ADPH North West DPH Group

North West Directors of Public Health Group

"Top Ten for Number Ten"

A Public Health Manifesto from the North West Directors of Public Health

July 2014

Foreword

One of the key elements of the Director of Public Health role is to provide population advice on behalf of their populations, and to advocate for evidenced based interventions at both a local and national level.

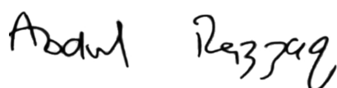
Our aim is simple. Collectively we are working to improve the health and wellbeing of individuals, families, communities, towns and cities. We are striving to address health equity and ensure that everyone has a fair chance in achieving their maximum potential and contributing towards their own wellbeing and that of others around them. Social capital and asset-based approaches are being pioneered in the North West with local residents leading the movement for change and control over their lives. However substantial health inequalities still exist in the North West and so national policy is also really important in helping us drive improvements in health for our populations.

There has been significant work undertaken over the last ten years on improving public health, for example with the implementation of the smoking ban, a government commitment to implement standardised packaging for tobacco, increases in seasonal influenza immunisation, and improvements in MMR vaccination uptake. However, there is still more work to do, for example the implementation of standardised packaging, and with continued discussions around price and taxation policies for both tobacco and alcohol.

It is with this in mind, and with the 2015 General Election on the horizon, that the North West Directors of Public Health have developed this public health manifesto, to provide a coherent set of top ten priorities for Local Authorities, NHS, Public Health England, policy makers, advocacy organisations and Government departments to consider for immediate implementation. The development of this North West public health manifesto also allows us to formally input into the national Association of Directors of Public Health (ADPH) and Faculty of Public Health (FPH) manifesto discussions.

The top ten priorities are based on a robust evidence-based approach that if implemented in full will result in improving the physical and mental health and wellbeing of the population, and reducing health inequalities, further and faster than current trajectories. Investment and implementation in the ten priorities will not only save countless lives but build a better quality of life for a new generation.

I look forward to your support and further dialogue on how we transform the manifesto into a charter and mandate for change in the best interests of the Public's Health.



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To sign up to support the priorities within this public health manifesto please visit www.phlive.org.uk/phmanifesto

Top ten priorities for public health

1. Introduce a minimum price of 50p per unit of alcohol sold to tackle alcohol-related harm and improve health and social outcomes.
2. Introduce a sugar sweetened beverage duty at 20p per litre to help address poor dental health, obesity and related conditions.
3. Commit to the eradication of childhood poverty to meet targets set by the Child Poverty Act 2010 and improve the health and wellbeing of all children.
4. Work with employers to increase payment of the living wage and introduce a higher minimum wage to improve quality of life, happiness and productivity in work.
5. Ban the marketing on television of foods high in fat, sugar and salt before 9pm to reduce children's exposure to unhealthy food advertising and improve diet choices.
6. Implement the recommendations contained within the "1001 critical days" cross party report to ensure all babies have the best possible start in life.
7. Implement tougher regulation of pay day loan companies to improve the health and wellbeing of people with debts.
8. Require all schools to provide a minimum of one hour of physical activity to all pupils every day in line with UK physical activity guidelines for 5-18 year olds.
9. Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing.
10. Require compulsory standardised front of pack labelling for all pre-packaged food and beverages (including alcoholic drinks) to encourage informed decision making about food and drink consumption.

Introduction

The North West Directors for Public Health (NW DsPH) commissioned this public health manifesto to:

- Raise awareness of important public health issues and evidenced based high impact interventions.
- Develop a consensus of shared priorities for action to improve the public's health across the North West.
- Influence cross party political manifestos ahead of the General Election in May 2015 and to inform the development of national public health policies.

The manifesto represents a consensus on priorities for public health action by the NW DsPH and stakeholders. The consensus was developed through the discussion and development of ideas at North West DPH meetings and a wider public health twitter discussion during May 2014[1].

A list of 40 potential priorities was formed based upon suggestions provided during this process. The NW DsPH voted to select their top ten, presented here and supported by a summary of the evidence around each issue.

The "Top Ten for Number Ten" includes challenging priorities that look at the whole public health spectrum, from food packaging and marketing to children to raising the living wage and tackling personal debt.

1. A full transcription of the twitter discussion is available to download: http://phlive.org.uk/phlive-twitter-discussion-21-may-2014-what-would-your-priority-be-in-a-public-health-election-manifesto/

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Priority 1:

Introduce a minimum price of 50p per unit of alcohol sold to tackle alcohol-related harm and improve health and social outcomes

Alcohol related harm is a major public health concern in the UK. In England alone, the cost to the NHS is estimated at £3.5 billion per year[1]. Current statistics indicate that 16% of men and 9% of women in the UK drink on five days per week, and 9% of men and 5% of women drink every day[2]. National surveys show that 27% of men and 18% of women drink more than double the government's lower risk guidelines for alcohol on at least one day a week (8 and 6 units respectively)[2].

The harms associated with alcohol consumption are well-established. In 2010, over 21,000 deaths were caused by alcohol consumption, 5% of all deaths in England[3] but the harmful consequences of alcohol consumption impact on a range of health, mental wellbeing and social outcomes at both a personal and societal levels. Evidence suggests that implementing minimum unit pricing for alcohol is an effective policy tool for reducing population levels of alcohol consumption and related harm amongst heavier drinkers without penalising moderate drinkers[4, 5]. Modelling of the impact of a minimum price of 50p per unit suggests it would reduce consumption by 7% in England[4] and by 6% in Scotland[6]. In England it is predicted that over time this would reduce alcohol-related deaths (3,060), hospital admissions (97,700) and crimes (42,500)[4].

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Priority 2:

Introduce a sugar sweetened beverage (SSB) duty at 20p per litre to help address poor dental health, obesity and related conditions

SSBs include any drink that has sugar added to it. SSBs make up 39% of all soft drink consumption in the UK, with overall consumption estimated at 92 litres per person per year[1]. SSBs are the most frequently consumed beverage for those aged 4-18 years and intake is particularly high amongst adolescents[2]. A range of poor health outcomes are strongly associated with intake of SSBs including being overweight and obesity, cardiovascular disease, type 2 diabetes, hypertension and dental caries[3, 4]. Childhood SSB consumption has been identified as a factor contributing to adult obesity[5].

There is evidence to suggest that a 20% price increase for SSBs would be acceptable to 52% of the population[6]. Assuming that price rises are passed on to the consumer, it is predicted that a 20% tax on SSBs would lead to a reduction in purchases, and therefore in overall consumption and daily energy intake[2, 7]. In the UK it has been estimated that this would lead to reductions of 1.3% (180,000 people) in the prevalence of obesity and 0.9% (285,000 people) in the number of people overweight, with the greatest effects likely to be seen among young people[7]. With additional anticipated benefits for dental health from reduced sugar consumption and no downsides for health from drinking less SSBs, a tax on SSBs has clear benefits as a policy tool for improving public health.

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Priority 3:

Commit to the eradication of childhood poverty to meet targets set by the Child Poverty Act 2010 and improve the health and wellbeing of all children

An estimated 3.5 million children in the UK, 27% of all children, live in poverty[1]. An estimated 2.5 million live in damp housing,1.5 million live in households that cannot afford to heat their home and over half a million are from families who cannot afford to feed them properly[2]. Growing up in poverty impacts on life chances and is associated with delayed cognitive development[3], lower school achievement[4] and unemployment, low income work and unskilled jobs in adulthood[4]. Children in poverty are at increased risk of a range of poor health and social outcomes including adverse birth outcomes, obesity, diabetes, asthma, mental health problems and reduced access to healthcare[4]. Children of persistently poor parents are at risk of becoming poor adults themselves and any children they have are at risk of growing up in poverty.

The Child Poverty Act (2010) includes two targets to be achieved in the UK by 2020: (i) less than 10% of children in relative poverty, and (ii) less than 5% of children in absolute poverty. While the Government have introduced policies to improve outcomes for children in poverty, current evidence indicates that these targets will be not achieved[5] and even with higher employment and benefit maximisation, projections suggest these targets could not be reached. It is clear that new ambitious actions across policy domains are needed to tackle child poverty to meet the targets of the 2010 Act and to improve health, wellbeing and social outcomes for children.

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Priority 4:

Work with employers to increase payment of the living wage and introduce a higher minimum wage to improve quality of life, happiness and productivity in work

The Living Wage is an hourly wage, calculated to provide an acceptable standard of living to employees and their families and it is currently optional for UK employers to pay a living wage. The Living Wage is set at £7.65 per hour outside of London in comparison to the National Minimum Wage of £6.31 per hour for workers aged over 21. It is estimated that over 5 million people in the UK, or one in five employees, earn less than the Living Wage[1]. The proportion of UK workers in low-paid work is higher than the average for other OECD countries, behind only the USA[2].

Lower income leads to reduced ability to afford essential goods such as food, clothing and heating, reduced participation in social activities and increased debt[3]. This can have a clear impact on the mental wellbeing and physical health of adults and children. Being paid the Living Wage has been associated with increased mental wellbeing and financial benefits in comparison to workers remaining on low pay[4, 5]. Employers also benefit from implementing the Living Wage through increased worker productivity and reduced staff turnover[6]. Wider implementation of the Living Wage and raising the national minimum wage are therefore essential policy tools for improving the quality of life of the UK's lowest earners.

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Priority 5:

Ban the marketing on television of foods high in fat, sugar and salt (HFSS) before 9pm to reduce children's exposure to unhealthy food advertising and improve diet choices

The obesity crisis in the UK is well documented and likely to worsen in the future, with an estimated 50% obesity rate by 2050 at a cost of £50 billion a year[1]. Currently around one third of 10-11 year olds are overweight with estimated obesity levels at 19%[2]. Furthermore an estimated 9% of 4-5 year olds are thought to be obese[2]. Childhood obesity predicts obesity during adulthood[3] and is associated with onset of diseases including diabetes, hypertension, heart disease and stroke. Evidence supports the influential effect of food marketing on children's food preferences and consumption[4]. Despite a UK ban on advertising HFSS foods in programmes made for children, a recent study showed that the level of exposure of children to television food advertising for HFSS foods has not reduced[5]. One reason may be that children are likely to watch programmes that also attract an older audience where advertising of HFSS foods is still permitted.

Further measures are therefore required to reduce children's exposure to unhealthy food advertising. NICE guidance recommends that restrictions on the television advertising of HFSS foods be extended until 9pm[6], with evidence suggesting that such action could reduce exposure amongst children by 82%[7]. A ban on advertising of HFSS foods on television before 9pm is therefore an essential policy priority in helping children make positive and healthy food preferences and choices.

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Priority 6:

Implement the recommendations contained within the "1001 critical days" cross party report to ensure all babies have the best possible start in life

The first few years of life are a critical period for a child's development. In 2013, over 5,500 children unborn and under the age of one in the UK were the subject of a child protection plan, and the NSPCC estimates that a quarter of all babies in the UK have a parent affected by domestic violence, mental health issues or drug and alcohol problems[1]. Evidence indicates that half of all adults in England suffer at least one adverse childhood experience with 9% suffering four or more[2].

Between birth and two years of age, a baby's brain grows from around 25% to 80% of its adult size[3]. While there are many factors that influence brain development, one of the main drivers of this policy approach is the belief that infants that are neglected, abused or exposed to stress are less likely to develop connections in the brain that support healthy social, emotional and cognitive development. Exposure to adverse experiences in childhood is associated with a wide range of health-harming behaviours in later life and to poor physical and mental health outcomes.

Interventions that develop secure attachments between infants and their caregivers are viewed as the key tools in this policy area; evidence suggests they support maternal mental health, promote positive parenting and can generate long-term cost savings[4]. Health visitors can reduce post natal depression, while home visiting programmes (e.g. Nurse Family Partnership[5]) for at risk mothers can improve health-related behaviours in pregnancy, reduce child maltreatment and childhood injuries, and reduce mental health problems, substance use and criminal behaviour in adolescence. Parenting programmes have shown positive impacts on both parent and child behaviours, particularly in reducing child conduct problems[6].

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Priority 7:

Implement tougher regulation of payday loan companies to improve the health and wellbeing of people with debts

It is estimated that between 7.4 and 8.2 million payday loans were arranged in the UK in 2011/2012 at a value of £2-2.2billion[1]. A payday loan is a short-term and unsecured loan repaid at a high interest rate in full on a fixed date. Such loans are seen as attractive due to very short approval periods from easily accessible lenders. The average cost of borrowing has been estimated at £25 per £100, but additional costs are accrued for transmission of funds and for late payments, which occur in approximately one in five loans[1].

Financial difficulty is a widespread issue for people who use payday lenders[2] and being in debt is associated with the development of a range of mental health problems including anxiety, stress and depression[3]. In addition seekers of short-term loans are more likely to have a low income and be in poverty, which further compounds the negative health outcomes for these individuals and their families. For those borrowing money, high interest rates and additional costs are likely to increase debt and financial insecurity, which may create a cycle of further debt and use of money lenders.

The Government has recognised the problems caused by easily accessible and harmful payday loans[4] and new regulations imposed by the Financial Conduct Authority[5] are expected to reduce the number of payday lenders. It is important that the impact of new regulations is closely monitored and that tougher regulations are introduced in the future if required. While regulation of payday loans is an important policy tool, as options for payday loans are reduced it will be important to encourage responsible money lending across other sources of short-term, high-cost credit, and to consider how other measures can improve access to credit and savings, and debt management advice, particularly for those on low incomes.

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Priority 8:

Require all schools to provide a minimum of one hour of physical activity to all pupils every day in line with UK physical activity guidelines for 5-18 year olds

Current UK guidelines recommend that children participate in moderate activity for at least 60-minutes every day, and vigorous activity on at least three days per week. Current data show that only 21% of boys and 16% of girls aged between 5 and 15 years in England, reach the recommended level[1]. Physical inactivity is a significant risk factor for obesity and several related chronic health diseases including type 2 diabetes, coronary heart disease, stroke and certain cancers. Being overweight in childhood is associated with a number of health problems, both during childhood[2] and in later life[3].

Policy action is therefore required to reduce the future burden of ill health arising from physical inactivity. For each inactive child who reaches the recommended activity levels, savings are estimated at £40,000 over the lifetime through reduced healthcare costs[4]. For school-aged children, physical activity not only improves physical health, but has positive implications for behaviour, attitudes and academic achievement[5]. Children up to the age of 16 spend up to 45% of their waking time at school during term-time[6], and as a consequence schools provide the optimum opportunity for influencing and promoting health and health behaviours in children.

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Priority 9:

Introduce policies to encourage active travel and use of public transport to improve the quality of local environments and improve road safety, health and wellbeing

Active travel incorporates physical activity into daily life. In 2012 only 39% of all urban trips under five miles made in England were by cycling or walking, with the average number of walking trips in the UK decreasing by 27% in 2012 from 1995/96[1]. Cyclists and pedestrians in the UK can be deterred by lack of facilities and misperceptions of poor road safety, while a perception of expensive fares and inconvenience (in comparison to car use) reduces use of public transport. Transport methods are strongly linked with a wide range of public health outcomes. In the UK an estimated 67% men and 57% women are overweight or obese[2] and physical inactivity contributes to obesity and a number of chronic conditions[3]. Emissions from cars reduce air quality and contribute to noise pollution and climate change with 25% of the total UK emissions of carbon dioxide estimated from road emissions[4]. Amongst young males, driving is associated with increased fatalities in comparison to methods of active transport[5].

Increasing levels of habitual physical activity by creating local environments where walking and cycling are safe and attractive, and facilitating use of public transport has therefore emerged as an important area of public health policy. Local policies can have a significant impact on the quality of the local environment as well as the health and wellbeing of residents. Nationally, a scenario of increased active travel, with subsequent reduced car use, produces estimated savings of £17 billion over 20 years through reduced spending on non-communicable diseases including type 2 diabetes, cardiovascular diseases, cancers, dementia and depression[6].

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Priority 10:

Require compulsory standardised front of pack labelling for all pre-packaged food and beverages (including alcoholic drinks) to encourage informed decision making about food and drink consumption

Front of pack labelling is viewed as an effective means of providing consumers with information to help them make informed decisions about their diet. In the UK, food manufacturers and supermarkets can currently opt in to the 'traffic light' front of pack labelling system for pre-packed food. Back of pack standardised labelling will be compulsory for all pre-packaged foods throughout the European Union by 2016. A voluntary agreement on alcohol labelling currently exists in the UK with information provided on unit content, drinking in pregnancy, and the daily benchmarks.

Excessive consumption of pre-packaged foods and alcohol is contributing to the rising health burden from non-communicable diseases such as diabetes, cancer and cardiovascular disease. The use of different measurements across food labels[1] and technical information[2] can make information difficult to understand and inconsistent food labelling is associated with the consumption of too much sugar, fat and salt[1]. Accurate tracking of alcohol intake requires knowledge of the alcohol content of different drink servings and evidence suggests that, on the whole, people who drink lack such an understanding[3].

Through simplifying and standardising labelling on all pre-packaged food, consumers will be better placed to make comparisons between products and make decisions based on accurate nutritional knowledge[4]. Standardised front of pack labelling is therefore viewed as an important policy tool to help improve dietary choices among the population. Evidence suggests text-based alcohol labelling has little impact on drinking behaviour and public health advocates have therefore called for clear and factual health warning labels on alcohol products, similar to the mandated warnings found on tobacco products[5].

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Cheshire and Merseyside Public Health Collaborative Service www.champspublichealth.com

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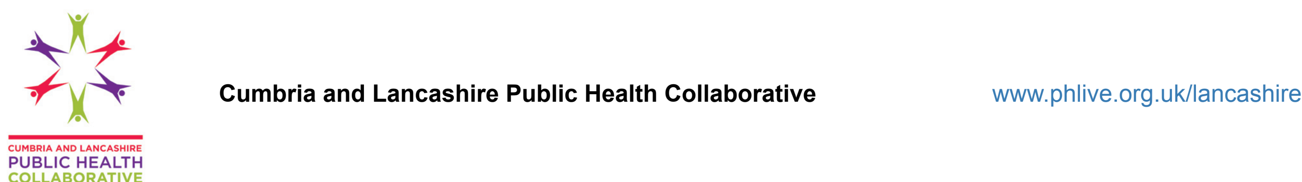

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