs in areas hit hardest by de-industrialisation and austerity	5
	Invest £85bn to create 1.25 million jobs in green transport, infrastructure tech and housing	5
	Create 600,000 jobs in public services	5
	Establish a state investment bank	5
	Improve support for those unable to work including sick leave and social security and cease emphasis on blame and sanctions	5
	Increase participation for the most marginalised workers and reduce the employment and pay gaps for disabled workers with a new approach to reasonable adjustments and provision of state funded occupational health. Require larger employers to report employment, progression and pay of people who are disabled	5, 6
	Improve workers' voice, particularly in 'gig' and platform economies, and give workers representation on company/organisation boards	5
	Increase funding for the Health, Safety Executive with enhanced programme of inspection and enforcement	5
	Legislate the 'right to disconnect' outside working hours	5
	Improve pay and conditions within the 'gig' economy	2, 4, 5

Policy Area	Proposals suggested for consideration by contributors	Chapter
Communities	Give direct support for local initiatives through longer term grants that are formally commissioned	4
	Within locales establish cross sectoral groups including businesses, public bodies and voluntary/ community groups to identify and act on local health priorities	4
	Provision of good outdoor environments for recreation/exercise and link existing green spaces	3, 4
Housing	Adoption of the Town, Country Planning Association's healthy homes principles by local authorities and/or implement the Healthy Homes Act at a national level	4
	Increase provision of social housing	2
	Tighten planning regulation to promote lifetime homes and improve standards of accessibility	6
	Increase the energy efficiency of housing	1
Education	Reduce school exclusions, improve inclusive education and increase opportunities for technical, vocational and lifelong training	4, 5, 6
Immigration	End the 'hostile environment' for asylum seekers	2
Public Finance	Explore establishment of a sovereign wealth fund that pays a 'universal minimum inheritance' to all young adults	2

Prescription for fairness

Policy Area	Proposals suggested for consideration by contributors	Chapter
Constitutional	Initiate electoral reform to improve representation and greater sharing of central power with councils, communities and citizens	2
Equalities	Formulate comprehensive policies and public health strategy to dismantle structural racism	2, 7
	Revitalise the public sector equality duty to ensure that every policy change and local decision is made with reference to a requirement to reduce inequalities	6
	Ensure all have the right to full participation in the community and the ability to live autonomous and connected lives	4, 6
Transport	Strengthen inclusivity/accessibility requirements for transport	6
	Decarbonise transport and promote active transport	1
Social Security	Recognise and reimburse the additional costs of disability and real world barriers to employment	6

Policy Area	Proposals suggested for consideration by contributors	Chapter
Health, Social Care	Improve access to services for disadvantaged areas and groups to address the 'inverse care law'	8
	Ensure health and social care leaders establish a purpose of service with long term users of services	6
	Reduce coercion within services and commit to year-on-year reductions of compulsory detention, restraint, seclusion and long-term segregation	6
	Within leadership teams achieve a better reflection of the those they serve and ensure communities have a meaningful say in decision making	4, 8
	Leverage influence of services as 'anchor institutions' to create social value and become more deeply rooted within communities	8
	Improve capture of ethnicity data to ensure adequate measurement of performance in addressing inequalities	8, 9
	Adoption of the 'Phoenix Way Approach' by leaders of Integrated Care Systems	7
	Reform social care to improve support for disabled, chronically ill and older people	4
	Restrict junk food advertising	3

Prescription for fairness

Policy Area	Proposals suggested for consideration by contributors	Chapter
Technology, Innovation	Exploit data science to understand how different aspects of disadvantage combine to impact inequalities and use these insights to target policy	9
	Integrate evidence generation across research councils and government departments and increase cross-collaboration focused on mitigating inequalities	9
	Prioritise and incentivise research that addresses factors which contribute to health inequalities, such as greener transport, improving air quality and safer housing	9
	Include relevant communities in setting the research and innovation agenda and ensure that systemic biases are not embedded in outputs, for example by ensuring disadvantaged groups are adequately represented in data sets	9

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77   See, for example, Nelson, Thomas E., et al. "Media Framing of a Civil Liberties Conflict and Its Effect on Tolerance." The American Political Science Review, vol. 91, no. 3, 1997, pp. 567–583.

78   Frameworks Institute, Don't Feed Fatalism...Put Forward Solutions Instead.

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Prescription for fairness

Remedying health inequalities in a post-Covid era

As we look to recover from the greatest public health crisis in a century, the need to tackle health inequalities has become even more critical and clear. The Covid-19 pandemic has exposed and exacerbated pre-existing health inequalities whilst also giving rise to a host of new challenges that threaten the goal of achieving equity within our health and social care system, bringing widespread attention to this issue as never before.

Yet although differences in health outcomes and drivers behind inequality have been well-observed, the policies to reduce them and how these might be prioritised require greater consideration by political leaders. This timely collection explores practical solutions for a future government committed to addressing health inequalities post-Covid-19 and determined to offer everyone the chance to a healthy life.

With an introduction by shadow health and social care secretary Jonathan Ashworth MP and contributions from Mala Rao, Parth Patel, Anne Longfield, Nigel Crisp, Frances O'Grady, Liz Sayce, Patrick Vernon, Anita Charlesworth, Christina Pagel, Kate Stanley and Emilie L'Hote.