The economic case for embedding prevention in everything the NHS does

Future NHS Stage

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Duncan:

Welcome, everybody. We are going to start with a bit of context. You have heard from Andy Burnham, so I might talk a little bit more about the context and what we mean by health and the opportunities for prevention and then David is going to go a bit more deeply about wider determinants and Matthew will bring us right back to the NHS and where the opportunities are. We will also try and create enough time for questions.

So, people will see the Times headline today about Britain being the sick man of Europe, did people see that? What I want to say to you is that that's just not the case. I want to begin by talking about the improvements over the last 20 to 30 years in the health of the people, particularly for men actually and they've been living longer than they've ever lived before. The issue is about a flattening or a slowing down of the rate of length of life, so people are still living longer but the rate of improvement is slowing down. Now, there's various speculative reasons for that but I'm more concerned about people that are living but living in poor health, if you like, so that the measure that we're getting increasingly familiar with about the length of life is even more important of a measure that whether you live longer in good health.

The difference in life expectancy between the affluent and the poor in this country is about ten years, that's how long people live. But the difference between life in good health and poor health doubles so that the difference in good health and poor health of people living in Bradford and Guildford is about 20 years. Typically, people aged over 60 will have two more chronic conditions and a quarter of people will have three or more. Yet, we know that people are going to be staying in work for longer with the ageing population and the retirement age.

Who thinks that they're middle-aged? You've hardly begun! You know, we are going to be working for longer and the key message is about how do we help people to stay well for longer and how do we help people to stay in work in good health for longer? How do we pay attention with more success than we've had about the variation that goes around the country? I don't want this to be a moment for pessimism because when we look at health overall, people are living a healthier life today than they ever did.

It is just that the rate of life expectancy is flattening and we've got a bigger problem which is the life in poor health that many of our people are experiencing. We have the lowest ever prevalence rate for smoking which is terrific, but it still accounts for half the difference between people that enjoy good and poor health. So, half of the health gap is still about tobacco.

We have alcohol admissions into hospital continuing to increase and liver cancer is the only cancer going in the right direction. On the other hand, we have a fabulous improvement in cardiovascular disease outcomes and lots to be proud of there, but we still have in England alone at least six million people living with cardiovascular disease that is in the main, amenable to prevention and there are things we can do about this.

So, to give a sense, I work in Waterloo, Lower Marsh, around the south of the

river and there is a big organisation in Lower Marsh, it's like Christian Aid and it's got a big sign outside saying, “We believe in life before death.”
Can we be less focussed on the illness and how we can prevent it? What can we do to intervene before people become unwell? Finally, when we talk about health, it's a conversation I have, do we think that the NHS is there, or if you like the leadership, that is us, of the NHS is there to run a highly efficient and productive, outcomes-focussed healthcare system, so that is a very reasonable belief, or is it to improve the health of the people?

They are not quite the same things, there is a relationship between the health service and good health and, Dave particularly will pick up on that, but it's still quite marginal about length of life and life in good health and the most important thing that you can offer people to improve their health is to have a decent income. We often talk about the north and the south and urban and rural, but the principle relationship is between income and outcome, wherever you happen to live. It's about deprivation. It's not about how good we are in the NHS as the principal determinant of how well people are living and how long they are living in good health, it's a contributor, but more important is income.

To have a home where you feel safe, where you can afford to turn on the heating, where you are not afraid to go outside and the importance of being connected in life, so life which has friendship in it, life that has relationships in it.

People are familiar with the leader of Newcastle for those who have heard me say this, talk about the importance of love and I said steady on! So, I am from north of the border and that is not really what we do. Well, I say I love everyone, but there is no touching, what we settled on was the importance of affection.

The point I am trying to get across is we often talk in the health service about

isolation in the elderly but it's about isolation throughout life and it's not about being soft or asking everyone to hold hands and fall in love with each other, this is a really important determinant of good health, so in some, there are three factors that affect good health and prevention can run through all of this.

There is the health service and what it, itself can do and there is massive opportunity with the Health Service itself can make a difference, cardiovascular disease and focus on hypertension. Less than 10 of them has a conversation with a doctor or a nurse or any healthcare professional about why that might not be a good idea. There are many opportunities for the NHS itself to make a difference, but the bigger contribution is about the behaviours that people exhibit about whether they smoke, drink, eat, whether they ever exercise and those are choices that everyone has got, but they are wider, depending on how wealthy you are, or how poor you are, but the single most important determinant in improving the health gap is to have a job. Did you know that having a job is good for your health? Yeah?

So, I travel by Southern Rail. I was in Oldham last week, I think Northern Rail were on strike. But having a reason to get up in the day, enough money to live on, something meaningful to do, someone to care for and about are the really important determinants of health. That is the context, there is a bit of humility that the NHS is a huge contributor, big employer, a lot it's contributing and there is a lot more it can do but the humility is about the wider system and remembering that we are part of the solution, we can't, of ourselves, make the biggest difference.

David:

I am going to follow up a little bit around partnership. For those who don't know me I life our forum at the King's Fund. My work is between partnerships and the NHS and people and communities themselves. To follow on from what Duncan said we know from the statistics and it depends what person you use, what method you use, but roughly 10-20% of our health can be

traced back, determined by something like the National Health Service, a publicly funded healthcare system.

The first thing is to say that is fantastic, that is amazing and that there is a lot more we can do around narrowing variation and equality in the NHS. Matthew is going to talk about that. That is a massive contribution; however an even more massive contribution is the role of partners with you and with you. I say that partly because Bev Taylor waved at me in the audience. Secondly, Duncan mentioned around social prescribing and that is about the relationship between the partnership of primary and the voluntary and local sector is starting to develop. It's always been there, it's always happened, it now has a big push from NHS England, and there is a fund from this on the NHS website how you can look at social prescribing examples.

But the particular work that I have been involved in, in the last three or four years and there is something coming out soon on primary care is volunteering. So, it astonished me when we did a piece of work in the Department of Health around the future of volunteering, we didn't have much statistics.

We didn't know how much volunteering went on around the NHS so we did our own survey, particularly of acute trusts around the time of the Olympics. If you remember from the Olympics, one of the big stories of that were the games makers. So, what we discovered there is at least that amount of volunteering going on which was not celebrated at that time.

We also have subsequent work, 1.6 million people volunteer in some formal way with the NHS, offering formal regular hours which is astonishing, but even more astonishing thing is six or seven million people said they would love to volunteer in the NHS to give time back, but they are ill, they are not able to do because of their illness. So, one of the challenges and opportunities for the NHS and for you is how do you work with people who are ill who want to give

time back? How do you make it easier for them to support you in your roles? So, I will leave you with that thought.

I could go through a long list and I will do of partners for the NHS, the work we have done. You will be glad to know I won't go into great detail of that work but it struck me how powerful local authorities are and how important they are as partners, particularly across the wider determinant of health, but specifically district councils.

Who knows what district councils do? Nobody, no one is speaking. Yes. All sorts of things - absolutely right. So, they cover about 60% of the area of England and about 40% of the population. You are absolutely right. They are responsible for things like green space, for economic development, for homelessness, supporting homelessness.

A lot of work engaging with communities and coming back to the communities' issue. So, you have partners out there that actually many people in the NHS currently around engaging with. They do things like environmental health protection, keep the rats away from the doors, literally. We are astonished about how important those partnerships can be as well as with county councils and upper tier authorities. We have also done some work on housing and health, particularly with Housing Associations.

Housing Associations are doing some marvellous things in partnership with the NHS, I won't go into detail, but there is astonishing and actuality and potential to do more between the NHS and Housing Associations. There is more through the STP process and as that goes forward in housing in particular, there are some great examples in housing. So, they are not that many. There is a challenge for you, be they Housing Associations or Housing Authorities.

But I want to move on to the NHS as a wider determinant of health itself. One

of the criticisms of the public health community is we tend to get stuck into various boxes. We either have the wider determinants of health here, we have lifestyles here and to some extent we have the contribution of services over here. We all know as people, not necessarily as experts, but as people, that those three things all interconnect and I am really keen to strengthen both the recognition of the role of the NHS as a wider determinant of health itself in all of your communities.

If the NHS wasn't here, as an experiment, if we had to purchase the NHS ourselves, income inequalities which are the widest which we know is bad for our health would be 15% wider than they are. The NHS by virtue of its existence doesn't matter whether it's producing TVs or treatments are a massive determinant of health in our communities. I don't think we recognise that enough, you don't, I am sure some of you do, but the NHS doesn't recognise it in the power it has in communities. Every pound spent on treatment the same pound could do something for prevention and does and the same could do something for the wider determinants of health.

There are fantastic examples across the NHS where that is happening, in terms of bringing in people from more deprived populations as apprentices, etc. A lot of examples, but as a whole I think the NHS needs to be a new and you need to be both understand your contribution to wider determinants of health, celebrate it, shout about it, talk to your partners about it in your local economies, getting back to Duncan's point about having a good job and frankly to be challenged a bit more on this.

We know from work from the Joseph Rowntree Foundation and the Centre of Health Economics that about 20%, the excess cost to the NHS to the budget of poverty is about 20% of the current budget. £25 billion. That is huge. But actually, the NHS is part of the solution as well as actually having to mop up the consequences of that, I think. So, the poorer parts of the country you are in, the bigger proportion, as an economic entity the NHS is.

That is a massive opportunity, so I guess I would leave you to say, maybe if one thing you thought about before going away after hearing me today is think about what is the opportunity in your community, in your role to maximise your economic impact in your local place, because that will improve health through the wider determinants of health. Thanks very much.

David:

We know that there is overuse and underuse in every single local health economy in England. We know that overuse is wasteful and that underuse leads to health inequalities and health inequalities which leads to overuse, which leads to more waste. So, the cycle continues. An example of variation is that you're twice more likely to successfully quit smoking if you're helped by the NHS in Northumberland than you are in East Lincolnshire.
The demographics and similar so the question is can that possibly be warranted variation? We also know that the manifestation of unwarranted variation in the system is too much activity in secondary care and not enough in primary and secondary prevention. Other things we know include that better detection and prevention of, for instance, atrial fibrillation would lead to 5,000 less strokes over five years and that would save £191 million in health and social care spend.

If everyone achieved the percentile performance amongst their demographic peers; that would save £59 million in emergency admissions alone.

That delivered 210 less deaths from stroke and MI from the first year of implementation. Avoiding those deaths solved more than 1.6 million in the medium term. By doing things like this in local economies and spreading that across the country and by working together to reallocate resources from overuse to underuse, we can all do this.

Duncan:

Public Health England has shared with STP leaders and quite widely the evidence, it's all NICE approved. Here are six things that if you were to get locally you could improve outcomes, increase demands and save money. They are actually very simple things.

I gave one example about smokers in hospital. This is not so much about asking people to not smoke outside a hospital, but it's more acceptable to smoke outside a hospital than a pub and it's something we should be bothered about that. What I am really bothered about are the one in four people in a hospital bed that no one is having a conversation with which costs nothing, but refer them to a stop smoking service. If you combine the most effective way of quitting which is accessing a stop smoking service with the most popular which is to use an e-cigarette than you can increase your chances of never smoking again six-fold, it's like staring us in the face and there is half a million admissions every year because of tobacco-related illness and for every person who dies early another 20 are ill.

Then there is two in alcohol, one that is in primary care about assessing people, getting them into some form of support and then there is support when you are in hospital, so when I was responsible for Brighton and Sussex University Hospitals we had hundreds of people who came in in an evening, paralytic, they were paralytic before they went out and whatever the worse is when they came in.

Our job as a hospital was to rehydrate them. The thing that bothered me the most was the ones that said they might have had a fall and we had to wait until the morning so we could x-ray their neck.

I never had a conversation about why, today, I take a -- and then there is action that could be taken on blood pressure, hypertension, the silent killer.

It's such an amazing opportunity, if we could increase the number of people

that we know have hypertension and did something about it, a statin or something like that, we could absolutely knock thousands of admissions out for stroke and heart attacks.

Remember when the NHS used to be surprised by winter? John Reid said to me, when he first started as Health Secretary, that I was the chief botherer of the NHS; I said do you mean the NHS is surprised by winter.

But today half of heart attacks or strokes come by surprise because we don't know a simple thing like what is our blood pressure. Matthew or Dave might have been talking about frail elderly and avoiding falls or long-acting contraception. That there are half a dozen measures, they are all easy to do, the point is not everyone does them and there is a whole lot of reasons for that, not least how busy everyone is and about how do you prioritise this sort of thing, but we don't have to be looking for the, you know the next, we don't have to be searching for an answer, it's right in front, right in front of us.

We were seeking to put it into a bit of context. This is about the NHS. We're a huge supporter of what Matthew is doing in RightCare and getting the evidence out to people, not hectoring but just saying here's how you're doing, here's how others are doing. There may be something in there for you to learn from.

Duncan:

It is a big question about housing and the ageing population and how we could help people stay in their own homes for longer and not have to go into statutory care. I think also the biggest shift in the last 20 years in housing and improvements in housing has been in social care housing and local government and housing associations but we've not seen anything like that improvement in private sector renting and new development.

The point is we could make further progress by working with existing housing

where people are living now as well, of course, be concerned with new build. David, did you want to answer?

David:
I completely agree with that. To give some sense of good practice, I mentioned our work with house associations. To be honest, I've not done so much work with local authority build themselves. There are some fantastic housing associations working closely with the NHS and local authorities looking at how to support people to live longer and more independently in their homes and that's both physically in terms of changing the nature of the housing, but also much more support for people in that housing, so I would urge you to look at other National Housing Federations or our website to look at that.

Sir Malcolm Grant is a champion for the Healthy New Towns partnership. They are piloting some innovation you're looking for. What came out of that... to be honest I wouldn't say it was a throwaway line in the NHS Five Year Forward View but a relatively small focus in the Five Year Forward View, but what has come out from that is from local areas trying to scale that up.

One of the challenges we have is healthy new towns but what about healthy old towns? Most towns are old. As Duncan said, their housing stock has improved dramatically in the housing sector but we know it's falling. The challenge is for the private rented in large urban areas like this and also in London. One good piece of news in London, I guess, and it comes back to the role of the mayor, is that recently in the last week or so the London Mayor has said no to a developer saying, "I want to reduce the proportion of social housing on the development." He said, "That development is going to be 100% social housing."

There is a stronger political appetite across the various partners to recognise the problem but that is not the answer to the problem. There is some good

practice out there.

The other thing for me is some really interesting trials going on around the country bringing the generations together. We don't have shortage of housing but it's distributed unequally where it's needed. There are really some fascinating trials where older people are living longer and connecting with younger people who can't afford housing.

Trust is really important in that, so the role of intermediaries like Age UK is really critical, but it is about bringing the generations together which has broader consequences and positives.

Question:

Hi, my name is Marsha. I have both physical and mental health problems. I recently spoke at the King's Fund on mental health and co-morbidities. Now, I take 30 tablets a day and they all have contradictions to each other, I have fibromyalgia which is an awful debilitating pain condition.

As that gentleman said about older people and housing, but there's no adapted housing for me. I'm 41; we need to consider that as well because it's over 55s, et cetera. When I contact the council to ask if they could put in, a walk-in shower to my council house, I'm told no, that they will move me elsewhere, but I have roots and everything there and there's stability. So, we need to really re-think everything and it would cost less money and less by actually putting in a wet room for me and one of the things about population plan is keeping people in their communities instead of moving them.

Duncan:

So people are living in places, they're not driven by institutions, professions. It is not about disease burden, but about you and where you're living and what matters to you in your life. David's point about social prescribing is at the heart of saying it's also economically very sensible. It is the economics of

prevention, to keep people as well as is possible where they are as comfortable as they can be. What matters to you and how you can live the life you most want to live and how we can support you in that, we can't define you by a medical condition and, you know, I'd love to know more about that conversation that you've been having locally but we can talk about that separately.

You're making a much broader point as well about the economics of prevention. My earlier point I was trying to make is that this affects everybody throughout life. This is not just about being old. It is about all of life.

Matthew:
Both connected points, but just to go back to the other age range of the others you mentioned. Two of my three children were born in your hospital so I have a warm place for you.

But there is a correlation, as Duncan alluded to, between quality of use and housing stock and variation therein and variation in healthcare and we are in discussion with Greater Manchester on trying to prototype some kind of combined help and variation data to try and pull that out because then that allows for people to identify where that variation is in their local economies, health and social care economies and then we can move on to the next stage of improvement which is well now we know where the variations are and which bits are unwarranted what would it look like if it wasn't there and can we deliver that? So, I completely agree and we are moving in that direction.

Duncan:
We are. It's to show the direct connection between a poorly heated or damp home and admission into hospital. I mean it's...

Matthew: We all know it we have to draw it out.

Duncan:

The costs are being incurred the trick is if you make the investment who gets the benefit and that is why the system has to come together and why we are keen on sustainability, transformation to be on a big enough scale so that we can pay attention to this because we know it will help as well as the individual of course.

Question:

Hi, I am Charlene, principle secretary of health from India. I liked your sentence it's life before death and that for, if you have a job you have greatest chance of having good health and good mental health as well. In that context, since we are talking of prevention, I would like to know if the King's Fund think-tank would like to explore the preventative aspects which are proven in terms of control of NCDs or mental health or general immunity through yoga and Ayurveda.

I have great clinical evidence to show that how the diabetes can be won over, cancer can be won over and many more. Many more and more specially the mental health, so I extend that to you, thank you.

Matthew:

That is one for me. I happen to have a conversation around mental health and resilience and we know some of the benefits for that, so happy to have a conversation afterwards. Thank you for coming the way.

Duncan:

Public health has a whole range of relationships in India and we are glad of those and there is much to learn from each other.

Question:

Hi, Arif from Blackpool. Just, don't disagree with anything you have said, but I just wondered if the focus is too adult focussed and we are missing the whole children and young people's piece.

I mean in terms of prevention, if we reduce obesity, breast-feed our kids and make sure that their speech and language is appropriate and they have appropriate school readiness and are emotionally attached to their parent or care giver, I think in the longer term that is going to reap rewards and I see from missing from the NHS currently.

Duncan:
So Arif, the work going on in Blackpool, by any measure you face many of the most difficult health profiles in the country, here is the two-minute public health lesson about what matters in the, in that if you know this, you don't have to go to Harvard.

The single most important thing you can do for a child is to get them ready for school aged five. School readiness at age five will tell you everything you need to know about the future prospects of that child. By the time they get to age 11, if they have Key Stage 2 reading at population they will do fine A-C or whatever it is these days at GCSE.

If you don't have that, your chances drop to 1-10, it drops by 90%, but you know at age five, so what Arif is talking about, about what we do and the NHS has a big contribution to this, but it's part of a wider range of things is the single most important metric and I think Andy Burnham spoke about this, about school readiness is what is going to drive early years for Greater Manchester.

The second most important thing is for young people to have something to do as they become an adult. So, at local Government that is talked about not in education, employment or training, NEETS, people heard of that? It's intuitive, but a young person having something to do, enough money to live on, a reasonable getting up in the day and becoming an adult and the third and final measure is to have a job.

Economic prosperity, equality prospective, creating jobs people with get. Arif, there is no point putting a high value employer into Blackpool and expecting local people to pick up the majority of jobs, you have to create work that people can get as you improve the education system and you improve the housing offer and you improve the range of ways in which people can engage in society which is what I know Blackpool is doing.

So, creating jobs that people can get, economic prosperity, money in their pockets. So, it is a wider determinant thing, but as the whole system recognising that our part to play in young children being ready, not through the lens of a health visitor, but through the lens of a teacher. Does that child know how to sit, ask for help, how to play, how to go to the bath room or hold a knife and a fork? These are the basics about what a child needs to be able to do and it matters to the entire life that they have before them.
So Arif, keep the revolution going. Never give up.

Question:
Just a quick reflection and very good challenge. To be honest my institution, we have recognised that our work on children has taken a back step. It's not as obvious as our work on older people, neither is our work on ageing populations, to be honest, so we are seeking to, we have brought our material together in into one place on the website at least and seeking to think about what we can do.

The other thing to say on children is there is some great news on children too. Compared to when I was young, children, as a whole are not experimenting anywhere as much with alcohol or tobacco.

Physical activity is a major issue for children. It's probably got worse since I was younger, but there are some positive trends in our population which we do not understand enough. So, we have to understand the positives as well as the challenges and then try and learn from that. But also, an area where

we know there are real challenges is around mental health for children, particularly young girls and I hope that the green paper which has been flagged, I think it's coming, I hope it's coming, will say something about that.

The other final thing to say is, it's important, Duncan, is that it's a critical road of schools. We did some work around multiple behaviours and how behaviours cluster in the population because 7 and 10, this would include me, these are paragons of virtue, but don't adhere to Government guidelines on two health behaviours and we know that is bad for your health and which know it's the same for kids.

So, schools really strong supportive, particularly emotional resilience at school we know is protective of developing risky lifestyle behaviours in children. So, the role of the school environment, of course the role of parents too, but it's really, really critical so just to reinforce that point. The not all about the NHS.

Duncan:
Of those four behaviours, do you drink? How much, do you smoke? Ever, what do you eat and if you ever exercise. If you are into middle age and you take action on one or two of those you will double your chance of being in good health when you are 70. I could give you pension planning on the basis of those risks. See me afterwards.

Mathew: I am going to see him afterwards.

Duncan:
In the middle of the room is there anyone who wanted to ask anything? Here and then gentleman at the front. Okay. I am afraid this will have to be the last question. Sorry for that. Do we have a microphone? Could you stand up and shout?

Duncan:

Yes, it does so the literature is very clear about this, it's often a challenge if you do this sort of thing doesn't that just cost the country more over time. That is comprehensively not the case. There are of course other reasons why you want to do this sort of thing and for, being in good health means that you can still be there for your grandchildren, that is quite an important factor affecting, but the literature is clear.

I can say as well in economic terms that as the population ages and as the population stays working, so think about 65, becomes 66 and 67, for every eight months that people remain in the workforce you increase GDP by 1%. You increase GDP, wealth of a nation increases by 1% for every eight months. That is quite an untapped potential for how we fund this sort of thing looking into. So, for those who were saying they might be retiring at some stage, please know you will probably be working for a long time to come. Matthew , last word and then.

Matthew:

I would go back to that point; a healthy workforce is helping the economy. Even if you take out the individual healthcare what we are trying to do helps. David: I would say is sometimes, but not always. Saving money, I guess the parallel is we don't do heart transplants to save money; we do them to improve health. So, I think the test for prevention should be the same as it should be for treatment which is cost effectiveness.

We have run ourselves, I think it's valuable to have a return on investment information, but I would say that and I am a health economist by background. Let's not kid ourselves that everything is going to be a return on investment, but neither should it. The first test is cost effectiveness and that should be a cost prevention and treatment. The second thing to say is actually if we, there is value to delaying expenditure too, so actually prevention can delay expenditure because people are healthier and people are living longer but we

unfortunately -- I hope it's not news to you -- but we all have to die some time so we will always rely on a well-funded and supported and powerful NHS but we should do prevention and there is far more cost-effective prevention than we do, we don't do it systemically and at scale. That is the challenge for us.

Duncan:

Thank you, Matthew. Thank you everyone and enjoy the rest of the day. Thank you.