

Directors of Public Health

**175 Years**

— 1847 - 2022 —



# ADPH Annual Conference 2022

**Working with Business: the good, the bad and the ugly**

30 November 2022



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Health

**#ADPHConf22**

# Reflecting on 175 Years, and the next 175: metaphors and models



**Prof Jim McManus, President**

30<sup>th</sup> November 2022

Directors of Public Health  
**175 Years**  
— 1847 - 2022 —

# 175 Years

- *1842 – Chadwick's report on public health direction to local authorities*
- **1847 – William Henry Duncan, Liverpool**
- 2047 – 200 Years

*You are the fabric from which the future of public health is being woven...*

# Coping with chaos while walking through fire

If you can keep your head, while all about you are losing theirs...

*then you're probably delusional*

# Being the glue when the system comes unstuck

- Covid
- Monkeypox
- Asylum Seekers
- Covid Inquiry

# ***Ressourcement***

Navigating the future by getting our bearings from where we have come

# Ressourcement 1: ADPH objects

To protect and improve public health for the public benefit by:

## 1. The advancement of public health practice:

- facilitating a support network for Directors of Public Health to share ideas and good practice and support problem solving.
- providing opportunities for Directors of Public Health to develop professional practice.

## 2. The promotion of public health policy:

- collating and presenting the views of Directors of Public Health on public health policy to stakeholders.
- advising on public health policy and legislation at a local, regional, national and international level.

# Ressourcement 2: Work Programmes 2021-2024

- **PH Policy**

The authoritative national voice of local leadership for health and well-being

- **Collective Voice**

Trusted to know our members and advocate their views

- **Improving PH practice**

Promoting and supporting demonstrable impact through Quality Improvement

- **DPH Support**

Consistently supporting all DsPH past, present and future

## **Governance & Management**

Strong, ethical and sustainable, providing continuity of offer for members and stakeholders



# Ressourcement 3: Some enduring values from our forebears – virtuous leadership

- Science
- Justice and the Common Good
- Prudence
- Fortitude
- *Temperance*

# Ressourcement 4: Temperance revisited

- Jean Twenge on the *iGen*
- Shannon Vallor on *Technology and the virtues*
- *The Distracted DPH*
- Temperance in an AI age

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**Prof Mark Petticrew**

**London School of Hygiene and Tropical  
Medicine**



# SPECTRUM

Shaping Public hEalth poliCies  
To Reduce ineqUalities and harM

## The good the bad and the ugly The rationales for working with business

Mark Peticrew

London School of Hygiene & Tropical Medicine

 [@peticrewmark](https://twitter.com/peticrewmark)

LONDON  
SCHOOL of  
HYGIENE  
& TROPICAL  
MEDICINE



Commercial  
Determinants  
Research Group

# 1. **The good:** the rationales and claims about the benefits of 'working with business':

- *The political rationale* includes:  
industry is more flexible, can react more rapidly: 'further, faster, less costly' (Andrew Lansley)

## *The business rationale:*

- We are stakeholders, so we need to be at the table
- Self-regulation: we are trustworthy actors and regulation is unnecessary
- We have a vested interest in improving the health of our customers, like you. We are your partners.



# *The Public Health rationale: We need their skills, expertise, reach*

- Duncan Selbie: *“Who are the most relevant to people, who can reach them and make a difference? Well, it’s not us. Local government, the big retailers, the big corporates, the voluntary sector, they are reaching people the statutory services can’t reach, in relevant and meaningful ways.”\**
- <https://quarterly.blog.gov.uk/2014/07/15/interview-with-duncan-selbie-chief-executive-of-public-health-england/>
- (Some of these are not like the others)

# Business and inequalities

- *“Business has a key part to play in improving these social conditions that affect health and health equity: in conditions of work and employment; in goods and services; and in impact on the wider society and environment.”*
- Michael Marmot & Nigel Wilson (Legal & General plc): The Business of Health Equity: The Marmot Review for Industry.

Also (from the same report):

- *“Many companies affect health and health inequalities through the commodities they produce. No matter how well they treat their employees, or how sustainable their environmental practices, a company that manufactures certain products will damage health and widen health inequalities. Tobacco products, alcohol and unhealthy food are among the most obvious examples, with direct impacts; others may act more indirectly, reducing people’s physical activity or increasing their exposure to air pollution.”*

## 2. The bad

- Next, a couple of examples of how some businesses use these partnerships

# Partnering to provide health information: more health information is good, surely?

- Not necessarily. It's a very *particular* type of health information that you get from industry-funded organisations like Drinkaware.
- We compared all tweets from 2016 from Drinkaware (UK); Drinkaware.ie (Ireland); and DrinkWise (Australia) (all alcohol industry-funded)
- Compared to non-industry-funded charities Alcohol Concern (UK), Alcohol Action Ireland, and FARE (Australia).



Topic	Industry-Funded	Non-Industry Funded	Chi-Squared	Z; Difference in % (95% CI <sup>1</sup> )	p Value
Drinking too much	118 (10.2%)	70 (4.25%)	38.72	Z = 6.21; 5.96 (4.08–7.84)	<0.0001 ***
Marketing, advertising, sponsorship or restrictions	0 (0%)	166 (10.1%)	123.5	Z = 11.14; 10.1 (8.32–11.88)	<0.00001 ***
Drink Driving	81 (7.0%)	83 (5.0%)	4.83	Z = 2.2; 1.98 (0.22–3.74)	0.028 **
Cancers	38 (3.3%)	90 (5.5%)	7.33	Z = 2.74 2.2 (0.63–3.77)	0.007 **
Cutting down/cutting back	114 (9.9%)	11(0.7%)	135.1	Z = 11.58;9.2 (7.64–10.76)	<0.00001 ***
Children/underage drinking	71 (6.2%)	43 (2.6%)	21.81	Z = 4.67; 3.54 (2.05–5.03)	0.000003 ***
Alcohol harms incl. dementia, diabetes, asthma, heart disease	25 (2.2%)	77 (4.7%)	12.16	Z = 3.43; 2.47 (1.06–3.88)	0.0005 ***
Calories/Obesity	93 (8.1%)	5 (0.3%)	120.9	Z = 11.04; 7.8 (6.42–9.18)	<0.00001 ***
Teens/parents	82 (7.1%)	5 (0.3%)	104	Z = 10.22; 6.8 (5.5–8.1)	<0.00001 ***
Mental Health	42 (3.6%)	40 (2.4%)	3.5	Z = 1.81; 1.17 (–0.09–2.43)	0.061
Alcohol Pricing or Taxation or MUP	0 (0%)	80 (4.9%)	57.66	Z = 7.59; 4.85 (3.6–6.1)	<0.00001 ***
Staying safe while drinking	76 (6.6%)	0 (0%)	111.49	Z = 10.58; 6.6 (5.38–7.82)	<0.00001 ***
Pregnancy or fertility	11 (0.95%)	46 (2.8%)	11.5	Z = 3.41; 1.85 (0.79–2.91)	0.0007 ***
Alcohol guidelines	37 (3.2%)	11 (0.7%)	25.96	Z = 5; 2.5 (1.52–3.48)	0.0000004 ***
Anger/Aggression	8 (0.7%)	32 (1.9%)	7.52	Z = 2.75; 1.25 (0.36–2.14)	0.006 **
Other peoples drinking	19 (1.7%)	20 (1.2%)	0.93	Z = 0.98; 0.44 (–0.44–1.32)	0.34
What's a unit	35 (3%)	1 (0.06%)	47.25	Z = 6.84; 2.94 (2.1–3.78)	<0.00001 ***
Alcohol-free or low alcohol drinks	20 (1.7%)	11 (0.7%)	7.04	Z = 2.64; 1.06 (0.27–1.85)	0.008 **
Impact of drinking on use of emergency services	7 (0.61%)	24 (1.46%)	4.48	Z = 2.11; 0.85 (0.06–1.64)	0.03 *
Other	123 (10.6%)	363 (22%)	61.22	Z = 7.85; 11.4 (8.56–14.24)	<0.00001 ***

\*  $p < 0.05$ ; \*\*  $p < 0.01$ ; \*\*\*  $p < 0.001$ . <sup>1</sup> Confidence interval.

# But that's just tweets...

- Well, not really
- We've analysed the content of alcohol industry-funded websites in repeated studies to understand what information they present about cancers, cardiovascular disease, and pregnancy, and how they present it
- Drinkaware, Drinkwise, Drinkware Ireland
- In every case the information from these organisations contains significant misinformation
- E.g. normalises alcohol consumption, selectively omits breast cancer
- Strong similarities to tobacco industry misinformation about smoking cancer

# Alcohol industry partnerships with schools

- Alcohol industry is extremely active in schools in the UK and overseas
- The materials for primary and secondary children are pro-alcohol; normalise and promote alcohol consumption; and contain the same sort of misleading health information we see in the other analyses

Van Schalkwyk et al. (2022) Distilling the curriculum: An analysis of alcohol industry-funded school-based youth education programmes

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0259560>



### 3. The ugly: FASD denialism. A Christmas story.

23 alcohol industry-funded bodies (e.g., Drinkaware [United Kingdom] and DrinkWise [Australia]), compared to 19 public health organizations (e.g., Health.gov and NHS Choices).

Comparative qualitative and quantitative analysis of the framing and completeness of this information was undertaken.

UK Chief Medical Officers'  
Low Risk Drinking  
Guidelines

## Pregnancy and drinking

The Chief Medical Officers' guideline is that:

- If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
- Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy.

If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. You should be aware that it is unlikely in most cases that your baby has been affected. If you are worried about alcohol use during pregnancy do talk to your doctor or midwife.

Alcohol industry-funded organizations were statistically significantly less likely than public health websites to provide information on fetal alcohol spectrum disorder and less likely to advise that no amount of alcohol is safe during pregnancy. They were significantly more likely to emphasize uncertainties and less likely to use direct language (e.g., "don't drink").

Some alcohol industry-funded (and no public health) websites appear to use "alternate causation" arguments, similar to those used by the tobacco industry, to cloud the relationship.

- They also emphasise uncertainty
- Drinkaware too a similar approach, apparently promoting lack of trust in pregnancy information in general:
- *“Understandably it can be hard to know where to go for trustworthy advice. This is especially true when it comes to advice about drinking alcohol when you’re pregnant.”*

# FASD Denialism

- Some alcohol industry organisations dispute the evidence on drinking in pregnancy, emphasising only ‘heavy’ drinking in pregnancy. E.g. IARD:
- *“there is no conclusive evidence of a link between occasional, light, or even moderate drinking during pregnancy and an increased risk for FASD.”*

# Health & Wellbeing

Our new and revised medical and health-related content is reviewed by our independent Medical Advisory Panel. Our resources are used by the NHS, local authorities, and a wide range of community groups in their alcohol education programmes.



## *Some conclusions*

- Businesses are not public health agencies. They have no competence in providing health promotion or education
- Worse, the evidence suggests that they misuse these opportunities:
- ...to disseminate harmful misinformation
- ...to 'healthwash' their activities through partnerships with other trusted bodies (schools, local government, NHS)
- ...to displace existing evidence-based initiatives (like MUP)

# ‘Working with business’

- The clue is in the name; they are businesses, their priority is their shareholders
- First step in “working with business” is maintaining boundaries and awareness of areas of competence
- Public Health has no competence in selling alcohol, burgers, or scratchcards
- Likewise, Business has no competence in public health
- Many businesses do, however, have a major conflict of interest; in the case of alcohol, its profits depend on sustaining and extending alcohol harms, and protecting its market



# The risks

- Healthwashing (DPH-washing)
- Active policy substitution and delay
- Ineffective, harmful framings (Nason...) and misinformation

# What to do?

- “Working with business” is an intervention
- An evidence-based approach:
- What is the **intervention**? Break down exactly what ‘engagement’ and ‘working with’ actually mean in each instance
- Widely accepted not to involve in **policy** development – same surely applies to **PH** intervention development; or education development
- Due diligence: analysis of COIs
- Be clear about what the intended **outcomes** are
- Consider the evidence: What are the risks & harms (not just at an individual-level)? Do the benefits outweigh the costs? What about public health ethics?
- And: Not just “unhealthy products” – consider vpractices and strategies

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**Dr Nason Maani**

**Global Health Policy Unit, University of  
Edinburgh**

# Commercial determinants of health: Drivers, wider effects, responses

Nason Maani

Global Health Policy Unit

University of Edinburgh



# Three observations

- The banality of CDoH
- Understanding the web of wider CDOH consequences
- Maximising the impact we can have as a result

**Tobacco industry: The true bad guys?**

# Only one thing exceptional about those tobacco industry executives...

They got caught.

Doubt is our product since it is the best means of competing with the "body of fact" that exists in the mind of the general public. It is also

<http://legacy.library.ucsf.edu/tid/rgy93f00>

***"Doubt is our product"***

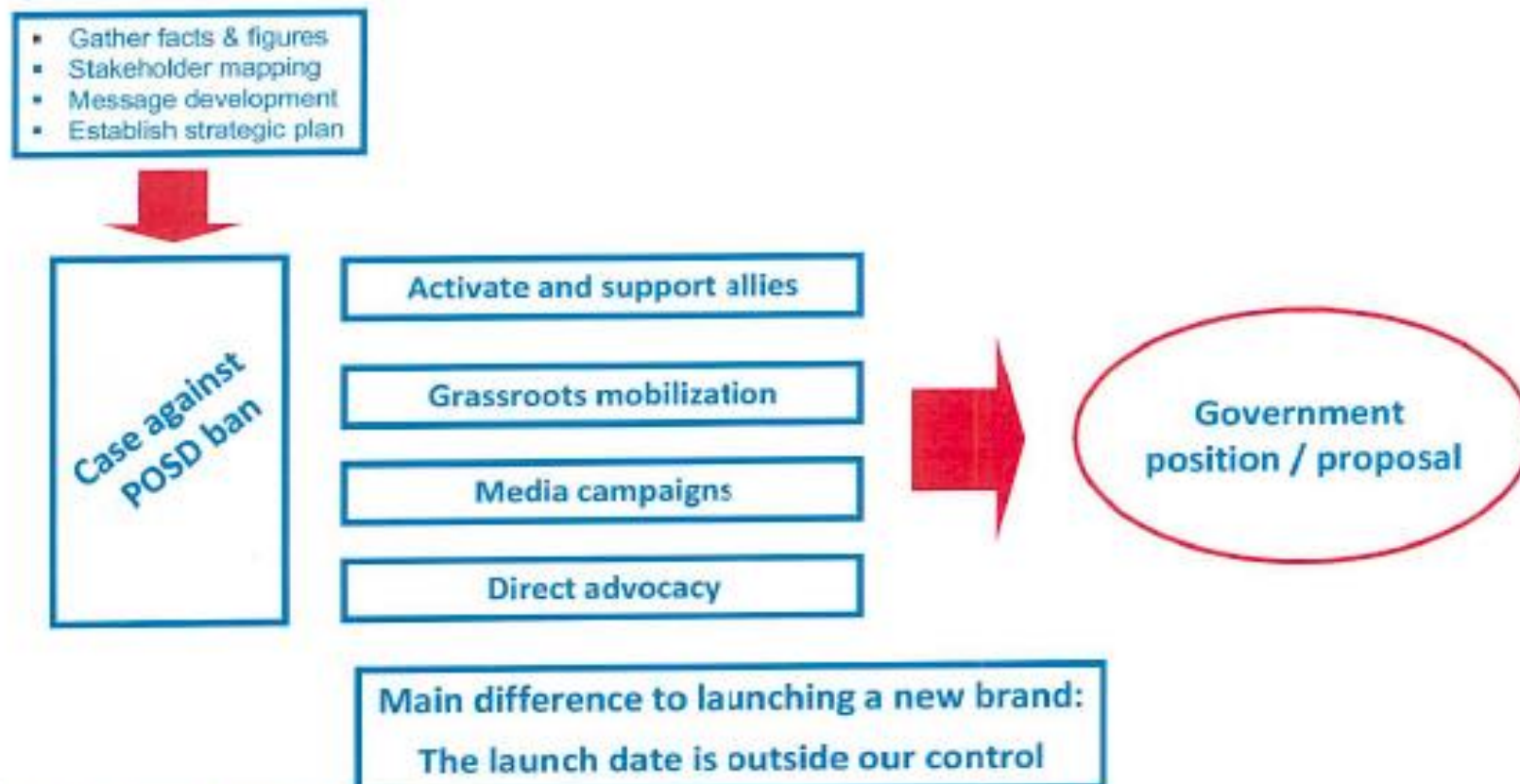




# The importance of being prepared

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## A typical brand launch in CA



## What are we aiming for?

No surprises

Political intelligence gathering

Early warning systems in place  
Right mindset – “Healthy paranoia”

Playing the political game

Full political engagement

Build allies across several ministries  
Ability to influence the influencers  
Complete political power map  
Speak the right language – be relevant

Shaping the public opinion

Media relations

Ability to find right spin  
Ability to sell stories direct & indirect  
Established relationships with:  
– Key reporters

Utilizing the low hanging fruit

Use our own people

Employees  
Distributors  
Suppliers

Alliance of credible messengers

Third party coalition building

Broad business organizations  
Trade & retailer organizations  
IPR, TM, & anti-counterfeiting orgs.  
Think-tanks and policy groups

Establishing a critical mass

Ability to mobilize broad groups

Retailer mobilization  
Grower mobilization  
Consumer mobilization  
Marketing & advertising organizations  
Trade associations, NGOs, etc.

Have the best expertise on our side

Effective use of consultants

Lobbyists  
Door-openers  
Strategists  
Spin doctors

The right messages

Market specific argumentation

One-liners for PMI and allies  
Message testing research  
Impact assessment studies  
Legal opinions



# Lessons from TI internal memos

## • Knowledge:

- Product causes harms (to users and those around them)
- Advertising to increase consumption
- Advertising targeted youth

## • Motives:

- **Profit**
  - Fear of litigation
  - Protecting from regulation
  - Concerns about credibility/image

## • Tactics:

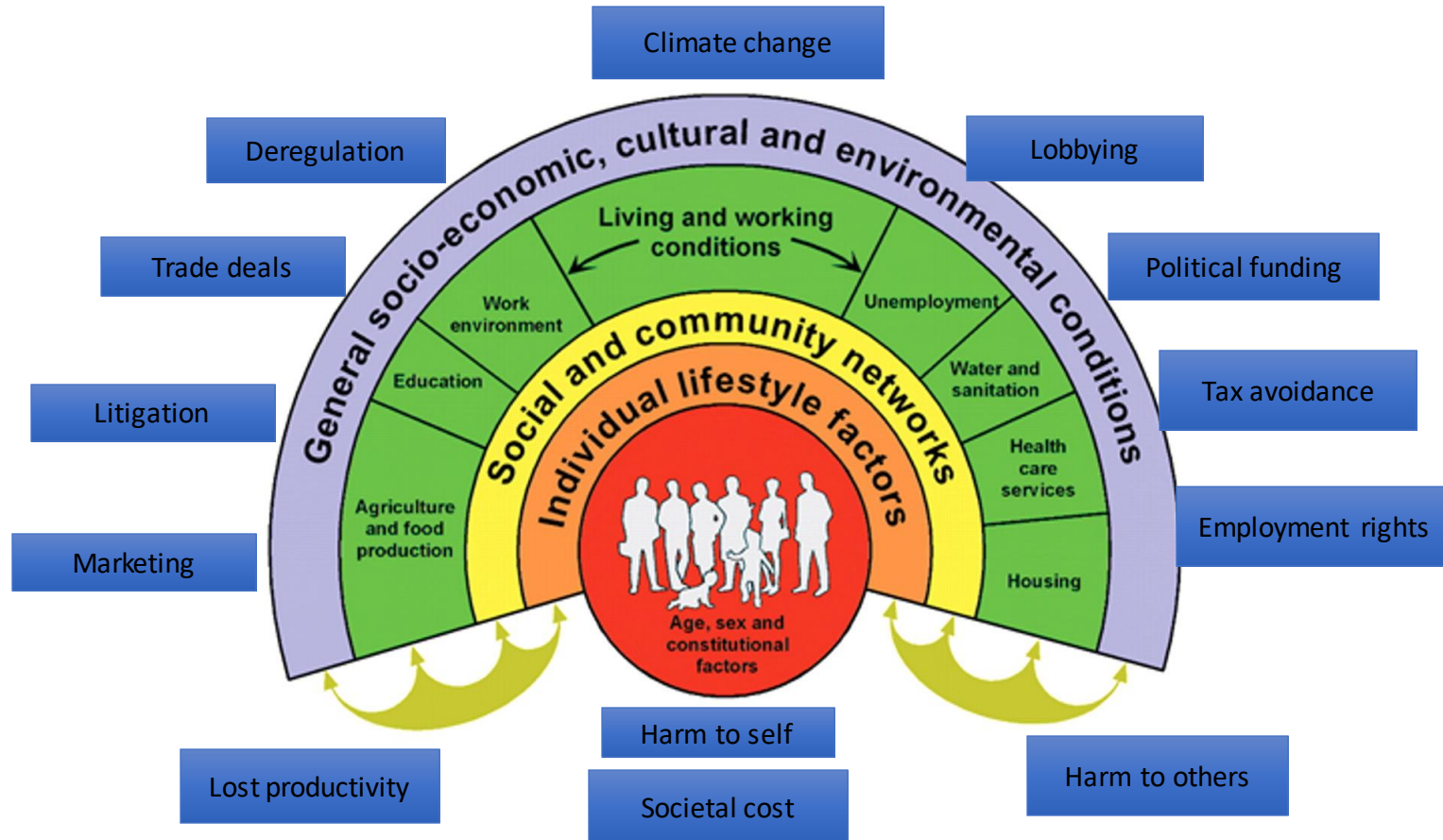
- Create controversy/doubt about the products role in harm
- Use third party organisations/front groups
- Oppose restrictions to availability/affordability/marketing
- Improve image through poorly evidenced CSR efforts

Exceptional?

# Three observations

- The banality of CDoH
- Understanding the web of wider CDOH consequences
- Maximising the impact we can have as a result

# Broader determinants



# Discrediting regulators and science

- WHO IARC declares Monsanto's glyphosate a probable human carcinogen in 2015
- “Campaign For Accuracy in Public Health Research” launched in 2017
  - Funded by American Chemistry Council, which represents leading chemical companies, including Monsanto

# Strong commonalities in strategies

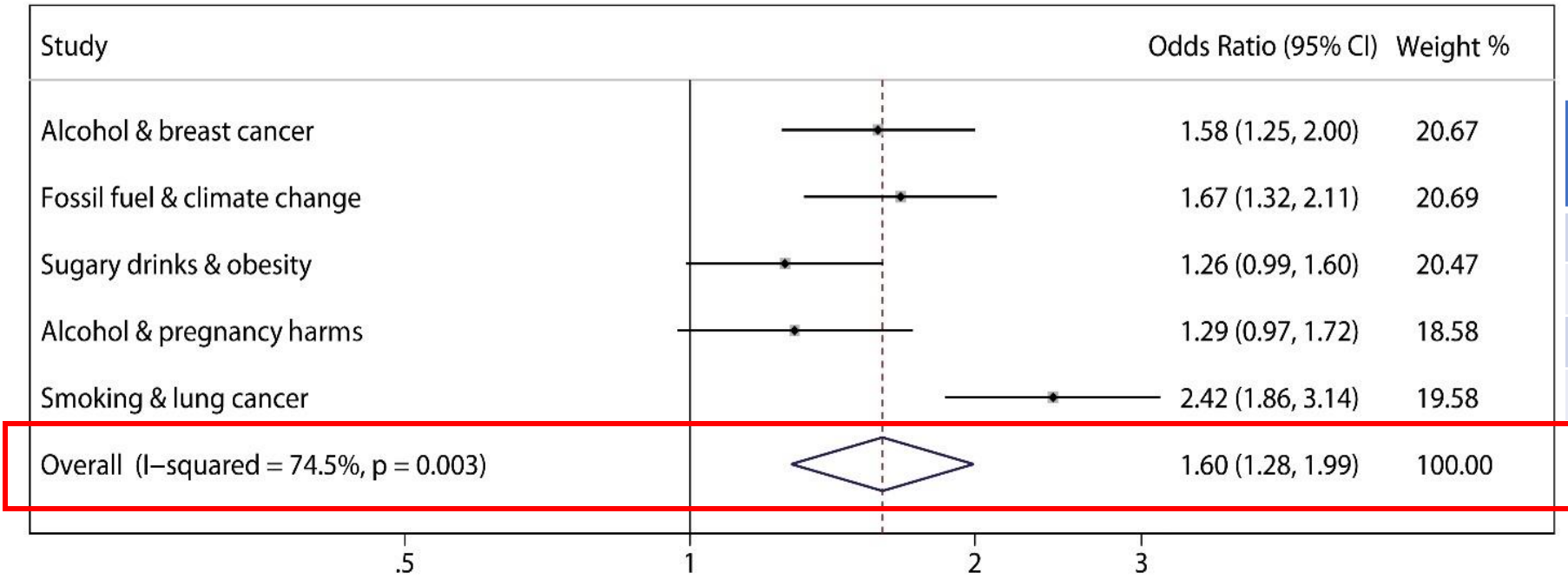
*“Cancer is a very complex disease. Many factors have been associated with this disease besides smoking, including occupational and environmental exposures, diet, viruses, heredity and stress. Clearly there are many gaps in knowledge about lung cancer that only further research will resolve.” BAT, 1992*

*“Problem gambling is complex and is about the person not the specific product.” Gala Coral, 2014*

*“We believe obesity is a complex problem which cannot be reduced to the demonization of one ingredient... there is no simple answer to the complex problems of obesity” Food and Drink Federation, 2015*

*“Is there a cause-and-effect relationship between firearms and suicide? Nearly everything gets blamed for suicide at one time or another--love, hate, religion, pain, boredom, fear, shame, guilt, alcoholism, drug addiction, family dissolution, loss of a job, a new job, the news media, music, the time of year, terminal illness, old age and even the weather.” NRA-ILA, 1999*

# Impact of industry messaging on public awareness



Non-industry text
n (%)
n=2521
377 (15.0)
520 (20.6)
1624 (64.4)

	Industry text n (%)	Non-industry text n (%)
	n=2511	n=2521
<b>Certain it doesn't increase risk</b>	384 (15.3)	377 (15.0)
<b>Uncertain</b>	697 (27.8)	520 (20.6)
<b>Certain it does increase risk</b>	1430 (57.0)	1624 (64.4)

Overall, industry-sponsored uncertainty messages significantly increased the odds of uncertainty, or false certainty, by 60%, compared to independent sources of information



# The pollution of discourse

- Emphasis on individual responsibility
- Emphasis on technological “downstream” solutions vs upstream societal ones
- Emphasis on self-regulation/de-regulation
- Disputation of public health evidence and public health more generally
- CSR focused on consumers/shareholders, not those most affected

# Three observations

- The banality of CDoH
- Understanding the web of wider CDOH consequences
- Maximising the impact we can have as a result

# Proposed CDOH competencies for PH (a bit US focused)

Define CDOH and relationship with other determinants of health

Apply CDOH frameworks to analysis of PH practice, research and policy

Assess marketing practices and corporate political activity among major health-harming industries

Identify key sources of evidence and data on distribution, impact and pathways by which CDOH influence health

Assess strengths and weaknesses of policy solutions and intragovernmental agreements to address CDOH

Assess impact of strategies, tactics, countermarketing and campaigns to address CDOH by civil society

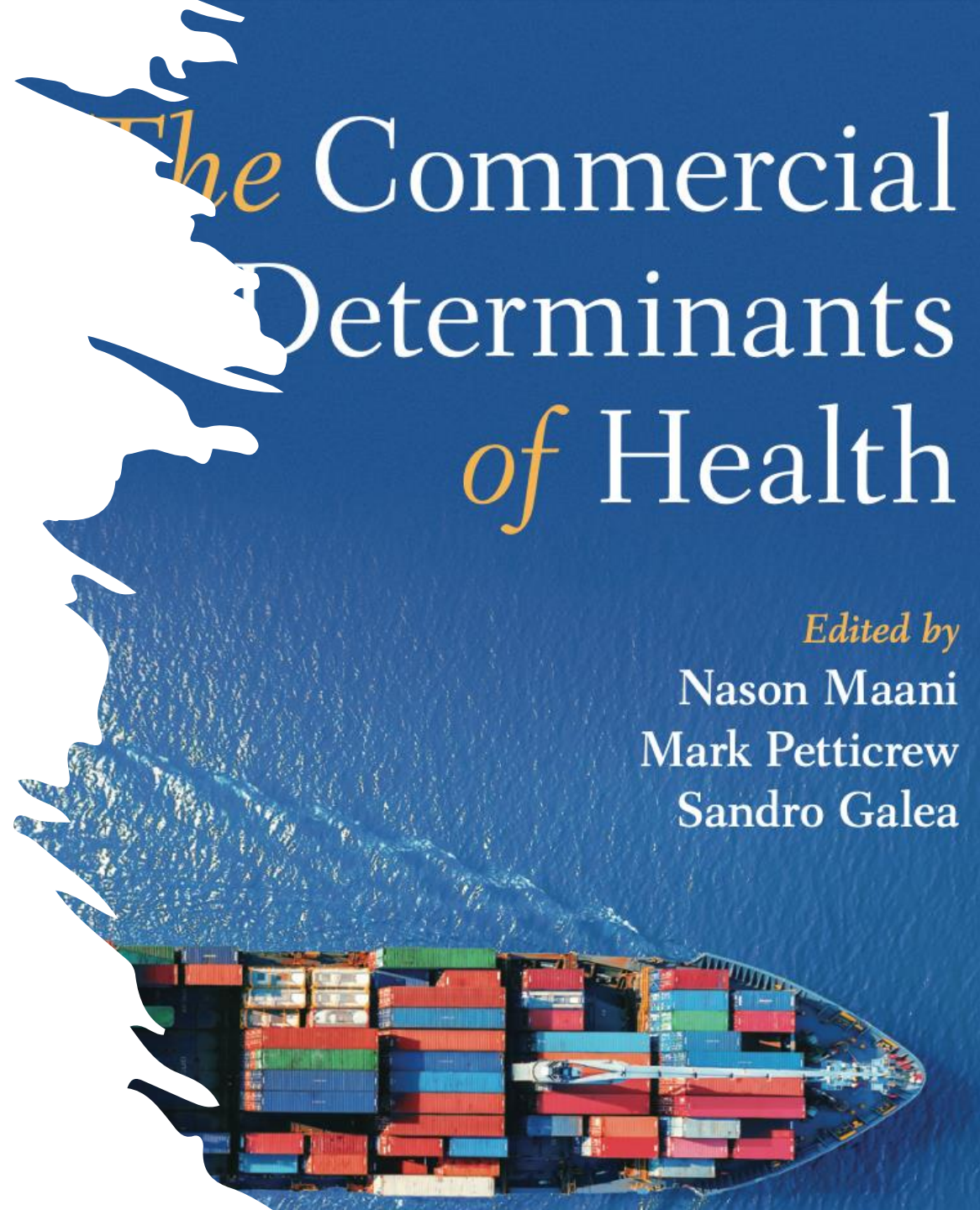
Assess impact of strategies designed to reduce CDOH harms

# At the local level

- Not so different to SDoH:
  - This is about using data, on determinants, to guide decision-making
- Establishing conflicts of interest procedures for engaging with industry
  - Trade-offs should include considering wide effects
- Building links between local and national efforts on marketing/availability/dealing with pushback
- Requiring evidence and impact assessment for CSR initiatives as for any other public health intervention
- Who is furthest away from the most vulnerable communities we serve? Harmful product industries that disproportionately target them

# Conclusions

- Commercial determinants offer a way of examining why, how, and what to do about business practices that affect health
- CDOH frameworks, lessons can be applied to PH practice at local, national, intl levels
- You are in many ways a vital generation of PH leaders, the first to attempt to turn this scholarship into practice
- I look forward to your thoughts



# Acknowledgements

Thanks to Mark Petticrew, May van Schalkwyk, Martin McKee, Sandro Galea

Email: [nmaani@ed.ac.uk](mailto:nmaani@ed.ac.uk)

Twitter: @spidermaani

“The guilty have a head start, and retribution  
Is always slow of foot, but it catches up.”  
Horace, Odes, Book III, Ode 2



Commercial  
Determinants  
Research Group



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**Daniel Hunt**

**Consultant, Commercial and Economic Determinants  
of Health, World Health Organization (WHO)**

Working with Business, Considerations for safeguarding health equity in  
local contexts





World Health  
Organization

# Working with Business

## *Considerations for safeguarding health equity in local contexts*

**Daniel Hunt**

Consultant, Commercial and Economic Determinants of Health  
World Health Organization (WHO)

[dhunt@who.int](mailto:dhunt@who.int) @DanHuntUK

06/12/2022

# Learning objectives and key themes

- Explore the rise of the commercial determinants of health (CDOH) as a vector of disease in 21<sup>st</sup> century public health crises
- Discuss some global tailwinds and domestic currents creating opportunities and challenges
- Introduce how WHO is designing its workplan on CDOH
- Explore why without learning from local contexts and interventions, global action cannot progress

# CDoH and public health crises of the 21st century

- Rising burden of noncommunicable diseases
- COVID-19 pandemic
- Climate disasters
- Environmental exposures to air and water pollution
- Housing stock
- Occupational illnesses / injuries from precarious work
- Mental health conditions including depression and anxiety

**“Commercial determinants are the leading cause of global burden of disease and threats to planetary health”**

***Professor Nick Freudenberg, December 2021***

# Global tailwinds and domestic currents

***“If tobacco was a virus, it would long ago have been called a pandemic. The world would marshal every resource to stop it. Instead, it is a multi-billion business profiting from death & disease, imposes big costs on health systems, and takes a huge economic toll in lost productivity.”***

# WHO Programme: Economic and Commercial Determinants of Health

- Reflects the **rise in both CDOH and private sector role in development**
  - **Building on existing WHO work** and evidence
  - **Spectrum of corporate behavior:** from supply chains through to regulatory influence
  - Focus on **power, equity and governance**
- 
- WHO Global Conference on CDOH
  - WHO Global Report on CDOH (TP2679)

”

# Proposed Theory of Change

## Commercial determinants: moving towards action

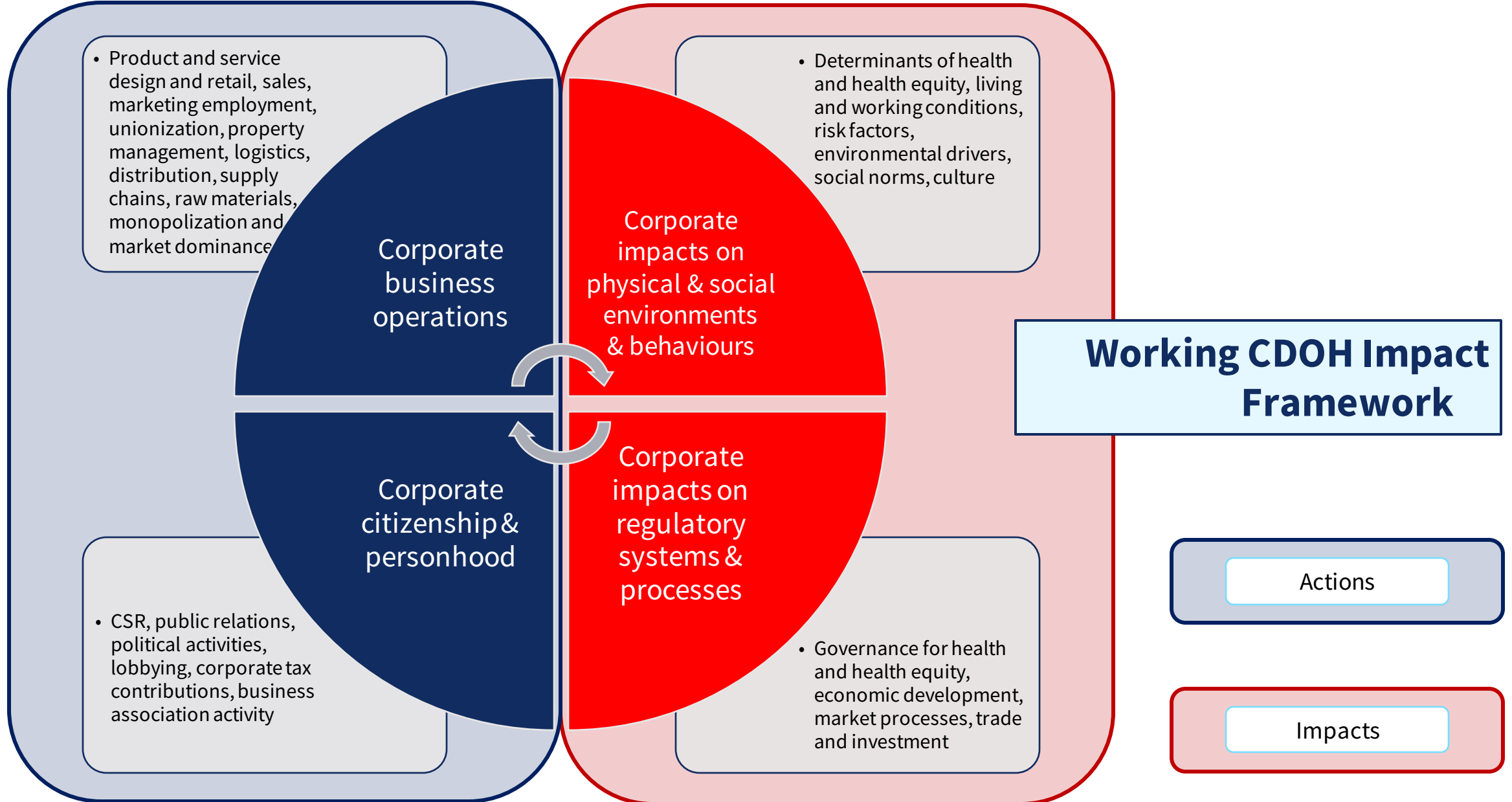
### Goal

Leveraging the power and potential of the private sector as a partner for better health and health equity, while protecting from conflicts of interest and public health harm.

### Underlying critical assumption

The obligation of commercial entities is to continue practices that prioritize economic gains over health, social and environmental and equity impacts, unless required to do so.

# Understanding impact, understanding risk

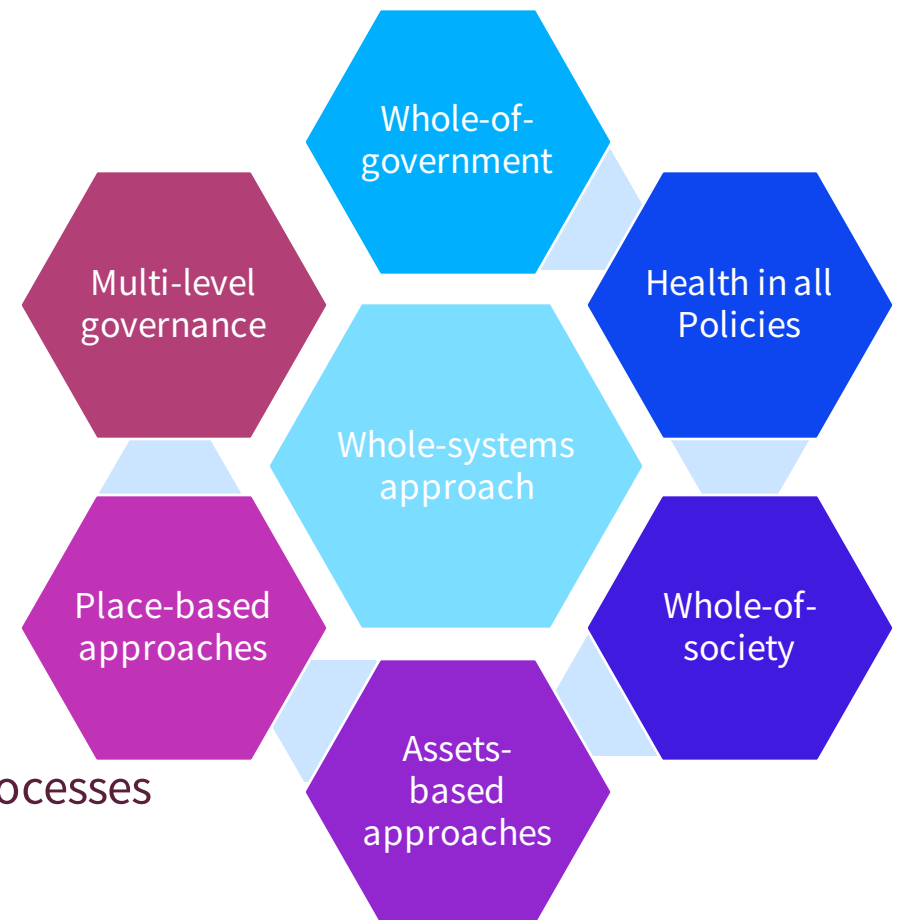




# Commercial determinants: moving towards action

**Five interlinked and interdependent drivers for action** on the commercial determinants of health:

- 1) **Public sector interventions and approaches**
  - *Working across government & public actors*
- 2) Corporate governance and investor action
  - *Working with business and investors*
- 3) Social demand for better corporate practices
  - *Working with communities and civil society actors*
- 4) Strengthened public interest knowledge environment
  - *Working with academia, knowledge partners & the media*
- 5) Prioritization of health in international instruments and processes
  - *Working through UN and multilateral partners, including financing*



# First Global Report on CDOH (TP2679)

**AIM: TO RAISE AWARENESS OF THE COMMERCIAL DETERMINANTS OF HEALTH AND PROVIDE RECOMMENDATIONS FOR ACTION**

The **objectives** of the Report are to:

- a) **clarify concepts and terminology** on the CDoH
- b) **present the case for action** on the CDoH
- c) **synthesize the existing global evidence** on the public health and health equity impact of the CDoH
- d) support countries with **evidence-informed policy recommendations**



Global Report on the Commercial Determinants of Health

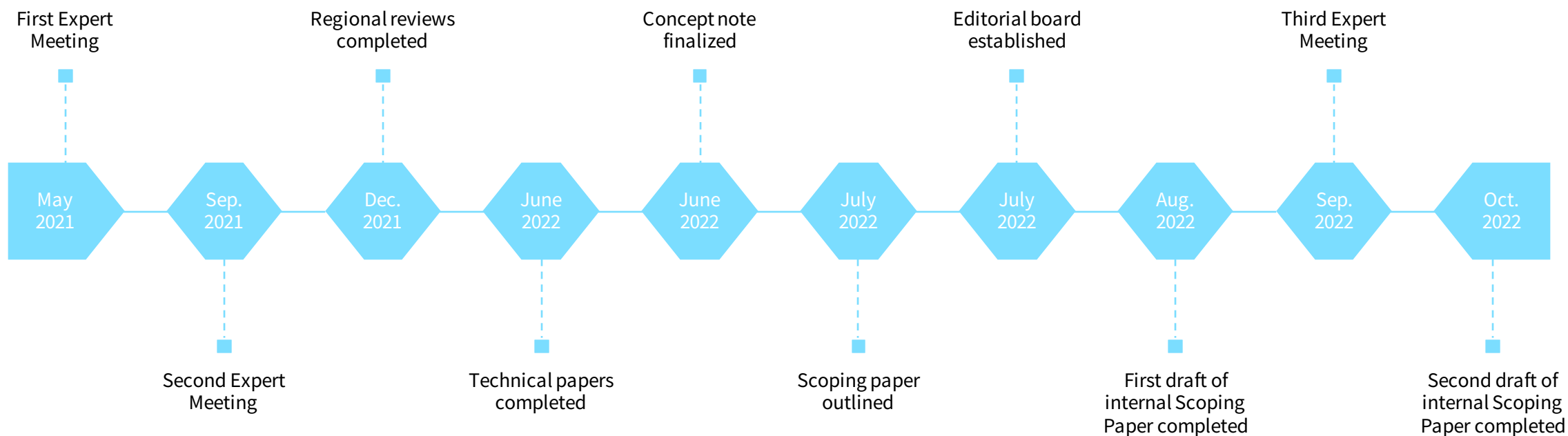
CONCEPT NOTE

June 2022

## Overview

The private sector has a major influence on health through its products and practices. This impact can help improve health, for example through the development of medicines and vaccines, but very often is

# Initial scoping for Global Report





World Health  
Organization

**Thank you: thoughts and  
feedback welcomed.**

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**! See separate file for these slides !**



**Ailsa Rutter**

**Director of Fresh and Balance**

**Amanda Healy**

**Director of Public Health, Durham**

Directors of Public Health

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**Tom Lloyd Goodwin**

**Centre for Local Economic Strategies**

(No slides)



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**Jo Bibby**  
**Health Foundation**

# The role of businesses in promoting health and wellbeing in local communities

Jo Bibby, Director of Health

November 2022



# Who are we?



[What we do](#) [Funding and partnerships](#) [News and comment](#) [Publications](#) [Search](#)

## How does UK health spending compare across Europe over the past decade?

Our new analysis finds that over the last decade the UK spent around a fifth less on average than the EU14 on day-to-day health care costs per person

[Read now](#)

### The Health Foundation responds to the Autumn Statement 2022

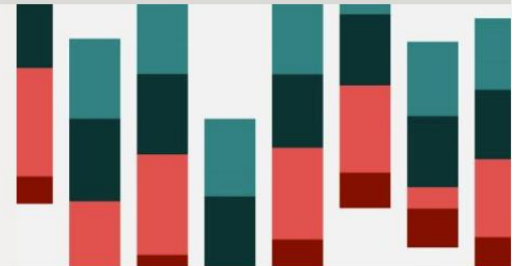
The Autumn Statement will provide short term respite for a chronically overstretched health and care service but fails to tackle the underlying challenges facing the system

[Read more](#)

### Health is wealth?

Andy Haldane, Chief Executive of the the Royal Society for the Encouragement of Arts, Manufactures and Commerce, speaks at our third annual REAL Challenge lecture

[Register now](#)



## Featured content

DISCOVER

### Evidence hub: What drives health inequalities?

Data and insight highlighting how the circumstances in which we live shape our opportunities for...

[Read more](#)

PODCAST

### What to do about dying? – with Richard Smith and Libby Sallnow

Ep.25 | 22 October 2022  
Episode 25. To many, death and dying have no value and are relegated to the margins of our lives....

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Working with business:


The good, the bad and the ~~opportunities...~~

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# Business is waking up....

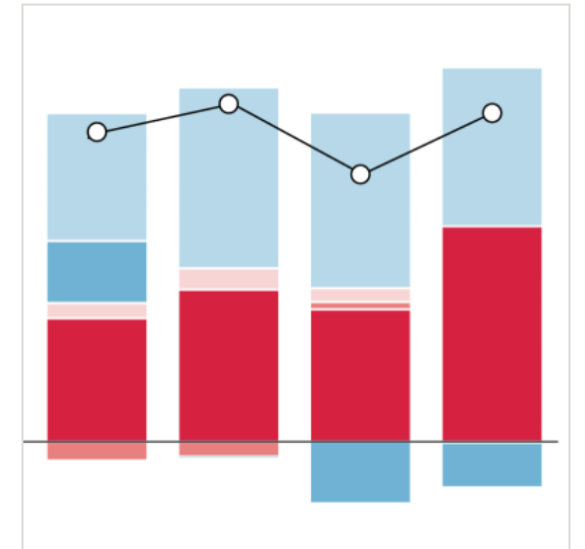
# Is poor health driving a rise in economic inactivity?

10 October 2022

 About 12 mins to read

 [Adam Tinson](#) | [Alice Major](#) | [David Finch](#)

 [Chart](#) | [Disability](#) | [Efficiency and productivity](#) | [Long-term conditions](#)

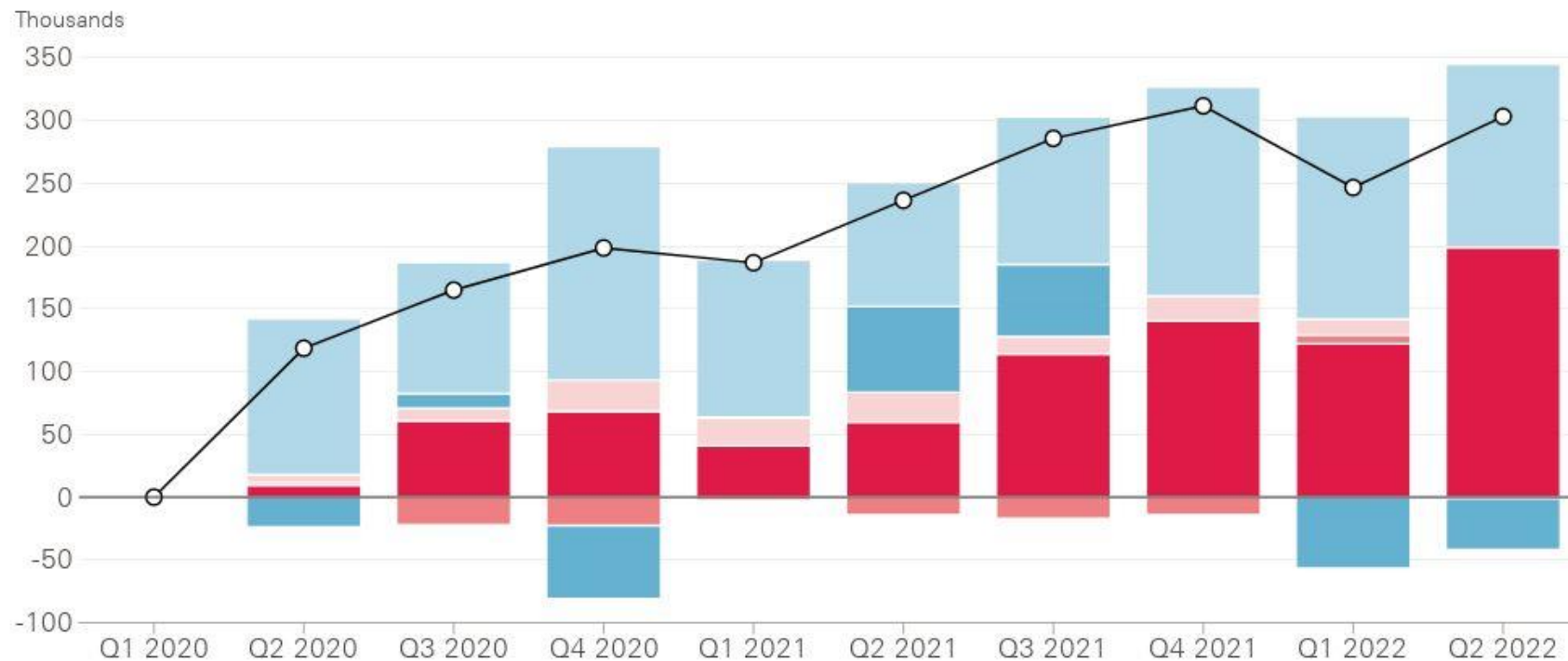


# Ill health and a shrinking UK workforce

## Ill-health has increasingly become the main reason for inactivity

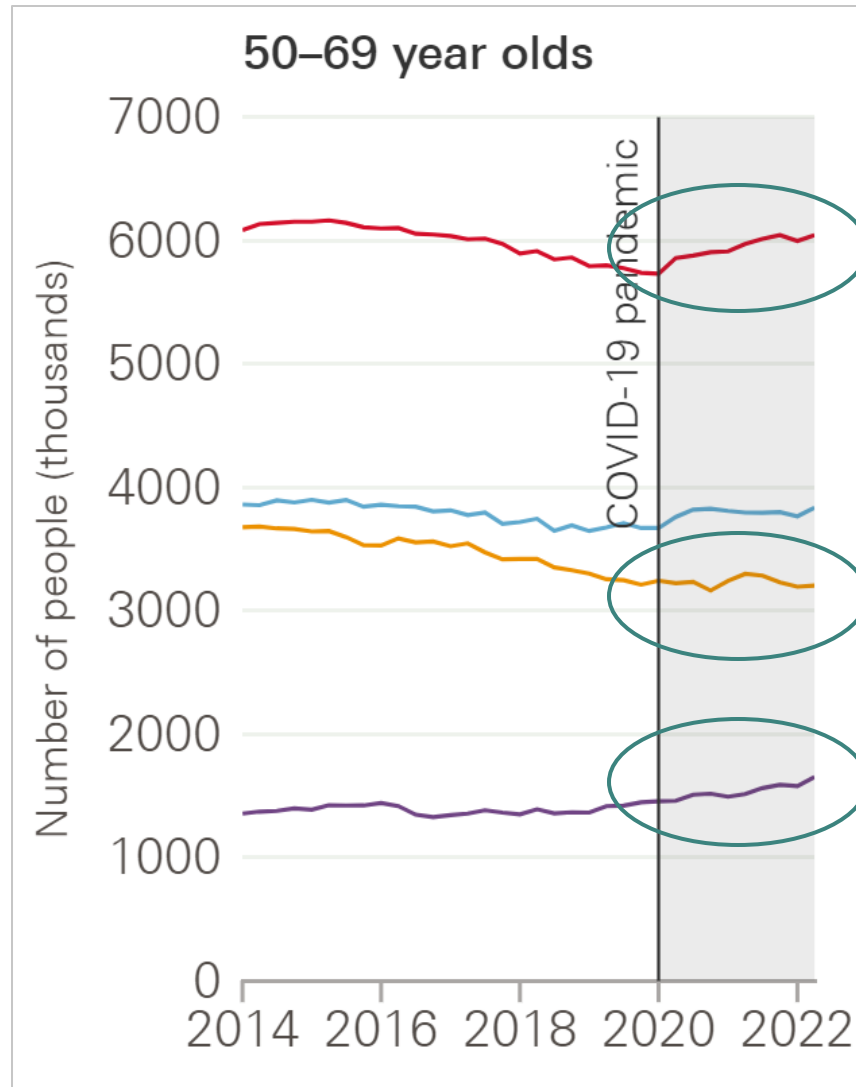
Change in number (1,000s) of 50–69 year olds who are inactive by main reason for inactivity and health as an additional reason: UK, Q1 2020 to Q2 2022

■ Total ■ Ill-health (main reason) ■ Retirement (main reason) + with ill-health ■ Other (main reason) + with ill-health  
■ Retirement (main reason) + without ill-health ■ Other (main reason) + without ill-health






# Long term trends in health and inactivity



 Inactive

 Inactive with long term health condition

 Retirement as reason for inactivity

 Ill-health as reason for inactivity

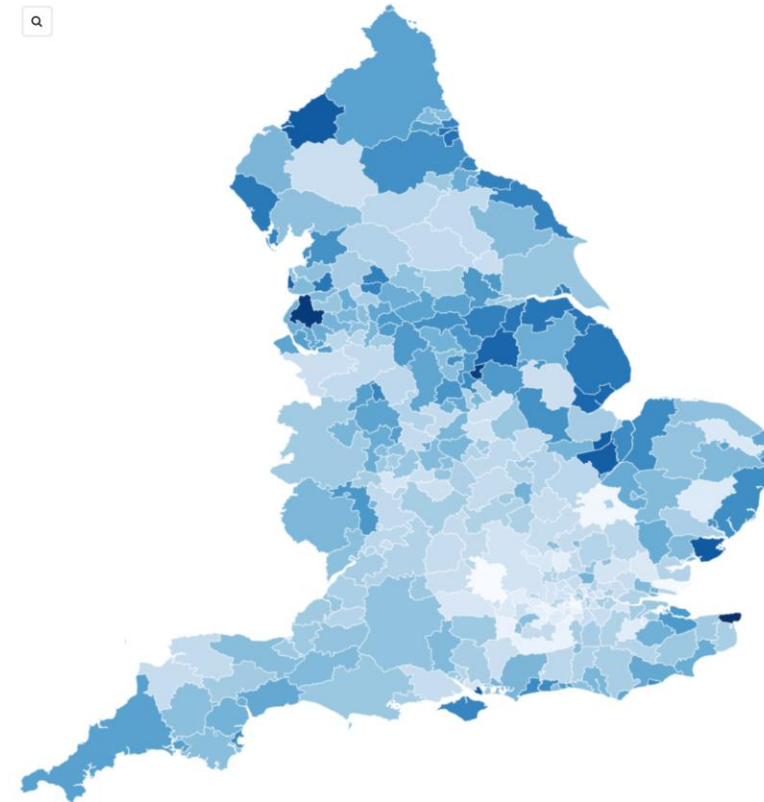
# Regional impact

- In 15% of council areas in Britain over a fifth of the working age population have a work-limiting health condition or impairment.
- Implications for current and future skills shortages
- How to understand the community needs as well as business needs in attracting investment for health and skills hand-in-hand

Prevalence of work-limiting conditions and disability in the working-age population

Proportion of 16-64 population who have a work limiting disability (%)

7.9 27.87



# Ways to engage business

# How businesses and investors affect health: 3 pillars

## Worker health



## Consumer health



## Community health



# Pillar 1: Worker health



Businesses complete a short survey on their policies, provisions and practices relating to employee health and productivity.

Businesses receive a benchmark against all index participants and then can compare with businesses of similar sectors, sizes regions and revenues.

Businesses have access to practical tools to develop their health offer including case studies and readily available support.

# Pillar 1: Worker health

**WORK**

Boost your health and wellbeing baseline

**LIVE**

Take a preventative approach

**MOVE**

Get your people living well

**THRIVE**

Support your people's wellbeing

# Pillar 2: Consumer health

The LIPH initiative helps investors to:



## Lead

Gain a competitive advantage by being a leader and making an early commitment to prioritise health – a social engagement theme gaining fast momentum.



## Collaborate

Join collaborative engagement initiatives to drive accelerated company progress and disclosure on key health issues.



## Learn

Learn from one another and get early insight and support to mitigate health-related risks within your portfolios – including best practice guidance, company benchmarks, and briefings.






## Influence

With our support, help influence policymakers and data providers to improve the health data landscape.

**ShareAction**»

# Pillar 2: Consumer health

Table 1: Prioritised health themes and issues, organised by ShareAction Impact Pillar

			
	Impact Pillar 1: <b>Worker Health</b>	Impact Pillar 2: <b>Consumer Health</b>	Impact Pillar 3: <b>Community Health</b>
Issues			
Alcohol Harm		●	
Anti-microbial Resistance (AMR)			●
Digital Well-being: Mental Health		●	
Financial Well-being: Financial Inclusion		●	
Financial Well-being: Over-indebtedness		●	
Food Safety: Chemicals & Pathogens		●	
Optimum Physical & Mental Health of Workers	●		
Healthcare: Access to Medicine & Vaccines			●
Housing: Access to Quality Housing		●	
Nutritious Diets: Infant & Young Child Nutrition		●	
Nutritious Diets: Adult Nutrition		●	
Pollution: Air Pollution	●		●
Pollution: Water Pollution			●
Smoking: Tobacco		●	
Human Rights			●

## Investor guide for health

15 priority health issues identified based on health impact and company influence













# LIPH's investor signatories



# Making councils accountable for their investments' impact on health

## UK councils that have the highest direct investments in tobacco stocks

A substantial amount of pension funds have investments in tobacco stocks.

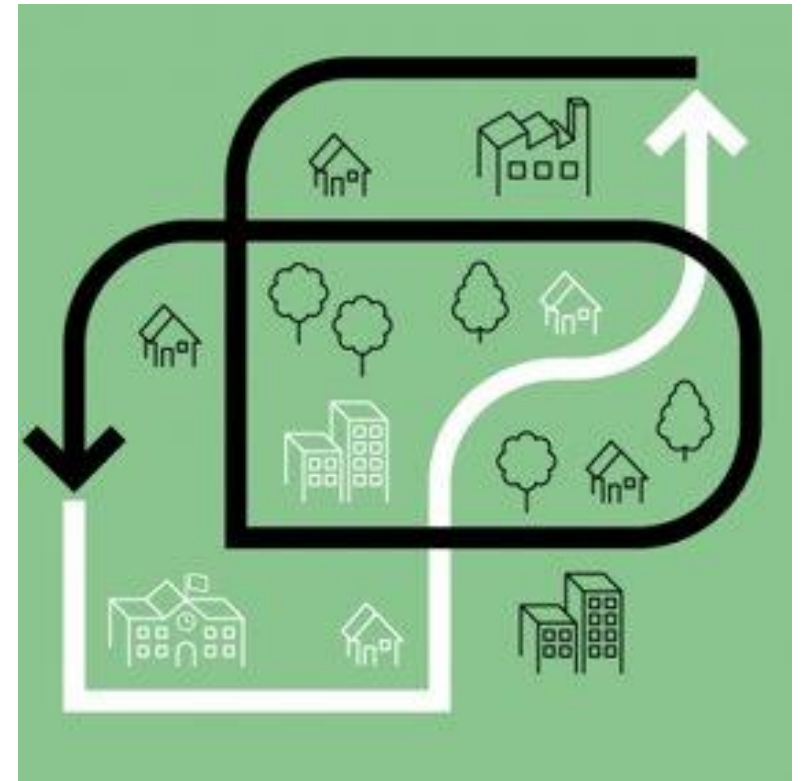
	<b>West Yorkshire</b> West Yorkshire	<b>£284m</b>
	<b>Lothian</b> Edinburgh and the Lothians	<b>£110m</b>
	<b>Nottinghamshire</b> Nottinghamshire	<b>£95m</b>
	<b>West Midlands</b> Wolverhampton	<b>£93m</b>
	<b>Hampshire</b> Hampshire	<b>£77.8m</b>
	<b>South Yorkshire</b> South Yorkshire	<b>£70.3m</b>
	<b>East Riding</b> East Riding of Yorkshire	<b>£68.7m</b>
	<b>Merseyside</b> Wirral	<b>£64m</b>
	<b>Teesside</b> Middlesbrough	<b>£57.5m</b>
	<b>Tayside</b> Dundee	<b>£56.3m</b>

Source: Freedom of Information requests to UK local councils The Guardian, 2018

- In 2020 Newham Council introduced tobacco investment exclusion.
- Current LIPH signatories include Local Authority Pension Fund Reform, Northern Local Government Pension Scheme representing a pool of LA pension funds.
- Opportunity for more pooled funds and councils themselves to get involved.

# Pillar 3: Community health and Economies for Healthier Lives

- Economies for Healthier Lives (EHL) is a Health Foundation programme supporting five councils over three years
- The programme aims to find out how best to use economic development to improve people's health.
- Local community involvement is central to each of the projects.
- Identifying the needs of the communities but also engaging with local businesses and supporting them to understand the impact they have on health.



# Our five council partnerships

Glasgow City Region	Havant Borough Council	Liverpool City Region	Leeds City Council	Salford City Council
<ul style="list-style-type: none"> <li>• Capital Investment Health Inequalities Impact Assessment Tool</li> <li>• How can capital spending projects improve health?</li> <li>• £2bn annual investment</li> <li>• 1.84m population in the Region</li> <li>• Pilot projects Metrolink and Housing retrofit using tool as it is developed – including testing with business</li> </ul>	<ul style="list-style-type: none"> <li>• Wraparound health and wellbeing support model</li> <li>• Focus on council estate Leigh Park. 27,000 residents and high rates of young people with poor health.</li> <li>• Linking up young people to regeneration plans e.g. Solent Freeport</li> </ul>	<ul style="list-style-type: none"> <li>• Redesign of employment services</li> <li>• Coordinating health and social needs on a household basis</li> <li>• Strengthening data infrastructure and metrics</li> <li>• Combined Authority with 1.5m inhabitants</li> </ul>	<ul style="list-style-type: none"> <li>• Leeds Inclusive Anchors Network</li> <li>• 13 institutions, 58,000 employees, £2bn+ annual expenditure</li> <li>• Linking up with priority neighbourhoods</li> <li>• Private sector progression framework to engage businesses</li> </ul>	<ul style="list-style-type: none"> <li>• Establishing new social enterprises through community wealth-building to build a fairer economy.</li> <li>• Engaging with local large scale anchors – public and private sector to develop supplier contracts.</li> <li>• Co-designed interventions with disadvantaged young people.</li> </ul>

Thank you



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# Table discussions



- What role do you as DsPH and local leaders play around good growth, work and health?
- What are the levers and structures you have locally/ regionally to progress this and what are the barriers?
- Are there specific national policies or changes which would help to improve the connectivity between the economy and health outcomes? What would you like ADPH's role to be in this agenda?

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**Sandra Husbands**

**DPH City of London and London Borough  
of Hackney**

**Christina Gray**

**DPH Bristol**

**Louise Wallace**

**DPH North Yorkshire**



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