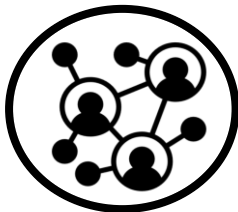
UNIVERSITY OF CAMBRIDGE

CSaP centre for science and policy

Centre for Science and Policy

Policy Workshop on Healthy Life Expectancy



East of England
Population Health Research Hub
EoE PHResH

Summary report of the discussion held on 24 April 2023

Darwin College, Cambridge

Prepared by Dr Jennie Leggat (Public Health Policy Fellow, CSaP)

Table of Contents

Introduction **3**

Executive Summary **4**

Summary of the discussion **6**

1. What is healthy life expectancy (HLE)? 6
2. How is HLE measured? 6
3. What are the determinants of HLE? 8
4. What actions can we take to improve HLE at local and regional levels? 9
5. What are the barriers to taking action to improve HLE, and how might we overcome them? 17

Closing remarks and next steps **18**

Appendices **20**

Introduction

In April 2023, the Centre for Science and Policy (CSaP), University of Cambridge, organised a Policy Workshop on Healthy Life Expectancy in partnership with the East of England Population Health Research Hub (EoE PHResH). The Policy Workshop brought together a group of local, regional, and national policymakers, academic researchers, and other relevant experts to discuss what determines healthy life expectancy alongside potential policy interventions in an East of England context. The objective of the event was to inform local and regional public health strategy and actions to improve healthy life expectancy in these populations.

The workshop aimed to explore the following questions:

- **What are the determinants of healthy life expectancy (HLE)?** What factors affect healthy life expectancy? What factors are driving inequality in healthy life expectancy? Which of these factors are modifiable?
- **What actions can we take to improve HLE and reduce inequalities at local and regional levels?** What are the unique or priority factors to address at local and regional levels? What are the local and regional levers to modify these factors and how are they being utilised? What evidence is available on the effectiveness of interventions?
- **How can we best measure HLE and inequality in HLE?** Is the current measurement fit for purpose? What role could the ONS Health Index play? What data or evidence gaps are there?
- **How best to monitor local and regional progress?** What are the priority indicators? What indicators are we measuring well now and what needs to improve? What data or evidence gaps are there?

Desired outcomes of the workshop included:

- Discuss recommendations for implementation at the local and regional levels to improve healthy life expectancy, reduce inequalities, and measure the change;
- Identify gaps and next steps to address this issue, with identified actions to be followed up by EoE PHResH.

Executive Summary

In April 2023, the Centre for Science and Policy, University of Cambridge, organised a policy workshop on Healthy Life Expectancy (HLE) in partnership with the East of England Population Health Research Hub. The workshop brought together policymakers, researchers, and other relevant experts to discuss what determines HLE and identify potential policy interventions to improve HLE in the East of England region. Whilst HLE in the East of England is higher than the national average, it stagnated between 2011 and 2022, and there are stark inequalities across the region, with much lower HLE in areas with high levels of deprivation. The workshop was organised around the discussion points set out below.

What is healthy life expectancy?

The workshop began with a discussion about what HLE is, how it is measured, and what the determinants of HLE are. HLE is a measure of what proportion of life is spent in good health. It is calculated by combining self-reported health with life expectancy measures for a given age. Participants considered the strengths and limitations of this measure and how it is supported by the ONS Health Index for England.

People's subjective health was considered to be the determinant that would most likely drive an improvement in HLE. Workshop participants noted that it could be assumed that self-reported health status is a true reflection of health given that self-reported health closely correlates with mortality. It therefore follows that the factors that drive ill-health and mortality are those that should be focused on to improve HLE. A UK-specific analysis of the 2016 Global Burden of Disease study lists the top five factors driving ill-health in the UK as: tobacco use, poor diet, high blood pressure, high body-mass index, and alcohol and drug misuse.

What actions can we take to improve HLE at local and regional levels?

The Levelling Up Agenda, with its cross-sector approach to improve health and HLE, was considered by workshop participants to be a crucial policy driver to improving HLE across the UK. They agreed that focusing on individual behaviour change has limited potential, and that changes to the external environment and systems improvements would have a greater impact in reducing inequalities and improving the wider determinants of health that drive HLE down.

Participants worked in small groups to identify interventions to improve HLE in the East of England, with specific ideas relating to the early identification and management of mental ill-health and hypertension. Other interventions focused on banning advertising of unhealthy foods, implementing

low-traffic neighbourhoods, and improving the environment in and around schools. The participants then identified national level policy changes that would help to facilitate these interventions.

What are the barriers to taking action to improve HLE and how might we overcome them? Throughout the workshop, several barriers to improving HLE were discussed. A major hurdle to improving HLE is the cross-sectoral nature of the actions required, and the limited direct influence of public health across sectors. At the local and regional level, the lack of cross-sectoral working is compounded by the centralisation of powers to national government, making many interventions difficult to implement.

Conclusion and next steps

The session concluded with discussion of the next steps to take to improve HLE in the East of England. These include:

- Creation of a steering group of policymakers and academics to define the research needed to support the implementation of policies to improve HLE.
- Follow up workshops that focus specifically on the main determinants of HLE and interventions that provide the most promise to improve HLE at local and national levels.
- Development of a schema of responsibilities to clearly establish the roles and responsibilities of actors across the system.

Summary of the discussion

1. What is healthy life expectancy (HLE)?

Healthy life expectancy (HLE) is a measure of what proportion of life is spent in good health. According to the most recent data from the period 2018-2020, the average HLE in England is 63.1 years for males and 63.9 years for females. However, significant disparities in HLE exist that correlate well with deprivation levels, with males living in the most deprived communities in England living on average 18.6 fewer years in good health than those living in the most affluent areas, whilst the gap is larger – at 19.3 years – for females. In the Levelling Up White Paper, the government committed to narrowing the gap in HLE between areas where it is highest and lowest by 2030, and to improving HLE across the country by five years by 2035. However, between 2011 and 2020, HLE did not improve in males or females across England, and the gap in HLE marginally widened. As such, it is predicted to take 192 years to achieve the government's ambition to improve HLE by 5 years.

Whilst HLE in the East of England is higher than the national average, the trend in HLE across the East of England is broadly similar to national data, with HLE stagnating between 2011 and 2020. However, this regional view masks within-region inequality. The East of England is generally regarded as an affluent area, but there are stark inequalities across the region, with some areas experiencing significant deprivation; for example, it was discussed that areas of Clacton "are more deprived than Blackpool". As such, looking at HLE data more granularly, there are a number of local authorities within the region that fare significantly worse than the national average for HLE, such as Luton and Peterborough, whilst other areas fare significantly better, such as Hertfordshire and Cambridgeshire. These data broadly correlate with the deprivation score of each area, suggesting that much of the variation in HLE can be explained by variations in deprivation levels between each local authority. These data suggest that much work is needed in the East of England to achieve the goals for HLE – particularly relating to narrowing the gap in HLE by 2030 – set out in the Levelling Up White Paper.

2. How is HLE measured?

HLE is calculated by combining self-reported health with life expectancy measures for a given age aggregated over 3 years, to give an overall estimate for the remaining expected number of healthy life

years. HLE therefore reflects the prevalence of both good health and mortality. It was discussed that this measure was introduced in an attempt to move away from "increasing the length of life for the sake of it", and to support the case for diverting money away from the NHS and into prevention budgets.

Across the UK, the likelihood of reporting that one's health is 'Bad' or 'Very Bad' increases in line with deprivation, i.e., the more money you have, the more likely you are to report that you are in good health. However, it was discussed that those living in deprived areas may be more likely to have a lower expectation of what 'health' is, and therefore may be *more likely* than those living in affluent areas to report 'Good' or 'Very Good' health at any given health status. This suggests that *objective* health in the most deprived areas may be even worse than is reported. Whilst highlighting a significant limitation of the measure – in that the measure is determined by subjective survey responses, not by actual health status – this also raised concerns regarding the true state of inequality in HLE across the country.

Despite these limitations, the workshop participants broadly considered HLE to be a good measure to describe the number of years spent in good health, as it captures aspects of both physical and mental health as well as quality and quantity of life. In addition, it could be argued that a person's perception of their own health and wellbeing is more important than their objective health. However, whilst HLE is a good measure of population health improvement, it is not all-encompassing, and whilst it is commonly used, it is not widely understood. It also cannot be disaggregated to determine *why* health is poor within a population. As such, the ONS has developed the Health Index for England, 2015 to 2020 to support HLE. The index provides a systematic, independent view of health in England, and can be used to compare health and outcomes over time and across geographies. It combines over 50 different indicators at local authority, Integrated Care System (ICS), regional, and national level, organised into three broad areas:

- **Healthy People**: covers health outcomes such as life expectancy, dementia, cancer, disability, and mental health.
- **Healthy Lives**: covers health-related behaviours and physiological risk factors such as smoking, drug misuse, cancer screening, obesity, and hypertension.
- **Healthy Places**: covers the wider determinants of health such as crime, unemployment, child poverty, pollution, and road traffic.

The Health Index is designed to *support* HLE measures, not to replace them. The measure is significantly more complex than HLE and therefore may be harder to understand by many. However,

it can be used to support local and regional decision-makers in identifying what drives health in their area, including what has changed in recent years due to annual updates of the Index. It also facilitates evaluation of the achievements of any interventions implemented, which will be an important step in monitoring the success of the Levelling Up missions and holding government to account. In future, the Health Index is looking to increase the granularity of the data provided in order to gain insights on more detailed geographies, aiming to reach lower layer super output area level (current limit is lower tier local authorities; LTLA). This increased granularity will support decision-makers in targeting interventions to improve health equity as it will give a better understanding of the needs and assets of populations within smaller areas. It was discussed that this will be important because a large proportion of deprived people live outside of the most deprived LTLAs and may therefore be missed by interventions targeted by area, potentially increasing health inequity for these small pockets of deprivation. For example, within Cambridgeshire the most deprived LTLA is Fenland, but approximately 70% of Cambridgeshire's most deprived *individuals* live outside of Fenland and therefore would not benefit from interventions targeted at the most deprived *area.* Despite this limitation, it was discussed that the Health Index is one of the most exciting prospects for CEOs in the NHS as it allows increased practicality for designing and implementing public health interventions, and that whilst we may give suggestions to enhance the Health Index – such as capturing the extent of multimorbidity alongside the assets within each area – we certainly don't want to lose it.

3. What are the determinants of HLE?

At the simplest level, the two determinants of HLE are people's subjective health and the mortality rate within an area. As such, HLE can be improved in two ways: by improving how people feel about their own health, and/or improving life expectancy. However, it was discussed that a 50-60% improvement in life expectancy would be required to deliver five additional healthy life years, whilst only an 8% improvement in self-reported health would be required to achieve the same thing. As such, focusing on self-reported health is the only feasible option to drive an improvement in HLE.

However, it was discussed that there is a lack of evidence regarding what will change the way people feel about their own health. As such, workshop participants noted that it could be assumed that self-reported health status is a true reflection of health given that self-reported health closely correlates with mortality, suggesting that on average individuals are good at identifying their own true health status. It therefore follows that the factors that drive ill-health and mortality are those that should be focused on improve HLE; these were identified by a UK-specific analysis of the Global Burden of

Disease Study 2016 and can be found in Appendix 1. For local authorities in the East of England specifically, drivers of poor health can be investigated using the Health Index for England.

4. What actions can we take to improve HLE at local and regional levels?

The Levelling Up Agenda is considered to be a crucial policy driver to improving HLE across the UK as it alludes to the fact that a cross-sector approach is required to improve health and HLE rather than the traditional siloed approach to health. Despite this, it was discussed that "we are not where we want to be" as far as improving HLE is concerned.

To improve HLE, we should improve health. According to the determinants in Appendix 1, this will largely require behaviour change, e.g., reducing smoking, reducing alcohol consumption, improving diet, increasing physical activity. However, it was discussed during the workshop that focusing on individual behaviour change has limited potential, with broad agreement that the policy discourse around individual responsibility is highly unlikely to improve HLE. This was complemented by discussion of anecdotal evidence of individually-focused interventions to reduce childhood obesity being less effective than environmental interventions such as changing the school food environment, as well as acknowledgement that individually-focused interventions are likely to increase inequalities because often only less deprived individuals are more likely to engage with the intervention. In support of this discussion, one of the participants discussed Kurt Lewin's 'Grand Truism' equation, $B = f(P, E)$, which states that behaviour is a function of the person – including their material, cognitive and social resources – and their environment, i.e., their physical, economic, and social surroundings. Based on this, changing behaviour in order to effect positive change in HLE will require changes in both personal resources and the external environment. It was briefly discussed that the most effective changes to personal resources in order to improve HLE *equitably* could be to increase income for the poorest households, to support lifelong education for everyone, and to ensure fair work for everyone. However, discussion largely focused on changes to the external environment during the workshop.

It was discussed that the key to improving HLE at local and regional levels will be to reduce inequalities in HLE as it is these inequalities that drive HLE down. In order to do this, it was discussed that *systems* should be improved as health inequalities are driven by the wider determinants of health more so than the health system itself, with many health risks clustering in deprived areas. An example was given that the density of fast food outlets is significantly higher in deprived areas than affluent areas,

which may in part account for differences in health behaviours and outcomes relative to deprivation such as the two times greater prevalence of childhood obesity in the most deprived areas relative to the least. Accordingly, it was discussed that the focus should be on healthy *equity* rather than equality, meaning that the wider determinants proportional to need should be improved rather than making the same changes across different areas and populations. An example of an intervention that prioritises health equity was given, which was the localisation of a mental health hub and sexual health clinic in a bus station in Stevenage, where those who are most likely to require those services are more likely to be able to access and engage with them.

Professor Marteau's Lancet paper from 2019 outlines a number of potential interventions that could be implemented to improve HLE that are evidence-based and targeted to areas with the potential for the largest effect sizes (Appendix 2). To add to these, small group breakout sessions were conducted during the workshop to consider action that could be taken to improve HLE in the East of England specifically. The resulting proposed interventions are listed below:

1. **Develop a mental health early intervention pathway**: mental illness is a significant contributor to poor health, particularly in the East of England where 'feelings of anxiety' is the lowest-scoring factor of the Health Index. An early intervention pathway would increase communication between health and care services to improve the identification and management of early-stage mental health issues with the aim of avoiding severe mental health crises. There is a fantastic opportunity to implement such an approach at present as the novel ICSs bring together many of the relevant agencies with a mandate to "improve population health and reduce health inequality". This may be particularly 'easy' in the East of England, where the majority of ICSs already have mental health collaboratives in place.
2. **Take action on employee health**: it was discussed that the workplace represents an area in which environmental improvements can have a significant impact on health as employees are "a captive audience". As such, we should empower employers to improve the physical and mental health of their workers. This can be done by developing a Toolkit based on the evidence regarding what makes people healthy in the workplace, drawing on good examples such as Business in the Community and South Asian Business Forum, as well as initiatives in place at Jaguar Land Rover in Solihull. Companies may be incentivised to do this by making the benefits of a healthy workforce clear, particularly in terms of reduced absenteeism, increased productivity, and increased retention. Support should be provided for small- and medium-sized enterprises to form a coalition in order to improve workplace health as they may not have the resource to do it alone. However, it must be considered that workplace initiatives in

isolation are likely to increase health inequity as more deprived individuals – who already experience the worst health outcomes – are more likely to work informally or in precarious contracts.

3. **Tackle hypertension**: a high number of excess deaths occur due to cardiovascular disease which is often driven by hypertension. It was raised that cardiovascular disease is an issue for the East of England, but that almost 60% of GP practices are not achieving the recommended level of management for hypertension. In order to tackle this issue, we should first improve the diagnosis of hypertension. This could be done by encouraging communities to engage with health services, providing at-home blood pressure monitors (approximately 65,000 given out in the region to date), or expanding the services in which blood pressure is assessed to non-health services such as hairdressers and barbers. Secondly, we should improve the management of hypertension, ensuring that those who receive a diagnosis are referred to their GP and provided the correct medication and follow-up. It was discussed that this is a low-cost intervention that has the potential for large impacts.
4. **Support the local voluntary, community, and social enterprise (VCSE) sector**: participants discussed that increasing social cohesion can improve both physical and mental health. A specific example was given regarding the observation that mortality during heatwaves is lower in communities with higher social cohesion. However, there is a significant gap in the knowledge regarding how to engage communities and optimise community assets to improve social cohesion and thereby improve health. However, one way to improve social cohesion is to support the local VCSE sector. It was discussed that being part of VCSE organisations can improve social cohesion and therefore can improve the physical and mental health of both volunteers and service users. Support does not necessarily have to be financial, as many VCSE organisations report needing different types of support such as mentoring, advertising support, and community event spaces, all of which may be provided at relatively low cost. However, it was discussed that the number of people volunteering has reduced in recent months, likely due to a combination of the cost-of-living crisis eroding community assets and an increase in people returning to old hobbies post-pandemic. As such, we must consider how to support the sector in re-engaging the public. This is likely to require an uplift across all services in the community and income redistribution to lift the weight of the crisis, which may be difficult to achieve – particularly at a local or regional level.
5. **Implement advertising bans across transport networks**: drawing on the success of the Transport for London advertising ban – in which advertising high fat, salt, and sugar (HFSS) foods was banned across the network, resulting in a significant reduction in purchasing with no loss of advertising revenue – HFSS advertising should be banned across transport networks

in the East of England. If acceptability to the public or politicians is likely to be an issue, framing the intervention from an environmental perspective may enhance support as it was discussed that acceptability of sustainable policies is relatively high. This intervention is likely to have a greater impact on those experiencing deprivation as these communities are most likely to use public transport, therefore the intervention may have a positive impact on inequalities in HLE. If successful, it would be important to think across risk factors and implement the same measures for other goods that are damaging to health, e.g., alcohol.

6. **Curb fast-food sale and advertising in deprived areas**: it was discussed that a number of junk food and fast-food companies specifically target advertising to deprived communities and localise outlets in deprived areas, and that efforts should be made to reduce this. However, much of the advertising space across the East of England is outside of the control of local authorities as it is privately-owned. Moreover, whilst local authorities have powers to limit the opening of fast-food outlets, it was mentioned that these are difficult to use in practice; for example, McDonalds is classed as a restaurant, not a fast-food outlet. Despite these barriers, local authorities can work with local businesses to encourage a shift in the environment *within* shops through incentivising provision of 'healthier' options. In addition, local authorities can insist that fast-food outlets such as McDonalds pay for all the litter they create under legal Restricted Covenants. Guidance can be sought from the Mayor of London's Takeaways Toolkit to design interventions, with the caveat that many London boroughs have enhanced capabilities in terms of planning relative to other local authorities across the UK.
7. **Implement low traffic neighbourhoods (LTNs)**: LTNs are areas in which motor vehicle through-traffic is greatly reduced, whether achieved by physical barriers or by cameras. LTNs have been shown to improve air quality, increase physical activity, increase social cohesion, and benefit local businesses through an increase in sales. LTNs should be implemented where they are likely to have the greatest impact, e.g., in areas with poor air quality, high obesity rates and/or low access to green space. It may be that this receives political pushback as many may perceive that reduced traffic will mean reduced footfall in local businesses, or that the inability to drive in certain places is reducing the agency of the local population, but the evidence to support this intervention is good and should be used to convince stakeholders of its advantages.
8. **Improve the environment in and around schools:** it was noted that one's health as an adult is closely linked to their health as a child, in part due to health behaviours learnt in childhood and carried through to adulthood. As such, for the sake of both current children and future adults, the focus on childhood health should be maintained. It was discussed that improving child health can be done through school-based interventions as children spend a large

proportion of their time at school. It was further discussed that individually-focused interventions are unlikely to be successful, with one participant sharing an experience in which an individually-focused obesity intervention within a local school only reached five students; as such, a focus on changing the school *environment* should be adopted. Opinions on school meals were shared, in which the quality of the main meal was described as "shocking", and it was reported that children are still receiving pudding. Accordingly, it was suggested that changing the food environment in schools may be beneficial; specifically, removing puddings and using the money saved to improve the quality of main meals. It was also suggested that initiatives such as the Daily Mile may be implemented to increase physical activity levels. Another participant discussed positive changes in a local area delivering 2-3 million school meals annually, in which a nutritionist was employed, the school catering offer was changed to make food options healthy, and the company was commercialised to make a profit from this, providing an example of how it could be done elsewhere. However, it was also raised that changing the environment in schools alone is likely to produce a "flat-line" in childhood obesity rates at best; this was countered with the argument that a "flat-line" in childhood obesity rates rather than an increase would be regarded a success. Nonetheless, it was discussed that additionally improving the environment *around* schools will be important to achieve maximal gains, e.g., reducing density of fast-food outlets and increasing options to walk/cycle to school safely. This is likely to be largely acceptable to both politicians and the public as the acceptability of interventions directed at children is generally higher than those directed at adults. However, challenges will be faced when it comes to planning laws as local authorities have limited influence in this sphere. In addition, there are many academies in the East of England in which local government has no jurisdiction to control the food offering, thus persuading these institutions to change their internal environment will likely present another barrier.

9. **Invest in lifelong education:** educational attainment is a strong predictor of both health and life expectancy, and largely stays stable throughout the life course. As such, we may be able to improve HLE by investing in lifelong learning. Services should be targeted to areas where educational attainment is lowest. However, barriers will be met in terms of individuals having time to take part (particularly if working multiple jobs and/or having caring responsibilities), affordability, and engagement.

In order to pilot these initiatives, it was suggested that collaborations with Tendring – which has received £18 million of Levelling Up funding – may be fruitful, and that conversations with the relevant parties could be set up by the Department of Levelling Up, Housing and Communities (DLUHC).

To facilitate the initiatives outlined above, several changes of national level policy will be extremely helpful, if not required. As such, it was discussed that these changes should be campaigned for. Briefly, these included:

1. **Devolution of planning regulation**: it was discussed that the primary complaint from local policymakers to DLUHC regards planning as local authorities have little agency in this arena. Devolving planning rules would provide local areas with the power to decide what aspects of the built environment should be changed to best suit the needs of their own populations, and to include health as a material consideration in planning.
2. **Funding for prevention and social care**: at present, the vast majority of health spending is spent in the NHS, with relatively little spent on prevention, meaning that many people are getting sick unnecessarily; this needs to change.
3. **Better quality housing**: it was raised that accessible, affordable, good quality housing is an important consideration for health.
4. **Implementing taxes on unhealthy products**: the food industry can shape the tastes of the population, which can improve health "without anyone noticing". This was observed following the implementation of taxes on sugar-sweetened beverages as this prompted reformulation, a reduction in sugar purchasing and associated improvements in health. Further taxes such as this should be implemented.
5. **Income redistribution**: it was discussed that the fundamental issue driving many of the inequalities in HLE that we observe across the East of England is differences in income, and that the political goal of 'growing the economy' largely only benefits corporations and the top 1%. As such, the argument of doing things to 'grow the economy' is erroneous. What is needed is income redistribution, e.g., corporation taxes to improve the commercial determinants of health and permit investment in social services/the welfare state. However, it was discussed that this is highly unlikely to happen in the current political climate.
6. **Negative licensing for tobacco:** at present, anyone has the right to sell tobacco in England, with that right only being revoked following illegal action. This should be changed such that individuals must earn the license prior to selling in order to reduce the number of tobacco vendors, as has been done in Scotland.
7. **Healthy work legislation:** it was discussed that the current Healthy Work Standard is "not good", and that this must be improved to protect and improve the health of workers. In addition, it was discussed that there are no award schemes that incentivise the implementation of healthy initiatives in the workplace, which may be beneficial for workplace health. Changes such as this may be achieved through working with the Confederation of

British Industry to create an appetite within businesses themselves as this government is unlikely to legislate for healthy work directly.

8. **Digital health legislation**: artificial intelligence will have huge implications for health. It has the power to improve health through increasing agency and eliciting behaviour change, but similarly is likely to impact health equity significantly due to such things as disparities in access to technology and digital literacy. As such, legislation around advancements in digital health must be made rapidly and appropriately.

Throughout the discussion, participants raised a number of additional aspects that should be considered when implementing interventions to improve HLE. These included:

1. **Coordination**: improving HLE in the East of England will require collaboration between a wide range of stakeholders including NHS, local authorities, academia, and VCSE organisations. As such, it will be vital to identify all the different actors, to clearly define their roles and responsibilities in a "leadership schema", and to facilitate regular communication between them to achieve our shared goal.
2. **Evaluation**: at present, evidence for many interventions is limited due to the lack of adequate evaluation of pilot studies. This complexifies the process of advocating for policies as evidence is often required to elicit change. As such, all interventions trialled should be registered in the public domain and have a framework for evaluation in place such that the data can be generated, and evidence used to guide interventions in future.
3. **Data**: to identify the drivers of ill-health in different areas, more granular data on health and the determinants of health will be required. This will also be required to enable evaluation of interventions in small areas. Efforts to increase the granularity of the ONS Health Index discussed earlier will aid this, but improved health intelligence functions at the local level will also be required.
4. **Intelligence**: it was mentioned that "we are data rich but intelligence poor", i.e., we may have lots of data, but we do not necessarily know what this data *means*. To combat this, analysts across NHS, public health and beyond should be upskilled in both how to analyse public policy and how to transform data into useable evidence.
5. **Demographics**: interventions targeted at children "give you the biggest bang for your buck", and the elderly population requires a lot of attention from health and public health. This means that working age adults are often "missed out" when it comes to interventions. This population presents two opportunities: firstly, they are often "captive audiences" within workplaces, benefits offices, and other public services; and secondly, they often interact with both children and the elderly in a caring capacity, thus can influence the health of other

demographics. As such, this sizeable portion of the population should not be ignored in public health interventions.

6. **Inclusion health**: when considering improving HLE, we must "take everyone with us", including inclusion health groups. When designing interventions, we must also carefully consider the compounded disadvantage that many individuals and groups experience, and the additive impacts of these disadvantages on health outcomes. We must improve our understanding of what health means to communities experiencing disadvantage, and what health outcomes these communities want to see.
7. **Engagement**: action on the wider determinants of health requires cross-sectoral participation. As such, policymakers across the spectrum must be engaged to act. This will require increased communication, training on the wider determinants, alongside discussing the advantages of improving population health in terms of the factors that will interest each sector. Whilst it was discussed that cost-benefit analysis may improve engagement from some departments, it was also cautioned that we must be careful not to 'dehumanise' when doing this, ensuring that we frame the positives from a person perspective, with the added benefit of cost savings.
8. **Communication**: many corporations "pollute the health discourse" to sell their products to the public and politicians. To challenge this, the issue should be framed from a public health lens to engage the public. The Health Foundation's Frameworks Toolkit may help with this framing as it outlines the best ways to talk about the wider determinants of health to achieve maximal engagement, e.g., using metaphors such as building blocks to explain the wider determinants.

5. What are the barriers to taking action to improve HLE, and how might we overcome them?

Throughout the workshop, several barriers to improving HLE were discussed. One statement that succinctly describes many of the barriers faced was made: "We live in the system that produces the problems, so developing pragmatic solutions within that system is not very easy".

A major hurdle to improving HLE is the cross-sectoral nature of the actions required. Given that the wider determinants of health account for the majority of health outcomes and that public health has limited direct influence across the sectors that define these determinants, making policies that support health across the system is very difficult. At the local and regional level, this lack of cross-sectoral working is compounded by the centralisation of many powers to national government, making many interventions difficult to implement. For example, local governments have little power to impact the commercial determinants of health as much of the relevant legislation is governed at a national level. This includes town planning regulation – as discussed previously – leaving local government effectively unable to regulate against the inclusion of establishments such as fast-food restaurants, alcohol vendors, and gambling establishments on high streets. It was discussed that enabling legislation in this sphere may allow for more movement at a local level, but that this may be unlikely as "the power sits with the money", i.e., the commercial interests. However, it was mentioned that whilst there is some interest in devolving planning powers within DLUHC, devolution of financial powers is lagging behind significantly, meaning that whilst local authorities may be given the power to make changes to the commercial determinants, funding for such changes may still be governed at national level. This is likely to be problematic as, given Treasury orthodoxy and the difficulty of proving transformational impacts, obtaining money from the Treasury to implement interventions in this arena is very difficult. This is despite evidence of the highly favourable cost-benefit ratios of many public health interventions – for example, Andy Haldane's essay on the economic benefit of the Levelling Up Agenda suggests that achieving the missions on health and wellbeing could result in annual gains in GDP of up to £150 billion.

Another barrier to improving HLE is that the most effective interventions are likely to be the least acceptable to both populations and policymakers and therefore will rarely be picked up. As such, change will almost certainly be slow as the focus must be on policies that we can "get across the line" in the current environment to build incremental change. Nonetheless, it was agreed that it remains important to continue discussing the high-impact policies. This is where academics could make a real difference as they are able to "say more" in the public space than policymakers and thus are able to shift the broader context underlying these policies. However, it was discussed that there is a relative

disconnect between policymakers and academics, making gaining this support difficult. This disconnect has also contributed to a dearth of evidence regarding what works in this sphere, making it difficult for policymakers to make the case for interventions, because a lack of collaboration between government and research institutions has meant that many measures implemented to improve population health to date have not been evaluated. For example, whilst the Office for Budget Responsibility has recently acknowledged that improved population health leads to a strong labour market and better productivity on the basis of a logic model, compelling evidence to support this notion does not exist, presenting a significant barrier to implementing large-scale policy changes. As such, relationships between policy and academia must be strengthened, with academics provided access to local data to perform research and generate evidence, allowing them to work with policymakers to develop pertinent research questions and practical interventions. To facilitate this, governance regarding data sharing must be simplified. Learning from important lessons highlighted during the COVID-19 pandemic regarding the need to share patient information, ICSs now have permission to share data between partner organisations through sublicensing agreements, and there is a view to share this data with academia in the future, but this will require strong collaborations and significantly improved communication in order to identify the appropriate data to share, the appropriate way to share data, and the appropriate people to share the data with.

Closing remarks and next steps

The session concluded with discussion of the next steps to take to improve HLE in the East of England:

1. It was discussed that a steering group of policy makers and academics could be created to define the research needed to support the implementation of policies to improve HLE. This steering group would represent a "two-way bridge", with academics advising on policy based on evidence generated, and policy makers advising on research projects based on barriers met in practice. It was discussed that a key output from this group would be to produce papers to disseminate evidence generated and to share best-practice. The main unanswered questions that were identified during the course of this workshop that could feed into this steering group initially were:
    a. ***What is the public's perception of health and HLE?*** What does the public understand by 'health' and 'healthy life expectancy'? What health outcomes do communities want? What would the public trade-off to improve HLE in terms of quantity of life versus quality of life?

   b. ***Does better population health lead to improved productivity and a stronger labour market?*** What are the illnesses that predominantly affect the working age population? What impact do these illnesses have on their ability to work? At the population level, do efforts to improve HLE lead to more people in the workforce and/or to increased productivity?

2. In addition to this steering group, there was consensus that follow-up workshops would be desirable. The format of these workshops could be a series of deep dives into the main determinants of HLE and interventions that provide the most promise to improve HLE at local and national levels; examples included workplace interventions, housing, and the built environment. It was discussed that other players from across the broader system of policy and research into each determinant should be invited to join the relevant workshop(s), as well as representatives from relevant local businesses and the VCSE sector. It was discussed that it would be important for these workshops to take place shortly to take advantage of the upcoming policy windows in terms of the Autumn Statement, Spring Budget, and General Election.
3. Following these workshops, a schema of responsibilities should be drawn up to clearly establish the roles and responsibilities of actors across the system.

Appendices

Appendix 1

The leading risk factors for years of life lost in England, taken from a UK-specific analysis of the Global Burden of Disease Study 2016:

1. Tobacco use
2. Poor diet
3. High blood pressure
4. High body-mass index
5. Alcohol and drug use
6. High total cholesterol
7. Occupational risks
8. High fasting plasma glucose
9. Air pollution
10. Low physical activity

Appendix 2

Recommendations for interventions to change the environment in order to improve healthy life expectancy, taken from Professor Marteau's 2019 Lancet paper:

- **Improving tobacco control**
  - *Fiscal measures*: tax to ensure annual real price increases in tobacco; reform to current tobacco taxes to ensure consistent unit prices.
  - *Marketing policies*: Well-designed mass media campaigns; inserts on tobacco packs about benefits of quitting; and signposting to smoking cessation services
  - *Changing availability*: Raise legal age to buy tobacco from 18 to 21 years.
- **Improving alcohol control**
  - *Fiscal measures*: Legislate for minimum unit price; tax to ensure annual real price increases in alcohol; reform current taxes on alcohol to ensure consistent unit prices.
  - *Marketing policies*: Restrict advertising and sponsorship to reduce exposure to children.

    - *Changing availability*: Reduce spatial, temporal, and age-based availability, e.g., cap number and density of outlets; early morning restriction orders; enforce existing minimum age purchase laws.

- **Promoting a healthy diet**
    - *Fiscal measures*: Tax to incentivise industry to reformulate—e.g., extend UK Soft Drinks Industry Levy to other drinks and foods high in sugar; restrict price promotions on unhealthier foods; increase affordability of fruit and vegetables for low-income families.
    - *Marketing policies*: Restrict advertising and sponsorship to reduce exposure of children to unhealthy food; mandate point of choice information—e.g., calorie labelling in the out-of-home sector.
    - *Changing availability*: Increase availability of lower salt products and reduce availability of higher salt products through voluntary or mandatory programmes; enforce and extend food buying standards in public sector outlets, including schools, hospitals, local and national government agencies; restrict placement of unhealthier foods in high-sales areas, including aisle ends and checkouts; mandate smaller portions of ready-to-eat foods.
- **Promoting physical activity**
    - *Fiscal measures*: Tax to shift affordability to public transport and away from car use—e.g., reinstate fuel duty escalator; road user pricing—e.g., parking and congestion zone charging.
    - *Marketing policies*: Mass media campaigns that promote physical activity—e.g., This Girl Can
    - *Changing availability*: Spatial and land use policy and regulations that deliver compact, mixed use urban design to promote physical activity, including integrated public transport and high walkability and cyclability, with safe and attractive infrastructure; regular mass participation events—e.g., Parkrun.