**SOCIALIST HEALTH ASSOCIATION (SHA) - Prevention and Public Health policy**

**Introduction**

The SHA Council agreed to pull together some of the existing policies on prevention and public health, introduce new proposals that have been identified and put them into a policy framework to influence socialist thinking, Labour Party (LP) manifestoes and future policy commitments. The SHA policy work is differentiated from other groups in that we are not funded by the industry, charitable foundations or by governments. We are a socialist society which is affiliated to the Labour Party (LP) and we participate in the LP policy process and promote policies which will help build a healthier and fairer society within the UK and globally. An SHA working group was established to draft papers for the Central Council to consider (Annex 1).

The group were asked to provide short statements on the rationale for specific policies (the **Why?**), reference the evidence base and prioritise specific policies (the **What?**). Prevention and Public Health are wide areas for cross government policy development so we have tried to selectively choose policies that would build a healthier population with greater equity between social groups especially by social class, ethnicity, gender and geographical localities. We have taken health and wellbeing to be a broad concept with acknowledgement that this must include mental wellbeing, reduce health inequalities as well as being in line with the principles of sustainable health for future generations locally and globally.

These short documents are divided into five sections to allow focus on specific policy areas as follows:

1. **Planetary health, global inequalities and sustainable development**
2. **Social and the wider determinants of health**
3. **Promoting people’s health and wellbeing**
4. **Protecting people’s health**
5. **Prevention in health and social care**

The working group have been succinct and not reiterated what is a given in public health policies and current LP policy. So for example we accept that smoking kills and what we will propose are specific policies that we should advocate to further tackle Big Tobacco globally, prevent the recruitment of children to become new young smokers, protect people from environmental smoke and enable smokers to quit. We look to a tobacco free society in the relatively near future. Whether tobacco, the food and drink industry, car manufacturers or the gambling sector we will emphasise the need to regulate advertising, protecting children and young people especially and make healthy choices easier and cheaper through regulations and taxation policies.

Wherever appropriate we take a lifecourse approach looking at planned parenthood, maternity and early years all the way through to ageing well. We recognise the importance of place such as the home environment, schools, communities and workplaces and include occupational health and spatial planning in our deliberations.

We discuss the NHS and social care sector and draw out specific priorities for prevention and public health delivery within these services. The vast number and repeated contact that people have with these servces provides opportunities to work with populations across the age groups, deliver specific prevention programmes and use the opportunities for contacts by users as well as carers and friends and relatives to cascade health messages and actions.

In each section we have identified up to ten priorities in that policy area. In order to provide a holistic selection of the overall top ten priorities we have formed a summary box of ten which identifies the goal, the means of achieving them and some success measures.

**Conclusion**

This work takes a broad view of prevention and public health. It starts with considering Planetary Health and the climate emergency, global inequalities and the fact that we and future generations live in One World. A central concern for socialists is building a fairer world and societies with greater equity between different social classes, ethnic groups, gender and locality. We appreciate that the determnants of such inequalities lie principally in social conditions, cultural and economic influences. These so called ‘wider determinants and social influences’ need to be addressed if we are to make progress. The sections on the different domains of public health policy and practice sets out a holistic, ecological and socialist approach to promoting health, preventing disease and injury and providing evidence based quality health and social care services for the population.

The work focuses on the **Why** and **What** but we recognise the need for further work to support the implementation of these priorities once agreed by the SHA Council. Some will be relatively straightforward but others will be innovative and we need to test them for ease of implementation. A new Public Health Act, as has been established in Wales, but for UK wide policies would make future public health legislation and regulation easier.

The next steps are for SHA CC to comment on the documents, identify other policy areas for inclusion and refine the current draft documents. The policies will then need to be reviewed and specific priorities identified by us to advocate for within the LP policy process and become manifesto commitments.

Dr Tony Jewell (Convener/Editor)

Central Council

**Annex 1**

**Members of the SHA Prevention and Public Health working group.**

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1. Planetary Health, global inequalities and SD - Tony Jewell

2. Social and the wider determinants of health - Stephen Watkins

3. Promoting people’s health and wellbeing - Stephen Watkins

4. Protecting people’s health - Tony Jewell

5. Prevention in health and social care - Kathrin Thomas

Tony Jewell was supported by David Pencheon; Stephen Watkins by Ruth Billheimer and Tessa Ratcliff; and Kathrin Thomas by Roy Trevelion. We acknowledge the input from other PH colleagues on specific policy issues.

**Summary of the SHA Public Health Priorities for Labour Manifesto**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Goal** | **How** | **Measures** |
|  | Prevent and mitigate the impact of climate change on planetary health and wellbeing | * Move to 100% renewable energy * Apply targets on carbon footprints by organisations * Reduce all pollution and apply ‘polluter pays’ principle * Improve energy efficiency and stop new domestic gas/oil boilers * Shift investment in roads to active travel, public transport and rail improvements * Reduce growth in aviation and apply tax to aviation fuel * Co-operate in developing an international high-speed rail links and reduce air and ocean pollution from shipping * Use International aid to support achieving UN SDGs * All citizens should have access to clean air and water at home, in their community and at work. | * Zero carbon targets with 100% renewables * Enforce IPPC targets * Monitor carbon footprint trends in all public and large organisations * Targets for national and local governments. * Air and water pollution measures * Achieve SDGs locally & globally by 2030 |
|  | Reduce income and wealth inequity: Give every person the means to participate in society and care for themselves and their families | Distribute wealth and income more equitably by:   * Taxing inherited wealth and unearned income * Ensure offshore wealth is returned to the taxpayer * Taxing high income earners * Ensure multinational organisation pay fair tax on earnings in UK * Eliminating the gender pay gap * Ensure the living wage is reviewed annually and is assessed fairly * Reforming the welfare system, introducing universal basic income * Health and Social Care staff to be paid fairly, and trained properly, and unionised. | * Substantial narrowing[[1]](#footnote-1) of the gap in disposable income between the richest and the poorest households * Monitor the Gini coefficient and move UK towards more equitable countries levels * Living wage keeps pace with earnings |
|  | Health in all policies | * Make environment & health impact assessment mandatory for all policy decisions * Annual Health & Environment Act alongside the annual Finance Act * Across Government team of public health Ministers * Ensure that every public body has adequate systems for public health advice * Proportionate universalism in all policies: distribute resources according to need * Spatial and planning controls | * Cross Government PH team * Public Health Ministers in place * Public health advisers in public bodies * Health & Environment Act introduced * Mandatory environment & health impact assessment in place * Resource according to need * Time-lag between policy development and delivery |
|  | Give every child the best start in life | * Eliminate child poverty * Focus on early years with child centres to support parenting skills * Fluoridation of drinking water * Provide generous maternity and child benefits for parents * Restore the cuts in services for children and young people and the cuts in youth services * Provide support to schools for statutory sex and relationship education (SRE) * Introduce a revitalised school health service acting as the public health input to all schools * Establish a legal right to breastfeed and require “breastfeeding welcome” notices in all public buildings | * Child poverty abolished * Breastfeeding rates * Proportion of public bodies qualifying for UNICEF “Baby Friendly” status * Child protection indicators * Air pollution in homes and schools * Vaccination uptake * Dental decay at age 5 * Under-18 conception rates and the London Measure of Unplanned Pregnancy * Youth crime levels * Mental health in young people |
|  | Promote physical activity | * Develop walking and cycling networks and living streets * Restore and expand public facilities for sport, swimming and physical activity * Support sport and reduce dependence on advertising alcohol, gambling and fast foods * Enhance access to the countryside, protect rights of way, and ensure that the 2026 cut-off date is not applied until after comprehensive revision of the definitive map. * Require pedestrian permeability and walkable neighbourhoods in spatial planning strategies | * Physical activity rates by gender, age and group * Participation in sport rates by gender and group * Sports advertising including on TV and social media * Access to the countryside |
|  | Address the commercial determinants and influences on health and wellbeing | * Adopt a regulatory approach which understands ‘choice editing’ People might have the right to make unhealthy choices, that does not create a commercial right to persuade them to do so * Introduce unhealthy food taxation such as an Avoidable Food Tax to ensure affordable healthy food. * Introduce an increasing minimum unit price for alcohol * Take population approach to reduce impact of gambling: restrict advertising of gambling, restrict access and increase treatment * Create smoke free places and make vaping available as a form of nicotine replacement therapy (NRT) to support smoking cessation but avoid becoming used by non smokers and young people * Tax advertising of health relevant products to fund better health information | * Overall consumption levels for healthy and unhealthy (HFSS) foods * Salt in food regulations applied * Sugar tax widened * Processed and fast foods controlled * Smoking and vaping rates * Rates of drug and alcohol-related harm * Rates of risky gambling behaviour |
|  | Address the health issues that arise at work | * Strengthen workers’ rights and unionisation * Implement workplace safety along the ‘Decent Jobs and Decent Lives’ manifesto * Strengthen enforcement of health and safety legislation whilst acting to stop it being discredited by disproportionate risk aversion * Ensure that every workplace has a comprehensive occupational health service, either provided by the NHS or provided by employer and trade unions acting together and licensed by the NHS | * Trade Union membership * Using the Adelstein & Fox methodology for calculating the proportion of health inequality attributable to work. * Reduced workplace stress and accidents * Monitor OHS in large and SMEs |
|  | Establish community oriented primary care to empower communities to create healthy communities | * Invest in public health programs * Strategically shift resources to primary and community care and social care * Implement the ‘Doctors in Unite’ proposals for public health in primary care * Place based approach and community development supported * Availability of small grants to small community organisations and front-line teams * Public health approach to alcohol, drug and violence reduction | * Measures of social networking * % NHS investment in primary care * % increase in social care spend and workforce * Uptake of vaccination and screening programmes in deprived communities * Selected health outcomes as per public health outcomes framework * Incidence of STIs * Rates of violence (crime rates, injuries) |
|  | Healthy ageing - people should spend more of their life fit, healthy and active | * Disability friendly and age friendly cities and towns * Promote physical activity into old age including as a treatment for frailty * Housing standards to keep warm and prevent falls | * Healthy life expectancy (HLE) both in years and as a proportion of life expectancy * Reduce inequalities in HLE by social class, ethnicity, gender and place. * Housing standards implemented – insulation and heating, accessibility, injuries from falls |
|  | Provide effective public information on health issues and services such as the NHS supporting people in choosing healthy lifestyles. | * Develop the preventive element of all patient pathways * Restore public health grant and PH expenditure to previous levels and fund major national campaigns * Improve drug and alcohol services, sexual health services, smoking cessation services and services relating to nutrition and physical activity * Ensure there is a public health specialist on the board of each NHS and LA organisation with statutory powers. * Ensure prevention workers in key places eg breastfeeding and smoking cessation works in maternity units, alcohol workers in A&E departments, health trainers in all primary care setting * Strengthen the agencies which enforce regulations protecting communities, consumers, workers and the environment * Improve communicable disease control services | * Dental decay at age 5 * Overall consumption levels for healthy and unhealthy (HFSS) food * Physical activity rates * Smoking rates * Rates of drug & alcohol-related harm * Rates of STIs * Under 18-conception rates and the London Measure of Unplanned Pregnancy * Accident and injury rates * Antibiotic resistance * Communicable and NCD rates |

**SHA Prevention and Public Health Policies**

**Section 1: Planetary health, global inequalities and sustainable development**

**Why this is important?**

The climate we experience, the air we breathe, the water we drink and food we eat all have a global connection - **we live in One World sustained by One Planet**. The homes we live in, our work and workforce, and the goods we trade and use in our daily lives, have a global dimension too. The Health of our Planet needs our attention as its shows signs of ill health with an escalating fever, loss of biodiversity and depleted natural resources. We live in a globally connected world and policies to tackle health inequalities within the UK or to develop the NHS and social care system needs to be seen in their global context as all our policy priorities have social, economic, cultural and political dimensions.

The SHA is rightly concerned about persisting and growing health inequalities within the UK but we cannot ignore global inequalities. Life expectancy in the African region for example is an average of 60 years - some 17 years less than Europe. Of the 20 countries with the highest maternal mortality 19 are in Africa. Under 5 child mortality is 81/1000 live births which is 5 times higher than the European region and 90% of the global malaria cases, which are mainly in the under 5s, are in Africa. Only 58% of Africans have access to a safe water supply. In terms of health workers and the aspiration of universal health coverage there are 2.7 physicians per 10,000 people compared to the 32 in Europe and 12.4 nurses/10,000 people compared to 80 in Europe (Source WHO 2018). The UN Sustainable Development Goals (SDGs) cover these aspects of poverty, water/sanitation and inequalities in their global goals.

Marmot’s work for the UN on the Social Determinants of Health provides a helpful link between our local actions within the UK alongside the need for global action. Socialism in one country has political resonance from a century ago but for a fairer UK today we need to press for a fairer world and this should be seen as part of the same journey - acting locally and globally. These policy priorities can be viewed through the lens of climate change, its adverse impacts on global poverty, political instability and war, migration and depleting the natural world.

Climate breakdown is now acknowledged to be one of the, if not the, biggest threat to health, wellbeing and social justice in the 21s t century. Climate change and related unsustainable developments such as pollution of air, water, and oceans; species extinction at 1000 times the natural rate, dangerous loss of biodiversity, migration, and human conflict are often framed as simply environmental issues. This has masked the toll on human health, the health of other living systems on which human health ultimately depends and the health of the planet’s natural and mineral resources – both now and in the future.

Climate change is therefore as much a health issue as an environmental issue. Moreover, the catastrophic consequences of ignoring the threat to health already falls disproportionately on those people, populations and living systems least able to cope, who are the least resilient, and who have over millennia always borne the brunt of system wide threats to health. Climate change is a health and social justice issue. It is already accelerating unacceptable differences in life chances over space (different communities, different countries), and over time (trans generation and inter generational). We are knowingly adversely affecting the health and wellbeing of communities and generations who have **less voice and choice** and often ***no* voice and choice**.

The scale and pace of change is not sufficiently recognised outside the purely scientific arena: certainly not in the public or political sense. Like tobacco, many people and governments know it is unhealthy, but few appreciate exactly the size of the threat and the scale and pace of the action needed if we are going to maintain the conditions necessary for just and fulfilling lives. Tobacco control is still partial but it has taken us over 60 years to get where we are and we simply don’t have the time. The strength of the science about how we are ***spoiling our nest*** is very strong, far stronger for instance, than the evidence base for most health care. Never in human history have so many scientists ever agreed on one issue: that we are knowingly and unsustainably changing the planet making it more difficult for the poor today and everyone tomorrow to lead meaningful, healthy and fair lives. The science of the problems is well understood, so is the science of the solutions: de-carbonising the world’s energy system, practicing a circular approach to resource use leading to a zero waste / zero pollution system, preserving biodiversity, and recognising that our planet contains finite resources. Enough for every person’s need but not enough for every person’s greed!

There is some very good news addressing climate change through the health lens: most interventions that will help mitigate climate change also deliver other, more immediate health benefits. Food systems that are compatible with a de-carbonised future (less meat, dairy, food travel miles, more sustainable soil practices) ***also***offer healthier diets now, reducing heart disease, obesity, and some cancers. Similarly, how we move ourselves around the planet more sustainably leads to both a healthier future and a healthier present. Less mechanised fossil-free travel options improve air quality and social cohesion. The consequential increase in physical activity, even at low levels, radically improves physical and mental health.

There are many inspiring case studies of how action on climate change and unsustainable development are improving health and social justice already. However, the scale of the challenge means that more widespread and ambitious pan-societal approaches are needed urgently. Health professionals are the most trusted people in most societies, and health organisations are often the largest employers in communities, especially when working in partnership with local government and universities. Such influence should be used effectively in line with the science and in line with the law. Failure to act on a duty to care will be not be looked on favourably by those who are less influential and less resilient to the effects of climate change on everything that makes life worth living. This is happening on our watch, and our actions will be our legacy. Leading health professionals are on record as stating that “...never in human history have we known so much and done so little.”

The strength of the evidence, the will of many informed people, and the co-benefits for health all mean that every responsible health professional and organisation should have an understanding and a position on this issue. This might include a pledge of actions, ranging from acknowledging and implementing national laws e.g. in the UK, the Climate Change Acts and the Social Value Acts such as the Well-being of Future Generations (Wales) Act 2015. Internationally: particularly the recommendations of the UN Intergovernmental Panel on Climate Change (IPCC), the agreement in Katowice in 2018 and the findings of the UN Global Climate Report in March 2019. The WHO Framework Convention for Tobacco control, the Global Action Plan on Anti-Microbial Resistance (AMR) and the UN Sustainable Development Goals (SDGs) all contribute to a global effort to secure a healthy and sustainable planet.

**Top Priorities for Planetary Health, reducing global inequalities and Sustainable Development:**

1. **Effectively implement existing laws that protect conditions that create and protect health and fairness**.

1.1 Polluter pays, zero carbon incentives, meeting climate change targets by rapid move to 100% renewables and a zero-carbon energy system.

1.2 Social value through employment, procurement, investment & partnerships.

2. **Measure value and benefit, not just cost of sustainable interventions that deliver immediate and long term health benefits (food, energy, travel)**

2.1 Infrastructure investments (especially housing, food, and transport)

2.2 Supply chains legally mandated, whole chain ethical auditing and Fair Trade

2.3 Alternative to traditional discounting rates of 3%, and 3 year Return on Investment (ROI).

3. **Redefine community health and prosperity beyond materialism to meeting needs and global equity.**

4. **Require use of Social, Health and Environmental impact tools in all policy and planning decisions.**

5**. Report progress by moving from Financial Reporting to financial, social and environmental reporting (“Triple bottom line reporting”, “Integrated reporting”).**

6. **Enforce and act on the Paris Accord (UN IPCC recommendations)**

**7. Mandate the national carbon targets at levels commensurate with the science.**

7.1 At increasingly local levels of governance such as hospitals and cities

7.2 Targets reflect consumption (imported goods) as well as production.

**8**. **Commit to delivering the UN Sustainable Development Goals (SDGs) in their entirety**

**9. UK government to continue to allocate 0.7% of GDP to International Aid to support the delivery of the UN SDGs**

**10. Demonstrate the UK’s contribution to planetary health and equity by working in partnerships internationally.**

**Figure 1: UN Sustainable Development Goals (SDGs) by 2030**



**SHA Prevention and public health policies**

**Section 2: Social and the wider determinants of health**

**Why is this important?**

Greater equality, wider life chances for all and better social and physical

environments are key socialist priorities in their own right. The poor die younger than the rich but experience greater sickness in their shorter lives. Women experience more sickness than men yet live longer and these inequalities appear to be gender differences rather than biological sex differences. There is a social gradient with life expectancy declining with every step down the income scale. Health inequalities arise in the social conditions in which people are born, grow, live, work and age. Where somebody lives is also a key geographical determinant. These inequalities of social class are overlaid with disadvantage of gender, ethnicity, sexual orientation, disability, age, religion and belief. The economic and human costs are unacceptable.

**What is a socialist approach?**

Inequalities result from social and economic circumstances created by class

differences in access to power, money and resources. They improve not as a

natural result of economic advance but through the successful struggles of the

powerless and the dispossessed. Denying their attribution simply to economic

progress, Nye Bevan said “Capitalism proudly displays the medals won in the battles it has lost”.

Neoliberalism and austerity have exacerbated social and health inequalities and long-term illness and premature deaths. The UN Special Rapporteur after his visit to the UK in November 2018 states:

“***Although the UK is the 5th largest economy, one fifth of its population (14m people) live in poverty, and 1.5m of them experienced destitution in 2017. Policies of austerity introduced in 2010 continue largely unabated, despite the tragic social consequences. Close to 40% of children are predicted to be living in poverty by 2021. Food banks have proliferated; homelessness and rough sleeping have increased greatly; tens of thousands of poor families must live in accommodation far from their schools, jobs and community networks; life expectancy is falling for certain groups; and the legal system has been decimated.***

***The social safety net has been badly damaged by drastic cuts to LA budgets, which have eliminated many social services, reduced policing services, closed libraries in record numbers, shrunk community and youth centres and sold off public spaces and buildings. The bottom line is that much of the glue that has held British society together since WW2 has been deliberately removed and replaced with a harsh and uncaring ethos. A booming economy, high employment and a budget surplus have not reversed austerity, a policy pursued more as an ideological than an economic agenda”.***

Austerity kills. Countries, which refused to cut social spending, following the economical crisis of 2008, have performed better economically and in health terms. Health, education, welfare and social protection have been shown to have economic benefits - a healthier workforce, greater productivity and an economy delivering the taxes needed. Inequality sets in early in life and we need to address this, and also to enhance services for children, young people and families decimated by austerity budget cuts. We need to reverse these trends and share a vision of society which is fairer with more equal opportunities at home and globally and which is built with a sustainable economy that does not deplete our resources and pollute the planet.

The association between occupation and health is clear but evidence of the

proportion of that which is causal is more limited. Historical best evidence indicates that about a quarter to a third of the variance in ill health is due to work-related circumstances, not just to associated factors. In a modern economy much of the ill health will be driven by alcohol and substance misuse alongside stress and mental ill health. As this is probably unchanged, attention to the quality of work is essential to addressing health inequalities.

We need radical action across the whole system with all levels of government providing transformational leadership, and robust partnerships with individuals and communities, for greener environments, empowering cultures, good, secure, affordable housing, efficient transport and management of climate change. This means an asset-based approach empowering people to take control of their health and wellbeing. Instead of relying on ineffective small-scale health improvement projects we must harness mainstream spending in co-production between public services and communities to address individual and collective health and wellbeing.

We need to invest in all public services including reversing the cuts in public health services such as drug and alcohol services and sexual health services. Public health in local government, although not part of the NHS, is statutorily part of “the heath service”. It is therefore a deceitful sleight of hand to have found money for “the NHS” by cutting spending on another part of “the health service”.

Stuckler & Reeves have shown that the fiscal multiplier for health, education, welfare and social protection exceeds 2.5, considerably more than for some other forms of government spending. This implies that spending in these areas will be self-financing (spend £1, generate £2.50 economic growth, tax @40%, add back £1 to public revenues). As we address climate change the calculation of GDP and hence of fiscal multipliers will change, but there is no reason to suppose that this will alter this particular relationship – indeed it may enhance the demonstrated benefits of these forms of expenditure.

**How do we do it?**

Reducing the social gradient requires collaborative partnership addressing health determinants across all key national and local government agencies. No single strategy or agency will be effective. Rather an intense concerted effort is needed tackling interacting factors in particular, income inequality, early years, education, good employment and working conditions, housing, urban planning, transport, access to good quality health and public services and adequate incomes to be able to participate fully in society. A statutory duty to explicitly address and reduce health inequalities should be held by Ministers leading collaborative action by a range of national and local bodies. Action should be taken across the whole of the UK including the devolved governments and local government.

A socialist government would reduce income and wealth inequity. It would ensure that every person has the means to participate in society and care for themselves and their families. The government would do this by progressive tax measures such as taxing inherited wealth, unearned income and ensuring that offshore wealth is returned to the taxpayer. The government would ensure that multinational organisations pay fair tax on earnings in UK. They would work to eliminate the gender pay gap, and ensure a fair living wage

A socialist government would significantly reform the welfare system, introducing universal basic income

Within the Westminster Government the Ministry of Housing, Communities & Local Government (MHCLG) and the Department of Health & Social Care (DHSC) should for example share a **Minister for Public Health** elevated to be a Minister of State. Public health should be a cross-government endeavour. There should be a Cabinet level public health team in which the Cabinet Minister for Public Health is supported by a team at Parliamentary Secretary level working across departments. Like the Treasury its remit should be seen as being the pursuit of a particular objective across Government, rather than just a limited range of direct individual responsibilities. Thus fulfilling for health and wellbeing the kind of role that the Financial Secretary to the Treasury plays for funding. An annual Health & Environment Act, like the Finance Act and contributed to by all departments, would overcome the problem that public health legislation is seen by DHSC as being outside its remit if it affects another department and is seen by that other department as being less important than its own priorities. This would change to a situation where departments saw the Health & Environment Act as another opportunity to legislate on issues.

By these methods there would, both at Ministerial and civil service level, be designated contacts between each department and the public health team, just as there would be with the Treasury, and these contacts should reach out into related public bodies. A renewed emphasis on local government and a close relationship with the Local Government Association (LGA) will help local councils with expert support and advice teams as well as restoring their funding. We support a house building programme concentrating on social and low-cost housing, with a council house building programme to reduce the current housing waiting list of over a million households. We should strengthen building control especially moving away from carbon based heating systems, requiring high standards of insulation and improve new home warranties. Millions of people are living with insecurity of tenure so we will introduce long-term, secure, enforceable rental contracts and increase funding to local government to enforce the rights of tenants. Measures will be taken to improve the condition of privately rented homes with funding for enforcement provided alongside the legislation to regulate overcrowding, multiple occupancy and minimum standards for warm, dry, well maintained homes. Outside the home, we need to regenerate neighbourhoods, providing a green infrastructure and living streets. Planning regulations will reflect the needs of their communities for a healthy environment.

We propose the following action on education and services for young people: provide generous maternity and child benefits for parents, reverse the cuts to Children’s Centres, Sure Start/Flying Start programs, and health visiting. Change the focus of the school curriculum setting preparation for life alongside academic achievement, including healthy lifestyles; life skills such as cooking, swimming, social media, and recreational and cultural activities; music, art, and drama. Provide support to schools for statutory sex and relationship education (SRE) which should remain statutory with more support to its provision and with sexual health services in schools. School nursing should be restored, revitalised and established as the public health adviser to the school.

We propose rebuilding and funding the Youth Services with counselling, advice, and mentoring programmes. Properly fund appropriate provision for excluded children and give better support to home-schooling when needed. We should intensively support vulnerable groups: young people at risk of teenage pregnancy; those who are not in employment, education or training (NEETs); and looked-after children. For disabled children and young people, councils should provide appropriate support both in and out of school and during transition to adult life. We will encourage young-people friendly, health provision, including mental health services and non-school-based

contraception/ sexual health services. We should support young parents and the post-natal mental health needs of young mothers.

Increased funding would empower local communities and their local police services. More community policing will help regain the confidence of the public, reducing the fear of crime and promote healthier lifestyles. To tackle crime and violencewe support a public health approach to the gang culture, and encourage zero tolerance towards violence in all its manifestations including domestic violence. Drug-related crime will be reduced by establishing a legal avenue of supply with a therapeutic approach, removing the need for illegal dealers.

The value of prevention (“a stitch in time saves nine”) across the whole of

Government should be embedded. We will ensure that all policies are subject to an assessment of their social, environmental and health impact to reduce the risk of economic growth conflicting with the goal of sustainability.

A socialist government should make “welfare to work” supportive, not punitive, and urgently overhaul Universal Credit (UC) and the criteria for disability benefits. On welfare reform the government should look at the provision of a universal basic income for healthy living. The Health and Safety Executive (HSE) has as its mission statement “It prevents work-related death, injury and ill health”. We will give the HSE more powers and as a first step require it to sponsor universal occupational health services (OHS).

An OHS could play an important role in all the relationships between work and health, including health and safety at work, employment rehabilitation, helping people back into work, creating healthy workplace cultures and providing basic health services at work. OHS have declined from a high point at which about a third of the workforce was supported by comprehensive occupational health services to a situation where they are unusual. This is partly because of the increasing role of small employers who find it difficult to provide such a service, and partly because of declining commitment on the part of large multinational employers. Where employers and trade unions do wish an employer to provide a comprehensive service, we should license that service whilst protecting its independence and ensuring stakeholder involvement in it as for a ‘People’s Industry’. However, the occupational health system is now generally so fragmented that public provision through an NHS style OHS, financed by a levy on employers, will be the right way forward. We must recognise the importance of workplace stress and the value of a shorter working week improving work/life balance.

The UK Department of Environment, Food and Rural Affairs (DEFRA)has a number of important roles in public health. It should play the lead role in food policy with clarity about the potential tension between healthy food policies and the business interests of the agricultural and food manufacturer’s sector. The overuse of antibiotics in animal husbandry is an example where this contributes to the growth of anti-microbial resistance. The Environment Agency is an important agency with other responsibilities that impact on human health such as access to the countryside. DEFRA is therefore one department which should have a Minister shared with the public health team. The links with Local Government in rights of way and the role of local government in inspecting food businesses and between the Environment Agency and environmental health functions of local government are self-evident. Labour should pursue an active environmental protection and improvement strategy.

A healthy transportstrategy is one in which people make short journeys on foot or by cycle and make longer journeys by walking or cycling to a station or other public transport stop and then using a train, a tram or bus. This should include an integrated rail/tram/BRT rapid transit network. A comprehensive infrastructure policy rooted in a healthy transport system will therefore see: the hierarchy for planning and resourcing provision with walking at the top, followed by cycling, then public transport, and single occupancy private cars

at the bottom of the hierarchy; rail or canal investment as a higher priority than new roads; local services as a higher priority than high speed services; high speed rail as a higher priority than airports; avoiding the need to travel through better internet facilities and better spatial planning as a higher priority than expanding the transport system; walking and cycling routes as a higher priority than facilities for cars; dealing with the problems of a saturated road system as a higher priority than delaying congestion by investment in additional road capacity

Industrial strategyshould focus on creating good quality jobs, not just any jobs, and should focus on creating healthy patterns of economic activity. Such a strategy needs to be consistent with developing a sustainable economy that does not damage the environment and our ecosystem.

**Top 10 priorities for social and the wider determinants of health**

**1. Statutory duty for the UK government** to lead a cross Government (including devolved governments and regions), multiagency partnership using a health and wellbeing in all policy framework to strategically reduce health inequalities and improve health beyond the electoral cycle.

2. **House building and community development programmes**, with updated building standards, enforcing legislation on private rented accommodation that protects tenants and developing green streets with public amenities. Encourage active, inclusive communities to take control of their environment.

3. **Reverse cuts to and increase investment in C & YP services** such as; Surestart/Flying start, Children's Centres, health visiting and youth work.

4. **Invest in young peoples’ futures** by eliminating child poverty, resourcing schools so they can deliver the broad curriculum (incl. SRE); provide school nurses; sexual health services including teenage pregnancy prevention and mental health provision

5. **Improve community safety** with community based policing, a public health approach to gang culture, alcohol and drug misuse and violence prevention.

6. **Welfare reform** and urgent overhaul of Universal Credit, promote a living wage and invest to prevent homelessness.

7. **Promoting healthy work**, including occupational health, employment for disabled people, enforcement of health and safety legislation and the ‘Decent Jobs and Decent Lives’ manifesto.

8. **Food policy**, active environmental protection in the food chain and improvement strategy to ensure the affordability of and access to healthy natural foods.

9. **Healthy transport**: applying a hierarchy of investment that starts with walking, cycling, public transport and only then private vehicles. Reduce the growth in aviation using measures such as taxing aviation fuel and carbon measures.

10. **Industrial strategy**: good quality jobs, tackling poverty and the gig economy, deliver a realistic living wage.

**SHA Prevention and Public Health Policies**

**Section 3: Promoting people’s health and wellbeing**

**WHY IS THIS A SOCIALIST ISSUE?**

Diseases and ill health caused by obesity, smoking, alcohol and physical inactivity are an increasing problem in society. Often described as diseases of affluent lifestyles, they actually affect the poor far more than the rich and are created by commercial determinants. Reducing inequality and incentivising socially responsible business, would improve multiple health outcomes.

Health improvement requires a range of risk factors to be addressed including environmental and economic factors, but the term “health promotion” usually relates to those aspects of health improvement which focus on behavioural factors, including the cultural factors, and access factors which often shape behaviour. It seeks to improve the health and well-being of the people by enabling healthy choices through providing opportunities across all ages and groups in society with services guided by need and progressive universalism.

**WHAT IS A SOCIALIST APPROACH?**

A socialist approach recognises that, although people may have the right to make unhealthy choices, it does not follow that commercial companies are free to profit by persuading them to do so. As such it recognises that many of the so-called behavioural determinants of health are in fact commercial profit motivated influences on behaviour mediated by “choice-editing”. This means presenting choice in a framework, which constrains it to a limited range of options. Another major factor is the unequal distribution of opportunities to access healthy lifestyles – for example healthy food may be more readily available in shopping centres accessible only by car, whilst the simple substitutions of low-fat, low-sugar, low salt and high-fibre alternatives, which are the easiest way to change diets, are often more expensive. Research suggests that poor people shopping for food are influenced most by price per calorie, which can be viewed as a rational way to buy food with limited income. It is often a lack of opportunity for healthy eating, not a lack of knowledge or commitment. The idea that the poor are ill because they are too affluent but the rich are not ill because they are too intelligent is an ideologically-motivated harmful victim-blaming absurdity.

**Information** – it is important that commercial interests are not allowed to go unchallenged in providing health information, framing cultural factors and lifestyle choices. Society must ensure that the health message is heard equally loudly. At the moment marketing expenditure far outweighs health messaging – this disparity must be reduced by taxing the former to fund the latter.

**Regulation** – the commercial determinants of health are a sufficiently important health issue to warrant regulation of the pricing and marketing strategies, which shape people’s lifestyle choices. We must clearly distinguish the individual’s freedom to choose from the corporate freedom to shape that choice.

**Taxation** – Taxation can influence commercial decisions – the sugar tax has been effective in changing the composition of soft drinks but needs to go much further. Taxation can also help shape markets to support more healthy choices. We must recognise benefit capture and pricing of externalities as being part of collective choice rather than being merely taxes.

**Incentives** – the idea that people need financial incentives to make healthy choices for themselves is not correct. However, where costs are a factor in people’s choices, especially for the poor, incentives can provide a countervailing force.

**Services** – behavioural change is not easy, particularly when addictive behaviours are involved. It is important to have services, which offer support whether for smoking cessation, alcohol dependency or encouraging physical activity and healthy eating. This is an essential part of the public health services wherever located.

**POLICIES**

**1. Food**

**Commercial determinants** – we recognise that the whole food supply system needs to be addressed as part of a healthy/sustainable future but note that the pricing and marketing policies of the food industry are the main driver of people’s food choices. We support taxation policies that spare healthy natural foods and tax unhealthy, often processed foods, high in fat, sugar and salt (HFSS). An unhealthy foods tax such as an Avoidable Food Tax (AFT) should be considered. This AFT would be a 20% tax on the turnover of companies producing or trading in food which would be avoidable by companies which trade only in healthy food (e.g. a greengrocer’s shop), by companies which engage in no marketing beyond giving notice of their existence, by small local companies which contract with their local authority to adopt healthy choices, health information and health-oriented marketing, and larger companies which achieve targets agreed with statutory public health bodies, to change the balance of their sales in a healthier direction. The large multinational companies, which have the greatest potential influence and the least roots in local communities, would face the most demanding targets.

**Information** - a tax on and greater regulation of food advertising should fund advertising messages on healthy eating at an equivalent scale. There needs to be a stronger regulatory control to protect children using social media and TV internet and games sites. There should be a mandatory traffic light information scheme including calories per serving and per pack.

**Catering** – food supplied by caterers, from sandwich makers to canteens to restaurants, contributes significantly to people’s diets and it is important that it is nutritionally appropriate. For commercial caterers this can be addressed through an AFT as described earlier. For works and schools’ canteens, which are in a monopoly position, legislation would be appropriate. “Healthy vending machines” are also important to positively promote and be required within NHS and LA services.

**Public Health Services** – the damaging decision of the Government to cut public health spending instead of protecting it as part of the health service has reduced the help available to people trying to lose weight and should be reversed.

**2. Alcohol**

**Price** - We support a minimum unit price as a way to address the problem of drinking cheap alcohol at home instead of drinking socially in licensed premises.

**Tax** - we should explore options that increase marginal tax rates on excessive consumption such as retail pricing on large volume bottles of cheap beer or cider.

**Licensing** – health should be a licensing objective and conditions should be attached to support responsible drinking. The sale of alcohol and tobacco within shops and supermarkets should be undertaken separately from the normal shop so that licensing oversight can be enforced. Pub and club licensees should be part of responsible drinking partnerships and contribute actively in local alcohol, drugs and violence prevention. The sports sector needs tighter regulation on advertising alcohol on their merchandising.

**Public Health Services** - there should be drug and alcohol workers in all A& E departments who are able to share information with partners on at-risk environments as well as signposting people to alcohol and drug support teams. The cuts in public health spending instead of protecting it as part of the health service has dramatically reduced the support available to people with drinking and drug problems and should be reversed.

**3. Physical Activity**

**Transport** – transport infrastructure spending needs to be strategically redirected away from roads and towards a healthy transport system in which short journeys are made on foot and cycle, and longer journeys are made by the combination of public transport and cycles. It is unacceptable that cyclists are an afterthought to rail operators – there should be a cycle parking at stations and a cycle van on every train. All cities should have a network of cycle routes and a network of aesthetically attractive and safe pedestrian routes.

**Schools** - school transport schemes which promote walking to school, such as “last half mile” policies, and walking buses, should be encouraged. As physical activity improves academic performance it is entirely appropriate for schools to be required to make provision for it, not only through traditional PE and sport, but also by more innovative approaches like starting the day with some healthy exercise or a fun run.

**Green space** – urban green space needs to be protected and not sacrificed to development. Roof gardens, green roofs and green walls and earth-sheltered buildings should be used much more widely to ease the conflict between development and green space. Evidence is growing of the health benefits of green space in promoting physical activity, and in creating tranquillity and reducing stress. It is also showing that physical activity in green space is even healthier than similar activity in an urban setting. Trees of course have multiple benefits to our natural world and planetary health.

**Recreational facilities** – We support healthy living centres, which combine active leisure facilities, facilities for community activities and primary care services.

**4. Tobacco**

**Tax** – the tax on tobacco products should continuously rise by more than inflation alongside stronger controls on advertising at point of sales but also on TV, in theatres and films.

**Smoking** – creating Smoke Free Places – the majority of smokers wish to give up. Creating smoke free places supports them in tackling their addiction. It is therefore empowering rather than constraining. Smoke free places should not therefore be justified only by the issue of secondary smoke. It is also key to supporting smokers giving up and creating norms which encourage them to do so. There is no other lawful product which is addictive to the extent that nicotine is or which kills a third of those who use it in the way it is intended to be used. We should not relax efforts to monitor and control the Big Tobacco companies who remain highly profitable 60 years after their product was shown to be harmful and a leading cause of premature death.

**Vaping** – vaping should be available as a form of nicotine replacement therapy (NRT) to support smoking cessation but it should not be allowed to develop as a new widespread lifestyle ‘e-cigarette’ choice since, although it is much safer than smoking, it is a source of nicotine and it is therefore implausible that it is harmless. We must not allow it to be a mechanism for introducing nicotine to a new young generation and note the heavy investment in these products by Big Tobacco who are making inroads once again in F1 motorsport advertising.

**Public Health Services** - the cuts in public health spending has reduced the help available for smoking cessation and should be reversed.

**Global health** – the government should support the WHO Framework Convention on Tobacco Control (WHO FCTC) and work with international partners to limit the malign advertising, which spreads smoking in Low and Middle-Income Countries (LMIC) bolstering the continuous profitability of Big Tobacco. It is estimated that smoking and exposure to tobacco smoke kills someone globally every six seconds. Tobacco should be excluded fully from so called ethical investment portfolios.

**5. Sexual Health**

**Public Health Services** – Syphilis, gonorrhoea and many other sexually transmitted infections (STIs) cases are rising and we are now seeing syphilis cases in young heterosexuals. The teenage pregnancy strategy has led to teenage pregnancy rates being at an all-time low and has embedded change in society. However, there are concerns that rates will rise again due to cuts in youth workers to support young people with healthy relationships, pressures on schools which affect Sex and Relationships Education (SRE) and cuts in other Young People friendly services. We need open access sexual health services with no age restrictions or other types of discrimination and with targeted outreach work for vulnerable groups to reduce the prevalence of STIs, make PrEP available to at risk people, reduce unplanned pregnancies and support parenting.

As in other service areas bureaucratic procurement rules, which excludes from the process anybody actually working in the field, has caused serious disruption. It is ridiculous that cervical smears cannot be carried out during a sexual health consultation because of artificial divisions in the commissioning process. HPV vaccination should be provided to males as well as females aiming to achieve a high uptake. We need a new sexual health strategy with a return to planning and collaboration rather than tendering of services.

**6. Breastfeeding**

**Welcoming Climate** – It is unacceptable that women are prevented from protecting their baby’s health by fear of social disapproval. There should be a legal right to breastfeed and local women can “Be a star”, alongside celebrity figures, prepared to act as role models. Notices saying “Breastfeeding Welcome Here” should be displayed in all public buildings. UNICEF Baby Friendly status should be pursued by all relevant public bodies.

**7. Gambling**

Whilst gambling gives excitement and hence pleasure to many, and whilst it contributes to raising funds for charities, gambling addiction is a serious public health problem and there is a need to develop appropriate regulation and support services to restrict the advertising links to sport, sponsorship and social media presence.

**Top 10 Priorities for Promoting People’s Health and Wellbeing**

1. Commercial interests should be challenged in framing our expectations and lifestyle choices. Society must ensure that the health message is heard equally loudly by for example an ‘Avoidable Food Tax’. This proposed 20% tax on the turnover of companies producing or trading in food which would be ‘avoidable’ by companies which deal only in healthy food, which do not market unhealthy products, or which achieve targets for effectively marketing healthier eating patterns.

2. The sugar tax should be strengthened so it covers sugary soda drinks and beverages to reduce the simple sugar daily intake that is found in cold fruit or sparkling soft drinks and hot beverages. Healthy alternatives should be promoted so they are attractive and cheaper.

3. The cuts in public health spending should be reversed to restore high quality sexual health services, smoking cessation services and drug and alcohol services.

4. We need new sexual health strategies with a return to planning and collaboration rather than tendering of services that occurs in England. Cervical smears should be available during a sexual health consultation, HPV vaccination should be provided to males as well as females and PrEP should be available for at risk people.

5. We support a minimum unit price for alcohol. Health should be a licensing objective and conditions should be attached to support responsible drinking including its availability in supermarkets and corner shops.

6. There should be drug and alcohol workers in all A& E departments to work with attendees and who also liaise with licensees and partners such as ambulance services and the police to feedback to licensees.

7. We support healthy living centres, which combine active leisure facilities, facilities for community activities and primary care services to include amenities for the ageing population.

8. The majority of smokers wish to give up. Creating smoke free places supports them in tackling their addiction. It is also key to supporting smokers to give up and creating norms which encourage them to do so.

9. Vaping should be available as a form of nicotine replacement therapy (NRT) to support smoking cessation but it should not be allowed to develop as a new widespread lifestyle ‘e-cigarette’ choice since, although it is much safer than smoking, it is a source of nicotine and it is therefore addictive. Big Tobacco companies are well aware of this and invest in these products to attract new young smokers.

10. There should be a legal right to breastfeed. Notices saying “Breastfeeding Welcome Here” should be displayed in all public buildings and provision identified in workplaces.

**SHA Prevention and public health policies**

**Section 4: Protecting people’s health**

**The Why?**

Protecting health is concerned with assuring the safety and quality of water, foods, air and the general environment as well as preventing the transmission of communicable diseases. We know that the enjoyment of clean air, green spaces, quality housing and safe workplaces is not distributed fairly across our society. A socialist approach sees the need to safeguard these basic requirements for life as being within the remit of governments whether international, national, regional or local.

To deliver these safeguards there needs to be a health protection workforce and statutory organisations able to continually monitor the environmental risks, regulate and respond to health emergencies such as infectious disease outbreaks and chemical, poisons and radiation emergencies. Such organisations need to have the knowledge and skills to communicate risk effectively to organisations and the public and advocate for changes in legislation/regulation when required. They need to provide independent public health advice to governments, including international regulators.

Effective health protection means providing leadership and working in partnership across organisations, both statutory and third sector, using statutory regulations when required but also fostering innovation and research into new knowledge and public information. Planning for emergencies is a crucial part of the remit and an ability to work through statutory organisations (Central and Devolved Govt., LAs and the NHS) to ensure preparedness. There are different settings where health protection organisations will help set standards and recommend regulations and legislation with methods of monitoring and enforcement.

**Water** - ensuring standards are set and maintained ensuring the provision of pure drinking water to the population without financial barriers. LAs and other Public Bodies should provide drinking water fountains and bottle filling taps. Hygiene also requires the provision of safe and effective sanitary and waste systems that do not pollute the environment. Potable tap water should be required to contain fluoride, a naturally occuring mineral, at recommended levels which are monitored to ensure that supplies remain within safe minimum and maximum limits. Public toilets are an important amenity and minimum provision needs to be defined and enforced. Sewerage needs to be treated effectively, including used as biomass and discharged safely into the environment.

**Food** - The agricultural sector also needs effective regulation to ensure that healthy foods are provided from ‘farm to fork’ without environmental damage and unsafe use of chemicals and antibiotics. In the USA it was reported by the Food and Drug Administration (FDA) that 80% of the antibiotic sales (amounting to 13.5m kgs in 2011) were sold to the agriculture sector. Rivers are found to contain high levels of antibiotics enough to increase the risk of developing biological anti-microbial resistance.

Fisheries need to be monitored internationally to ensure stocks are not depleted as well as monitoring poisonous contamination such as mercury levels and pathogens in seafood. There should be international agreements to stop pollution and commercial fishing in key UN declared ‘blue zones’ in the seas and oceans.

The food industry is increasingly complex and agencies such as the Food Standards Agency (FSA) need their remit extended and powers improved to take on the anti-health forces such as the fast food and sugary drinks manufacturers and distributors.

Health protection measures should also include safe salt levels, sugar and fat content. These need to be clearly traffic lighted according to international agreements on recommended daily doses/portion sizes. Food regulations need to be set at international as well as national levels and should ensure safe quality foods are provided to the population.

**Air quality** - The clean air acts need to be constantly monitored and improved with greater enforcement for the PM2.5, PM10 particulates and nitrous oxide (NOX) levels. Motor vehicles contribute the majority of the air pollution in urban areas and policies should give priority to pedestrianisation, bicycles, public environmentally friendly bus/train vehicles and electric cars. Burning coal and natural gas should be phased out as soon as possible for their polluting effects as well as releasing carbon dioxide into the atmosphere. We should meet the EU air quality standards and monitor the reduction from the estimated 40-80,000 premature deaths per year in the UK from air pollution. People and especially children who live in the relatively deprived areas of cities need to be protected from air pollution in their communities, homes and schools.

Tobacco smokefree air should be ensured in all enclosed public spaces, in cars with child passengers and in rooms that children use in the home. This is justified as part of child protection measures.

**Housing** - The home is where preschool children and older or disabled people spend a high proportion of their time and housing standards should be strengthened to protect health by ensuring adequate ventilation, insulation, central heating, space and cooking/bathroom facilities. Revisiting housing/home standards and setting/housing regulation/inspection regimes is recommended to fit the modern world. Residential areas should have easy pedestrian/cycling access to green spaces.

In view of the Grenfell fire we also expect Fire Regulations and building regulations to be tightened to prevent a recurrence and ensure remediation of at risk buildings. This requires independent building/fire inspections to enforce compliance against independent professionally recommended standards for materials and building.

**Workplaces** - Working age people spend a high proportion of their week travelling to work as well as within a working environment. All workplaces need to consider how their staff and customers/users travel to work eg school buses/park and ride schemes for city centres.

We believe that all workplaces should ensure their workers have access to occupational health services (OHS) - to include prevention (manufacturing machines as well as desk ergonomics) as well as responsive to occupational health needs in particular stress, mental ill health and alcohol dependency. There needs to be a NHS led occupational health service which supports government in terms of setting standards for occupational health and provides services directly to small and medium sized employers funded by an employer levy. Larger organisations may provide their own OHS, unless they choose to subscribe to the NHS led service, but this will be subject to independent inspection and regulation. We should stop people having to attend GPs just to get a ‘sick note’.

**Injury prevention** - Injury prevention is an important part of protecting health and can be divided into - road/transport safety, environmental safety, homes and workplaces. We recommend strengthening the safety requirements and enforcement for motorised vehicles such as lowering the drink drive alcohol levels with escalating penalties from 20mg blood alcohol levels. Increasing the penalties for seat belt misuse, using hand held mobile phones, speeding and MOT/Insurance crimes and improving enforcement. Urban residential streets should have a default 20 mph speed limit with school zones particularly well signposted and closely camera monitored and housing areas also designed to reduce speeding/improve pedestrian visibility.

Homes are where the majority of injuries and falls occur in young and older people. Safety regimes need to be in place and observed by all workers accessing homes whether for fire safety checks, gas safety checks, or direct care provision. Information for families and carers should be easy to understand and local community based one stop shops provided for direct access, telephone or internet connection.

**Health services** - Protecting health regulations should apply to NHS organisations as important employers and providers of public services. This means that occupational health standards apply as well as links to health protection services and adherence to policy recommendations such as antibiotic prescribing to reduce the risk of antimicrobial resistance (AMR). Clinical safety of equipment and medical products, pharmaceuticals/medical gases/surgical instruments/blood products, all need to be part of the package of standards.

**Health Protection agencies** - There need to be statutory agencies, with the powers to regulate and enforce, that work in partnership with the NHS and LAs. Specific areas such as Drinking Water and Food Standards need to be covered and work alongside the industry such as the water, agricultural and food sectors. These organisations need the capacity to research and keep up to date as well as the ability to respond to new threats and emergencies such as radiation incidents and chemical poisoning.

**Top Priorities for protecting people’s health and wellbeing**

**1.Water**: **Ensure that there is national oversight of water and waste disposal providers which ensures that the public interest is upheld on natural resources and their stewardship.**

1.1 Regain national strategic control over water resources and bring water utility companies under public ownership.

1.2 The drinking water inspectorates powers should be strengthened and the requirement on water providers to test and monitor the piped water should be maintained.

1.3 There should be a maximum and minimum level of fluoride in all piped drinking water.

1.4 Wastage of water should be reduced from the unacceptable 30% level with targets set and monitored by independent regulators.

1.5 Public toilets should be provided as an important amenity.

1.6 Strict controls over sewerage disposal to prevent pollution of rivers and seaside resorts and promote sustainable methods of treatment and reclaiming water.

2.**Food**: **There needs to be tighter standards and monitoring of intensive farming with controls over the use of chemicals (including antibiotics) and standards for animal husbandry.**

2.1 The farm to fork pathway needs to be mapped out with monitoring and controls at key points.

2.2 Locally accessed food should be encouraged and food miles monitored and reduced.

2.3 Food that is retailed as processed food or in a packaged way should have clear labelling using internationally agreed traffic light and Recommended Daily Intake (RDI) data provided.

2.4 Foods High in saturated Fat, Salt and free Sugars (HFSS) should be flagged in easy to understand labelling.

2.5 Fast food products need monitoring and their HFSS content publicised.

2.6 Taxation of unhealthy foods and relieving natural products such as fruit and vegetables of taxes should be designed to make healthy foods cheaper.

2.7 There should be planning restrictions on Fast Food and sugary drink/confectionery outlets near schools and controls over advertising in the digital and social media environment.

2.8 The sugar tax needs to be tightened especially in the soda drink sector and hot beverages market.

2.9 All public sector sites (NHS/LA/Universities/Government) bodies should ban unhealthy vending machines and specify menu/products for outlets on their sites.

3.**Air quality**: **All citizens need to have access to clean air at home, in their community and at work.**

3.1 The EU standards on PM25, PM10 and NOX levels need to be enforced.

3.2 Transport policies need to move toward banning diesel cars/lorries and prioritising walking/cycling and public transport options that do not use hydrocarbon fuels. Support Ultra low emission zones (ULEZ) in cities and electric vehicles.

3.3 Cars should be smoke free if there are children present as should living areas in the home where children can be exposed to environmental smoke. Child protection and safeguarding responsibilities do not cease inside the front door.

3.4 Strict air regulations need to apply to industrial polluters and there needs to be a restrictions on industrial pollution applying the polluter pays principle.

4.**Housing**: **All renovations and new housing should meet environmental standards for energy efficiency with good insulation, non carbon heating and effective ventilation.**

4.1 The internal space standards should be met to ensure clarity on occupancy and provide adequate living space.

4.2 Heating should move from carbon fuels and insulation standards raised.

4.3 Private landlords need more regulation and oversight to ensure compliance with safety standards and prevent overcrowding.

4.4 Housing developments need access to green spaces and public amenities.

4.5 Existing and new housing should be disability friendly and we should aim for intergenerational age friendly cities and towns

5.**Workplaces**: **Workers should be protected from hazards at work whether from machinery, air, chemical or radiation hazards.**

5.1 The HSE and workplace inspectors powers need to be strengthened with appropriate legal enforcement options and tougher penalties for repeat offenders.

5.2 Best ergometric assessments of the workplace needs to be applied including desk based workers using computer or telephonic communications.

5.3 All large employers need a sustainable travel to work, flexible and home working plans.

6.**Injury prevention**: **Spatial planning needs to have regard for minimising risks from falls, vehicular crashes and other hazards.**

6.1 Within the home - staff who routinely visit families with children under 5, older and disabled people need training on identifying risks and empowered to refer people to agencies who can intervene whether fire, household risks or health and social care providers.

6.2 Speed controls on the roads needs better enforcement with maximum speed limits for lorries and checking tachometers.

7.**NHS and Social Care: Health and social care staff need to be trained consistently on assessing health risks and empowered to advise and intervene to protect their patients/clients wellbeing.**

8.**Health Protection statutory powers and agencies (including the third sector)**. **There has been a neoliberal trend away from requiring independent inspectorates with powers to enforce compliance with H&S, building and environmental standards.**

8.1 Labour should take a position on reviewing these powers to enforce standards and so contribute to making the homes, communities and workplaces safer environments for people and safer household appliances that meet trading standards.

8.2 The specialist public health providers such as PH England (PHE) and PH Wales (PHW) and the equivalents across the UK need to be strengthened to ensure that population health data and trends are monitored and that preparedness for communicable disease, chemical and radiation emergencies are enhanced.

SHA **Prevention and Public Health Priorities**

**Section 5: Prevention in Health and Social Care.**

**WHY IS THIS A SOCIALIST ISSUE?**

Socialism is about social justice and leaving no one behind. This holds most strongly for those public goods that are most vulnerable to market failure: namely social security, healthcare and social care. No one should face financial ruin because of payments for health care or social care. The public has remained loyal to the principle of healthcare being available to everyone in need regardless of the ability to pay. Social care too should be based on need and free at the point of use, in the same way as health care.

Privatisation of healthcare will cause more market failures, as is already demonstrated by social care. It will lead to less investment in prevention and will be led by the profit motive rather than the needs of the population or evidence on what would provide maximum benefit. When provision fails or it becomes less profitable - it will be handed back to the State.

**WHAT IS A SOCIALIST APPROACH?**

A socialist approach sees universal health and social care as an essential part of society. Such health and care systems should be funded by all according to a progressive taxation system and are readily accessible, meet people’s needs and are free at the point of use.

A health care system covers a spectrum from prevention, diagnosis, treatment, management and care to end of life care. All are important but evidence based prevention is the most cost effective approach, and usually has greatest benefit for the poorest and most vulnerable. We know that health services account for about 10-20% of health outcomes, so the NHS has a vital public health role. The NHS is currently spending less than 5% of its budget on prevention, in spite of strong evidence for many preventive over treatment interventions.

Social care should also prioritise prevention and early intervention, especially for children, disable people and for helping older people maintain their independence. A socialist approach recognises that the health and care system also has a role in mitigating the adverse impact on people of policies in other areas such as food, housing, transport, income and unemployment.

**Policy Areas**

**1.Research, evidence and innovation**

Current health research is heavily dominated by the private and charitable sector, in particular the global pharmaceutical companies. There is insufficient research into how healthcare systems can improve health outcomes by prevention, in particular who benefits and who pays the cost. Research into social care policy and practice is even less well resourced.

Research priorities should be in public strategic control and address the questions that would enable evidence to support better health and social care policy improving outcomes for all and reduce inequities. Innovation and new developments should be implemented with an equity lens at all times, in particular the digital policies which have the potential to widen inequities and exclude many. Specific health care priorities such as the need to develop new antibiotics/reduce microbial drug resistance and develop vaccinations and preventive measures for many rare conditions and so called ‘tropical diseases’. We recommend creating a National Institute for Preventive Health and Wellbeing to advocate academic research, provide funding for development in these fields.

**2. Co-production**

Co-production is the shared process where professionals work with NHS users and carers. This applies at a macro level, planning local and national NHS services in collaboration with citizens and users; it also applies at an individual level in the consultation between patient and clinician where shared decision-making takes place. The community can, with help, identify key issues that matter to them and work with the statutory sector to address those issues – evidence shows that this process protects health. Community development is one key mechanism as is the use of citizen’s juries.

1. **Screening programs**

Programs that fit with the criteria for screening, such as the original criteria (Wilson&Junger 1968) and more recent modifications in the light of genomics and informed consent, should be continued and implemented in a way that ensures equity of access and benefit for all. New programs should be evidence-based and not rolled out until the clinical and cost benefit can be demonstrated and the program approved by the National Screening Committee.

1. **Vaccination programs**

Vaccination programs are among the most effective and cheapest prevention interventions. The childhood vaccination program in particular has prevented huge numbers of early deaths, disability and hospital admissions. There should be investment in much better public health messaging to counter the very dangerous global anti-vaccination campaigns such as we witnessed against the Whooping Cough vaccine in the 1970s and more recently the MMR vaccine and its links with purveyors of ‘fake news’. Travel immunisation plays an important role too as well as adult population programs for pneumococcal and shingles prevention in the older population.

1. **Reducing inequities in health outcomes**

**Resource allocation**: The overall % of funding for health should be a strategic investment of at least 10% GDP nationally with needs based formulae for regional and local allocations.

Funding to services for disadvantaged communities and groups should be allocated according to need. Budgets to Local Authorities and NHS organisations should take much greater account of need.  Services should also be matched to need with higher staffing levels for GPs and primary/community care teams in areas of deprivation as needs and workload are significantly higher. Pay rates and allowances should reflect this including serving rural and isolated communities.

**Proportionate universalism**: All prevention activity in health and social care should be carefully planned to avoid widening inequities in health. There is usually a ‘slope’ from minimal resource requirement to considerable investment in resources to achieve the same outcome. Examples are the NHS Health Check program, breastfeeding initiatives, and screening programs. All have found with few exceptions that the wealthiest will respond to a simple invitation while the least affluent require greater investment and different approaches to gain the same uptake and benefit.

1. **Alcohol and tobacco**

Alcohol, tobacco and other drug policies need to be addressed nationally through taxation, regulation and education. Within the NHS clinicians should make every contact count (MECC).There is good evidence that helping people identify when they are ready to stop/reduce smoking or drinking to excess works especially at a critical time such as an A&E attendance or frequent GP visits. With an estimated 300m patient contacts per year with GPs, 100m Out Patient attendances and 23m A&E attendances every health and social care worker can apply MECC and should be empowered and trained to do so.

Programs that help people who wish to change their behaviours should be evidence based and accessible and of high quality. Drug and Alcohol support workers should be in every emergency department to reach in and pull people into these services.

**7. NHS/Social care as employer**

NHS and Social Care services are the biggest employers in the UK. Good work, done with a sense of pride, is very important for the mental and physical health of individuals and for the wellbeing of their families and communities. Financially insecure work (e.g. zero hours contracts) and bad working conditions are damaging.

Social care services are run or commissioned by Local Authorities and have a degree of democratic accountability, which should be extended to local NHS services. They are struggling though through lack of sustained investment and much provision is provided by for profit organisations many of who were attracted to the market by property assets rather than a mission for service provision.

Within the NHS and Social Care sector we should ensure a minimum living wage for all employees directly employed and in commissioned services. Roll out maximum pay ratios of less than 20:1 in NHS and LAs, and in companies bidding for public contracts. Address the gender pay gap where women are systematically disadvantaged. Match social care workers pay with equivalent in NHS pay and place a greater value on caring.

Ensuring access to training and good jobs/ careers at all levels with positive discrimination for groups currently less represented, actively promoting social mobility: for example increasing the medical school intake to have more doctors from social classes 3-5 families and from the local medical school area, actively supporting people from disadvantaged groups in local communities into employment (young people not in education or employment, people with disabilities, ex-offenders).

Encourage and facilitate Trade Union membership and engage in collective bargaining. Volunteers should be used appropriately and not in place of skilled workers. All employers should be required to meet minimum standards (e.g. Welsh Corporate Health Standard), and to provide services for staff wellbeing. Employers should allow paid time and provide suitable facilities for physical activity, healthy eating and social interaction.  They should also protect the health of employees from occupational hazards, including sleep deprivation, and excess sedentary work. It should be the responsibility of the NHS to provide a national service with local generalist and more specialist regional resources, for all employees in the NHS and social care.

Ensure all employees have an understanding of their role in prevention and are putting this into practice this in their day jobs. Significantly increase the capacity and capability of the specialist public health workforce, across health and local government. Local authorities, NHS organisations and government departments need access to specialist public health advice with Director level leadership such as Directors of Public Health and Chief Medical Officer posts. These leaders should actively advocate for prevention and health promotion in any systems approaches with partners. NHS agencies and providers will ensure that every locality has a thriving third sector largely funded by grants rather than contracts.

The NHS and social care employers will adhere to ethical recruitment policies and develop a mechanism to repay the health and care services of low income countries where a significant number of their citizens are working in the UK. Punitive charges for visas for skilled workers and contributions to the cost of NHS services for their families should be waived.

NHS and social care premises and sites are community assets and should promote healthy transport, green spaces and public amenities. Their carbon footprints need to be recorded with targets to move towards agreed NHS sustainability standards. Smoke free sites should be mandatory making all health and social care premises smoke-free (excluding those which are people’s homes)

Ethical standards (Fair Trade, use local suppliers, healthy food, ensure suppliers have good employment practices) should be applied to procurement. NHS organisations will be expected to take an active part in neighbourhood partnerships and to encourage users and carers groups to do so. Health agencies will play an active part in deploying community development to improve health protection through community empowerment, help tackle health inequalities and encourage responsive statutory agencies

1. **Giving every child the best start in life**

Prevention is most effective the earlier it is done, in the course of a potential disease and in the course of a life. Marmot's first recommendation from his “Healthy Lives” report was ***to give every child the best start in life*.** This is the best way to close the gap in health outcomes between the richest and poorest in society in a generation. The evidence from the research into Adverse Childhood Experiences (ACE) shows too that early experiences are cumulative and can have lifelong impacts. Poverty is a root cause of inequalities in life chances and we should commit to abolish child poverty which is an achievable goal that had been on target to achieve by 2020 prior to the Coalition Governments austerity policies.

**Pre pregnancy**: Invest in services that help prevent unplanned pregnancies, ensure contraception and sexual health clinics are easily accessible to reduce the risk of sexually transmitted diseases and unwanted pregnancy, every school must have a named school nurse and a school counsellor, for which more funding will be required

**Healthy pregnancies**: More investment in the training and employment of midwives and health visitors to ensure that sufficient support from midwives and health visitors is available for women and babies, especiallysolo parents and young mothers, invest in services that help women stop smoking and drinking alcohol before, during and after pregnancy, invest in perinatal mental health services

**Supporting parenting**:Reinvest in and reopen Sure Start/Flying Start centres and ensure close working with NHS and social care services, and in particular in parenting classes and programs, invest in breastfeeding support across all NHS settings

**Vulnerable families and Looked After Children**: Develop a strategy for the wholesale improvement of the care system that delivers for all, not just those children being considered for adoption. Promote the care and educational achievement of our most vulnerable children and increase support for children in kinship and foster care, and their families. Prevent the private sector and subsidiaries of private companies from running child protection services, ensure every child has equitable access to a regular GP and health services that meet their needs.

**10. Mental wellbeing and mental health**

There should be parity of esteem and funding with physical health for mental health promotion and prevention of mental illness. This has been an unacceptability long time coming over the 70 years of the NHS.

Early intervention for children and young people should be the goal. It is estimated that half of people with mental health problems as adults present with symptoms by the age of 14 years. There should be investment into early intervention by increasing the proportion of mental health budgets spent on support for children and young people. Ensure that access to a counselling service is available for all children in secondary schools.

Children’s mental health services need to be improved and made adequate for the speedy identification and treatment of mental disorders in children in the least stigmatising way.

**11. Primary and community care**

Local health services should be place based, integrated, community oriented and accountable to the local people, with a 30-50,000 population in urban areas. Neighbourhood approaches should drive all decision-making, with a greater investment in population health skills.

Resource across the NHS should be allocated according to need with a review of the formulas for doing this across countries and in the GMS contract, to mitigate the impact of deprivation.

NHS resources (money, people and estate) should be strategically shifted to primary care with an expansion in the wider primary care team. This should lead the model of NHS owned premises and salaried GPs and other ‘independent contractor’ staff. Primary and community care services should integrate with social care at provider and commissioner levels.

**TOP 10 PRIORITIES for PREVENTION in HEALTH AND SOCIAL CARE SERVICES**

1. Give every child the best start in life: through enabling more pregnancies to be wanted and healthy, and every child to receive the health and social care support  they could benefit from in their first 1000 days.

2. Strategically increase investment in community oriented primary care: because of its underpinning value as a community asset that demonstrably delivers health gains and its role in delivering many specific PH interventions.

3. Invest in the public health workforce, with the priority on countering the commercial determinants of disease and mitigating the impacts of climate change, and implement the ‘Doctors in Unite’ proposals for public health in primary care

4. Develop and implement a long-term plan for how the NHS and social care can help reduce health inequities.

5. Take a public health evidence-based approach to alcohol, drug and violence reduction and (vaccination/smoking/ /sexual health/screening),

6. Invest in supporting mental wellbeing and resilience, prioritising children and young people, those with a mental illness and NHS/social care staff.

7. Health and Social Care staff to be paid fairly, and trained properly, and unionised, whether in public, private or voluntary sector and use socially responsible recruitment to benefit local communities

8. Ensure that society and the health and care system respects healthy ageing, with an age friendly environment, leisure facilities and frailty aware health and care services.

9. Public research and development investment should be under government’s strategic oversight and with controls to address the questions that would enable evidence to support better health and social care policy, improving outcomes for all and reduce inequities.

10. The health and social care system should be co- produced with patients and the public, investing in public engagement for example though the use of small grants to small community organisations and front-line teams

1. Substantial reductions in the proportions of the population receiving, after tax and benefits and adjustment for dependents, less than two thirds of median income or more than eight times median income. The aim should be that the first figure should reduce to zero and the second figure should reduce to zero except for highly successful entrepreneurs. [↑](#footnote-ref-1)