

**MRC/CSO Social and Public Health Sciences Unit Consultation Response**

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| **Title of consultation** |
| Advancing our health: prevention in the 2020s |
| **Name of the consulting body** |
| UK Government: Department of Health and Social Care; Cabinet Office |
| **Link to consultation** |
| [https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-](https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document#contents) [2020s/advancing-our-health-prevention-in-the-2020s-consultation-document#contents](https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document#contents) |
| **Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?** |
| Many of the questions were very relevant to the Unit’s work, and we were able to provide learning from research in Scotland that may inform policy in England and the UK more broadly. |
| **Our consultation response** |
| [**Question: What is your priority for making England the best country in the world to grow old in,**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-07-16.7223430135/?_ga=2.157967162.10836603.1566987707-1005558667.1504690768)[**alongside the work of PHE and national partner organisations?**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-07-16.7223430135/?_ga=2.157967162.10836603.1566987707-1005558667.1504690768)  Pick “Other”: Recognise that healthy/active/successful ageing is a multifaceted concept, exploring and giving more credence to the priorities of older people.  Models of healthy/active/successful ageing often focus on disease and disability with only those who are free from illness and with no difficulties with physical and cognitive functioning considered to be ageing well. However, evidence suggests that these aspects of ageing are relatively unimportant to older people, who are more likely to prioritise aspects such as independence, maintaining mobility, autonomy and social engagement. In addition, older people are often more positive about their ageing than those responsible for their care, with many older people who fail to meet traditional definitions of successful ageing considering themselves to be ageing well. Conversely, absence of disease and disability is not necessarily an indication of successful ageing and there is a recognised problem of loneliness and social isolation among older people.  The priorities of older people need to be better understood and should directly inform policies and initiatives for healthy/active/successful ageing. Support to help older people stay in employment may be appropriate for some, as retirement has been shown to be associated with reduced social engagement and self-esteem. However, this may not be the best course for all older people and initiatives that encourage active engagement with family, friends and the wider community are also important. In addition we need to understand more about what makes neighbourhoods “age-friendly”, again based on the priorities of older people themselves.  [**Question: How can we better support families with children aged 0 to 5 years to eat well?**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-06-11.3357262426/?_ga=2.159033274.10836603.1566987707-1005558667.1504690768) |

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| Two areas must be addressed: 1) Families’ access to adequate resources and 2) Creating a culture of healthy food environments.  Family resources:   1. Families with higher incomes and educational levels are more likely to eat well and are less likely to be overweight or to experience dental decay. 2. Families need adequate income and spending power to provide a nutritionally balanced diet. 3. This can be realised through:    1. Support to gain skills and qualifications that will enable secure employment and incomes.    2. Affordable childcare.    3. Adequate levels of welfare.    4. Increasing mothers’ levels of education (an overwhelmingly strong predictor for children’s dietary outcomes).   Healthy food environment   1. Support the provision of healthy food in all environments where children spend significant amounts of time through legislation, guidelines and adequate funding, e.g. home; nursery and school settings; other formal and informal childcare settings; leisure centres and playgroups. 2. Reformulation of food and drink products for children aged 0-5 to reduce sugar, salt and fat content; these foods are often above recommended salt, sugar and fat levels. 3. Improve the labelling of food and beverage products for children aged 0-5 years of age. Ensure labelling is honest and reflects scientific evidence base regarding healthy eating practices for children aged 0-5 years old. 4. Reduce the promotion of high in fat, sugar and salt products directed at parents and young children. The promotion of HFSS products at all ages until the age of 18 impacts on children’s dietary preferences.   [**Question: What could the government do to help people live more healthily: in homes and**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-06-11.3894650084/?_ga=2.157967162.10836603.1566987707-1005558667.1504690768)[**neighbourhoods, when going somewhere, in workplaces, in communities?**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-06-11.3894650084/?_ga=2.157967162.10836603.1566987707-1005558667.1504690768)  The disparity in availability of unhealthy products is something we can, and should, do something about to ensure equity in opportunities for health. Access to unhealthy goods and services are greater in areas where the most income deprived reside. Evidence from Scotland has shown that outlets selling potentially health-damaging goods/services, such as alcohol, fast food, tobacco and gambling clustered linearly from the least to the most income deprived areas ([Macdonald et al 2018](https://www.sciencedirect.com/science/article/pii/S1353829217310778?via%3Dihub)). Governments can intervene to tackle the co-occurrence of unhealthy behaviours and contribute to policies tackling higher numbers of ‘environmental bads’ within deprived areas.  Population-level health interventions have reduced unhealthy behaviours such as smoking prevalence. However, large inequalities remain. Smoking prevalence in deprived areas is three times higher than in the least deprived areas. Research using individual mobility data shows that children in socially disadvantaged areas accumulate higher levels of exposure to tobacco retailing than expected from disparities in home neighbourhood densities; those from the most deprived areas accumulated six times the duration and seven times the frequency of exposure as children from the least deprived areas ([Caryl et al 2019](http://dx.doi.org/10.1136/tobaccocontrol-2018-054891)). Reducing tobacco outlet availability, particularly in areas frequently used by children, might be crucial to policies aimed at creating ‘tobacco-free’ generations.  The recently documented success of the minimum unit pricing of alcohol in Scotland shows how effective policies that deliberately tackle inequity—by targeting high-volume, low-income drinkers--can be |

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| ([O’Donnell et al. 2019](https://doi.org/10.1136/bmj.l5274)). Other unhealthy commodities can, and should, be targeted in this way, such as by implementing tobacco control policies that target reducing availability of unhealthy products in areas of deprivation, where they cause the most harm.  **Question: Do you have any ideas for how the NHS Health Checks programme could be improved?**  The NHS Health Checks programme should be abandoned. There is substantial evidence from randomised trials that general health checks are ineffective and a waste of resources. This was shown in a Cochrane review published five years ago and updated this year ([Krogsbøll et al 2019](https://doi.org/10.1002/14651858.CD009009.pub3)). There is also evidence [(Si et](https://doi.org/10.3399/bjgp14X676456) [al 2014](https://doi.org/10.3399/bjgp14X676456)), including results from a large UK trial ([Caley et al](https://doi.org/10.3399/bjgp14X681013)), that health checks carried out in primary care are ineffective. The resources currently spent on general health checks should be invested in screening and prevention programmes known to be effective, such as colorectal cancer screening. Uptake rates in England were below 60% and barely improving before the new FIT test was introduced in 2019. [Evidence](https://www.isdscotland.org/Health-Topics/Cancer/Publications/2019-08-06/2019-08-06-Bowel-Screening-Publication-Report.pdf) [from Scotland,](https://www.isdscotland.org/Health-Topics/Cancer/Publications/2019-08-06/2019-08-06-Bowel-Screening-Publication-Report.pdf) where the new test was adopted earlier, suggests that FIT will improve uptake, but substantial inequalities will remain. Improving uptake among disadvantaged populations will save lives and reduce inequalities in mortality.  **Question: What government policies (outside of health and social care) do you think have the biggest impact on people’s mental and physical health? Please describe a top 3.**  Social security policies, which account for around 40% of all public spending in High Income Countries ([Eurostat, 2018](https://ec.europa.eu/eurostat/statistics-explained/index.php/Government_expenditure_on_social_protection)), are a key determinant of population health and health inequalities. They set the level of income that many of the poorest households can rely on, and the degree of income stability they can expect. People who are coping with immediate material hardship or the stress of managing on a low or uncertain income cannot be expected to prioritise behaviours that will improve their future health (such as stopping smoking or taking more exercise), and are therefore unlikely to benefit from prevention programmes that require active engagement. The weakening of social safety nets, through cuts in benefit levels or the increased use of conditionality or sanctions, may also be actively harmful. Austerity policies have been linked with the stalling of life expectancy improvement in the UK, via their effect on health and social care services for older people ([Hiam et al 2018](https://doi.org/10.1136/jech-2017-210401)), and may also affect mortality at younger ages.  Policies that have reduced the real value of welfare benefits for working age families, leading to increased child poverty, have been implicated in the recent rise in infant mortality in England ([Taylor-Robinson D et](https://doi.org/10.1136/bmjopen-2019-029424) [al 2019](https://doi.org/10.1136/bmjopen-2019-029424)). Infant mortality is rare in high income countries so this rise is likely to be an indicator of a broader trend of worsening child health outcomes. Monitoring and evaluating social security policies for their health impacts, and prior modelling and appraisal of the health impacts of changes to welfare and related polices (such as minimum wage and employment protection), should therefore be a priority for population health monitoring and research.  **Question: What other areas (in addition to those set out in this green paper) would you like future government policy on prevention to cover?**  We refer to our answer under ‘Prevention in wider policies.’  [**Question: How else can we help people reach and stay at a healthier weight?**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-06-11.4095636477/?_ga=2.153658296.10836603.1566987707-1005558667.1504690768)  As in other answers, there are different policy-level interventions that are likely to have greatest impact on population health, including those that are likely to affect weight. Here we provide additional individual-level suggestions, with the caveat that broader environmental considerations are required. For example, [the Scottish Government’s diet and healthy weight plan](https://www.gov.scot/publications/healthier-future-scotlands-diet-healthy-weight-delivery-plan/pages/8/) highlights that we cannot rely on individual action but includes strategy relating to food environment, e.g. policy restrictions to the  marketing of unhealthy food/beverages, and other population measures drawing on learning from the |

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| smoking ban.  Social support, goal setting and self-monitoring are known to be three of the most effective behaviour change strategies for weight loss ([Greaves et al, 2011](https://doi.org/10.1186/1471-2458-11-119); [Michie et al, 2009](http://dx.doi.org/10.1037/a0016136)). Goal setting and self- monitoring are frequently used, but the nature of social support is varied. Social support plays an integral role in health behaviour, with positive and negative influence. Interventions which harness positive social support and mitigate negative support are important in changing health behaviour. Social support is positively correlated with healthy diet ([Ferranti et al, 2013](https://doi.org/10.1002/nur.21532)) and increased physical activity ([Molloy et al,](https://onlinelibrary.wiley.com/doi/full/10.1348/135910710X490406) [2010](https://onlinelibrary.wiley.com/doi/full/10.1348/135910710X490406)). The evidence base demonstrates that using a ‘helper’ can be effective for weight loss. For example, in a 15-week online weight loss programme with 704 participants, 54% of chose to use a buddy and they lost more weight than those who didn’t have a buddy ([Dailey et al, 2018](https://doi.org/10.1080/10810730.2018.1436622)). In relation to digital technology, the HelpMeDoIt! feasibility trial ([Simpson et al, in press](http://dx.doi.org/10.1136/bmjopen-2017-017159)) found that an app was a feasible way of formally engaging social support from family/friends in relation to weight loss goals. This suggests that guiding/informing people to think about their social network is an important factor in reaching and maintaining a healthy weight. Information is also needed for the helper to confidently support their friend.  [**Question: We recognise that sleep deprivation (not getting enough sleep) is bad for your health in**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-06-10.3197456771/?_ga=2.186804008.10836603.1566987707-1005558667.1504690768)[**several ways. What would help people get 7 to 9 hours of sleep a night?**](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-06-10.3197456771/?_ga=2.186804008.10836603.1566987707-1005558667.1504690768)  There are numerous reasons that people may not get 7-9 hours sleep per night, not least the concern caused by other policy areas, e.g. welfare and social security policy, local employment availability, working hours, NHS etc. However, here we draw specifically upon our recently conducted review of evidence exploring the association between screen time and sleep (and mental health) among adolescents, therefore the response is with the qualifier that this is just one small aspect of the issue.  For adolescents, access to and use of a media device at bedtime is associated with poor sleep quality, inadequate sleep quantity, and daytime sleepiness. Extended periods of screen time have been associated with displacements of positive activities (e.g., outdoor physical activity) that are beneficial for sleep and health outcomes.  In our recently conducted rapid review on screen time, sleep, and mental health and wellbeing in adolescents we found that:   * Sleep quality was negatively influenced by mobile phone use in general and social media use in particular. * Experiencing pressure to socially engage using a mobile phone was associated with poor sleep hygiene (i.e. bedtime behaviours). * Experiences of cybervictimisation were indirectly associated with sleeping less than the recommended 8 hours per night. The factor linking cybervictimisation with shorter sleep was repetitively thinking and obsessing about distressing thoughts, emotions, and memories (i.e. ruminative coping). * Other *potential* mechanisms through which mobile device screen time or use affect sleep outcomes are displacement of sleep time, increased alertness through blue light exposure, psychophysiological arousal through binge watching and/or watching violent or upsetting content.   Possible interventions include:   * Protecting young people from cybervictimisation and enacting mandatory requirements of social media platforms to develop algorithms that block aggressive and upsetting content. * Education around the impact of cybervictimisation and how to avoid it (e.g. adequate privacy |

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| settings) could be embedded in the school curriculum.  [**Question**: What are the top 3 things you’d like to see covered in a future strategy on sexual and](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-07-02.3436383142/?_ga=2.229755676.10836603.1566987707-1005558667.1504690768) [reproductive health?](https://consultations.dh.gov.uk/prevention/a09d31b8/consultation/subpage.2019-07-02.3436383142/?_ga=2.229755676.10836603.1566987707-1005558667.1504690768)   * **Educating people for lifelong sexual health.** Stronger investment in high-quality, comprehensive, positive, inclusive (all genders and sexualities), and skills-based sex education in school and tertiary levels that prepares young people for lifelong sexual wellbeing. This should be flexible to keep pace with the contexts and issues relevant to young people. It should prioritise the development of media and digital literacy skills, so that young people are able to: access reliable information and sources of help; think critically about sexually explicit material, gender roles and portrayals of normative practice; and effectively and safely negotiate online environments to minimise risk. * **A shift in focus to sexual wellbeing.** The focus of sexual health strategies and funding has been heavily focused on the reduction of risky sexual behaviour. Strategies in UK have yet to fully take on the holistic conceptualisation of sexual health proposed by WHO in 2006, which argued for an emphasis on wellbeing and satisfaction as well as reduction of risk. There is an enduring absence of discussion of pleasure in sex education and almost complete neglect of services focused on ameliorating sexual difficulties and promoting sexual wellbeing. This is short-sighted, since the same factors typically underpin both risk and wellbeing. High risk practices such as chemsex are often undertaken to mask low self-esteem and confidence in relation to sexual performance; high numbers of partners may reflect a lack of understanding that good sex with one partner takes practice and communication skills. There is evidence that goals related to sexual satisfaction shape both risk taking and risk reduction, and interventions that fully understand this are more likely to be effective. In an age of easy access to porn and sexualised imagery, it is no longer justifiable for health services and education to ignore this central component of sexual health. And the rationale goes beyond risk- reduction; positive sexuality is good for both mental and physical health and strongly associated with both. * **Investment in improved prophylaxis technology, including promotion of ‘intelligent prevention’ applied to condom use.** The steady decline in unplanned pregnancy has not been mirrored by decline in STIs. With the threat of increasing antibiotic resistant strains of gonorrhoea and sphyillis only likely to increase, it is paramount that any sexual health strategy invests both in improved condom technology and in more effective interventions to support error-free use. Sex education focuses on how to use a condom but much less on how to negotiate it’s use, or on how to incorporate it as a positive part of sex, rather than as an irritating interruption. There needs to be strong efforts to counteract the misperception that once on long-acting contraception you are ‘sorted’ for prophylaxis. Renewed investment in creative public education on condoms, as well as investment in female- controlled technologies to prevent STI transmission should be priorities. Without these investments we will be as vulnerable to the impacts of the next sexually-transmitted epidemic as we were to HIV in the eighties. |
| **When was the response submitted?** |
| 11/10/19 |
| **Find out more about our research in this area** |
| Varied consultation in terms of topics—relevant research across the SPHSU website |
| **Who to contact about this response** |
| Kathryn Skivngton |