INSTITUTE of HEALTH EQUITY

Legal & General

THE BUSINESS OF HEALTH EQUITY: THE MARMOT REVIEW FOR INDUSTRY

CONTENTS

ABOUT THE UCL INSTITUTE OF HEALTH EQUITY AND LEGAL & GENERAL

UCL INSTITUTE OF HEALTH EQUITY

The Institute of Health Equity (IHE) at University College London (UCL) is led by internationally renowned epidemiologist Professor Sir Michael Marmot. It was established in 2011, following the publication of the landmark 2010 report Fair Society, Healthy Lives, known as the Marmot Review (1). That report set out how social, economic and environmental conditions – or 'social determinants' – shape health to a much greater extent than healthcare does, and how inequalities in these social determinants lead to widespread inequalities in health.

The Marmot Review made a series of recommendations to government to take action on the social determinants of health. In February 2020, just before the COVID-19 pandemic, IHE published Health Equity in England: The Marmot Review 10 Years On. The health picture that it presented was not encouraging, suggesting that policies of austerity had damaged health (2). In 2020 IHE published Build Back Fairer, a programme for action in response to the inequalities exposed and amplified by COVID-19. Since 2010, IHE has worked with national and local governments, the NHS, public health bodies, the voluntary sector and communities to embed effective approaches to reducing health inequalities. The Institute also works globally and has led major reviews across the world, influenced action by governments and international organisations, and led the social determinants and health equity movement. All the IHE reports and further information about the Institute's work can be found at instituteofhealthequity.org.

LEGAL & GENERAL

Legal & General has a strong and longstanding social purpose, 'to improve the lives of [its] customers, build a better society for the long term and create value for [its] shareholders ..., to use [its] long-term assets in an economically and socially useful way to benefit everyone in [its] communities' (3). Legal & General describes its ethos as 'inclusive capitalism' – a recognition that the benefits of economic growth must be shared by all. This means wealth, but also health.

Legal & General's impact comes not only from how the business is run, but also how the group invests its £95 billion of proprietary assets, and how it uses its influence as an asset manager, with £1.4 trillion in assets under management (4). Beyond those companies in which Legal & General holds shares, or has influence with shareholders, there is a network of suppliers and contractors, at a local level, nationally and internationally. Legal & General has an influence on the entire business ecosystem as a leader, and with government. Legal & General's move to make health equity a central concern is a new and welcome contribution that could have highly significant, positive and wide-reaching impacts on health.

The COVID-19 pandemic has motivated Legal & General to strengthen its role in reducing health inequalities through action on the social determinants of health by partnering with IHE, as detailed below. Legal & General is committed to levelling up disadvantaged areas of the UK and ensuring that the country builds back fairer, as well as better.

THE LEGAL & GENERAL AND UCL IHE PARTNERSHIP

Legal & General and UCL IHE have entered into a four-year partnership to further the role of business in reducing inequalities in health in the UK and to establish a UK-wide health equity network. This report, setting out how businesses can achieve improvements in health equity, is the first output from the partnership and is expected to lead to specific commitments from Legal & General and from other businesses operating in the UK. The analysis is also relevant globally. The Legal & General/IHE Health Equity Network for reducing health inequalities launches in March 2022 and will enable businesses and other partners from places across the UK to learn from each other, share best practice, and monitor and evaluate their impacts on health inequalities.

FOREWORD

The good society can be thought of as one in which all people can lead lives that they have reason to value. A great body of evidence, summarised in our series of reports, shows that as societies improve so health improves, not just because of stunning improvements in medical technology, but because of improvements in the conditions in which people are born, grow, live, work and age – the social determinants of health. A society in which people can lead flourishing lives is a healthy society, literally and metaphorically.

In the UK, as in some other countries, health improvements have slowed in recent years and have been far from uniform. There are large and, now deepening inequalities in health, closely linked to inequalities in the social determinants of health. The greater the social disadvantage the shorter the healthy life expectancy. So marked are these inequalities that for groups at greater disadvantage, health has stopped improving or is even getting worse. All of this was exacerbated by the COVID-19 pandemic. Because many of these health inequalities could reasonably be reduced or eliminated, their existence is unfair. We call these inequities.

Business has a key part to play in improving these social conditions that affect health and health equity: in conditions of work and employment; in goods and services; and in impact on the wider society and environment. The present report builds on the good practices of businesses that are showing the way. Implicitly, it deals with two objections: *this is all so complicated, where do we start?* and *won't such actions be costly and interfere with the central purpose of business?* The report shows very practical ways to get started. It also shows that it is in the interest of business to have regard to health equity as well as to ESG, environmental, social and governance concerns. More generally, it recognises that businesses can and should be responsible actors improving the quality of people's lives and the environment, and as a result be forces for good in creating greater health equity.

'Health equals Wealth' – this is demonstrably true at an individual, community, and national level. Layered as it was upon already-widening, unacceptable health inequalities, COVID-19 demonstrated beyond doubt the importance to the economy of health resilience at every level.

The role of business in influencing positive health outcomes – for better or for worse – has not historically been a major part of the debate around public health. 'Health & Safety' is mainly about safety. Business however needs to lean in and take action. Our businesses are more productive if we have workforces which are physically and mentally well; and at a time of tight labour markets, it is not just a human tragedy but a lost opportunity if experienced workers are forced to leave the workforce for health reasons before they want to.

The climate debate has moved in leaps and bounds over the last few years – COP26 demonstrated how trillions of pounds of institutional investment is lining up to support net zero, ably shepherded by Mark Carney. The health debate needs to move in the same direction, for good ethical but also for good commercial reasons, and hopefully we can do this without 26 COPs.

ESG (Environmental, Social and Governance) investing needs to become ESHG investing, explicitly including health. There is a risk/reward point here: nobody wants to end up owning the health equivalent of a stranded asset coal mine, or an asset which may be taxed, regulated or litigated against. There is also a positive agenda – about how we can invest in better housing, better food, cleaner environments and better jobs to reduce the negative social determinants of health.

This is a big challenge – but there is nobody better qualified to work with us on it than Professor Marmot. This paper is the start of a process which I am confident will lead to tangible results – we would encourage others to join us on that journey.

Professor Sir Michael Marmot
Director, UCL Institute of Health Equity

Sir Nigel Wilson
Group Chief Executive, Legal & General Plc

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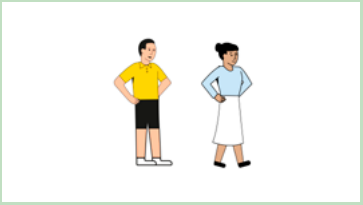
How businesses shape our health: the stories of George and Sumita



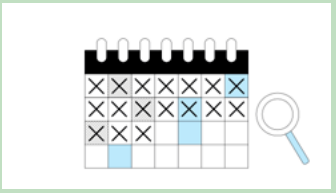
When George left school, he got a job in data entry. George's parents, both immigrants to the UK, were not wealthy, and although George did not think of himself as coming from a disadvantaged background and did well at school, he had no particular contacts to draw on in starting a career. The job did not really interest him, as he found the work repetitive, and he never felt he was making much progress.

Although he had been a keen footballer at school, he found that he began to put on weight quite rapidly. He would have liked to cycle into work, but he was worried that a bike would be stolen if locked up in front of the building, and there was nowhere to shower when he got in. He sat all day at a desk, looking at a screen, and generally found that his back was sore and his eyes hurt at the end of the day, so rather than go out and exercise he would stretch out on his sofa. With what he was paid, he could only afford to rent a small flat, far from any public transport, so it was late when he got home, anyway. George didn't go out much, as he was always worried about money.

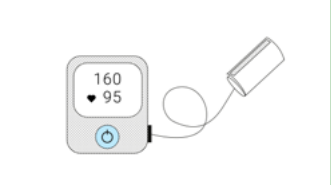
After a few years, the company George worked for closed down. The company had always found it hard to hang on to employees, and despite everyone working long hours, productivity kept declining. Management worried about excessive sick days, so restricted sickness pay, but then found that coughs and colds kept spreading about the office.

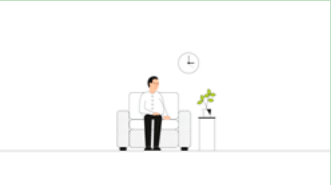
George found it difficult to get another job, as he hadn't really gained any skills during his time at the company. He started driving passengers using a smartphone app. He was technically self-employed, but didn't really find that he had as much flexibility as he thought he would. The app company's terms forced him to take a certain number of passengers, and he couldn't turn down any routes. He found working shifts very tiring.

Previously, he had mostly cooked his own meals, and taken pride in being a pretty good cook – although he did find buying ingredients expensive, as he rarely had enough money at one time to buy in bulk, even if he had had room to store it. Cooking in the small flat's kitchen took a lot of the fun out of it, and limited his options – he was a little worried about a patch of damp in there as well, but he could never get hold of his landlord. Now he often found that at the end of a long shift he lacked the energy or the wherewithal to cook, and went to the local takeaway. George wasn't stupid, and he knew that this was bad for him, but after a stressful day he craved something simple and comforting – and anyway, there were always doctors and nurses from the local hospital in there coming off their night shifts, so it couldn't be that bad.



Although George's social life was still quite limited, he was lucky enough to meet a woman and fall in love. They married, and with both of them working they were able to afford to move to a slightly bigger flat. The condition of the flat wasn't much better than the last one, but the rent was still too high to enable him to save for a deposit. Soon they had a son and a daughter. As George was self-employed, he was not entitled to any parental leave, and he had to keep working to pay the bills. His wife would have liked to continue at her job, but the cost of childcare would be more than she earned so she had to give it up. George worked longer hours to compensate, but missed having time with his kids.





As they grew up, the children spent a lot of time inside the flat. George didn't like them to play outside – the main road was dangerous and congested during the day, and you could smell the fumes coming off the cars. The nearest park was too far to walk to, and George didn't like the look of the young people who gathered there as it got late, anyway.

George found his work harder and harder as he got older, but with no savings there was no prospect of retirement. He was diagnosed with type-2 diabetes and high blood pressure by his doctor, and started on medication. He asked how he had contracted these, and the doctor warned him about his weight, and also told him that he really should avoid stress, so that was another thing to worry about. When he had a few episodes of low blood sugar, his driver's licence was taken away, so he had to stop work. George's wife had gone back to work, so there was some money coming in, but her years out of employment meant she went back in at a very junior level. She found working alongside much younger colleagues to be a bit of a struggle.

At 63 years old, George had his first heart attack, although the doctor said it was a minor one. The second one, three years later, was more serious, and George spent a few weeks in intensive care. He went through cardiac rehabilitation, which got him moving again, although he now got out of breath just walking to the corner shop, which put paid to any idea of finding work. The next year he had his third heart attack. The doctors said that with his health problems, intensive care would not be appropriate. George died at 68 years old.

If you had asked George about his life, he wouldn't have had many complaints. He loved his wife and he had two wonderful children. But he couldn't shake the feeling that he hadn't really been in charge of his own life sometimes. He felt something had been wasted – not just all the money he'd spent on rent, with no home to leave his children, nor all the money he'd spent on his car, just to go nowhere, nor all the money he'd spent on food, only to be told that his diet was killing him. He felt that, in some way, he had been wasted, and his potential squandered.

When Sumita left school, she also went to work in IT, in an apprenticeship for a data analysis company. The company she went to work for had a new initiative to recruit locally and had sent someone to talk to school leavers. They were looking particularly to recruit among underrepresented groups, and although Sumita, also the child of immigrants, didn't know anyone in the industry, they made her feel like a pioneer, rather than an outsider. Sumita really felt she learned a lot at work, and her manager took a real interest in her progress. She was given a lot to do, and it was hard work, but she felt challenged and she felt genuine satisfaction when she completed a project, as well as being congratulated by her team. She knew this was the way to get ahead. When her apprenticeship was over, she took a permanent job at the same company.

Sumita's company provided a lot of useful information. She started saving for retirement right away, after a really useful seminar, and she was able to access personal financial advice through work. She moved into a flat in a beautiful new development, at an affordable rent so that she could save for a deposit. The building had shared facilities, including work space, so she could work from home one or two days a week, which really suited her lifestyle. When she did go into work, she usually cycled there, left her bike in one of the lockers and had a shower before putting on her work clothes.

Sumita often ate lunch at the work canteen, where the food was healthy and pretty good. At home she cooked a lot – she often cooked large portions at the weekend, and she had a big freezer she could keep those in to have quick meals cheaply during the week. She had an active social life, and went

out quite a lot. Having flexibility in her work really helped her maintain her hobbies. She didn't mind working late into the night when she thought she needed to, as long as it was her choice. It was in the course of one of her hobbies – acting in a local bit of amateur dramatics – that she met the man who was to become her husband.

Sumita also had two children, a daughter and a son. Both her and her partner's work offered shared parental leave, so they both got to spend a lot of time with the kids when they were young. Sumita went back to work after her first child, but worked more from home than previously. Eventually, she moved her family out of town, having looked around and found a nice area with good schools and lots of open spaces to play in. Her company provided a lot of guidance and helped her secure a mortgage. She was also moving up through the company, and had gained a number of professional qualifications.

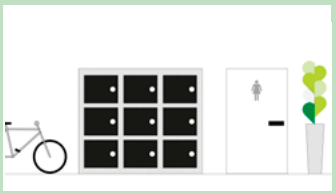
After her second child was born, Sumita had quite bad post-natal depression. Her company were really supportive, and she was given all the time she needed, as well as some signposting towards appropriate therapy. After she returned to work, she started travelling in one day a week again, as she found it helped her feel connected to what was going on. After a few more years, she finally moved on to another job, but she stayed in touch with her previous employer, and in fact helped place a number of young people into jobs there.

Sumita went on to a job at a smaller company, a tech start-up making an app for mental health. She was attracted by the company's strong social purpose. This had always been important to her, and a few years before she had moved her pension to a fund that aimed to use her money for positive social impact. She had decided this was more important than getting maximum return – after all, she found she worried less and less about money – but had been pleasantly surprised to see this fund outperform her old one. It seemed lots of people wanted to put their money into good business.

Sumita also volunteered part-time with a charity supporting young women into careers in tech. They met at the building where she used to work, as her old company had donated the use of some of their office space in the evenings.

Sumita developed a few health problems as she got older, but nothing that she felt really held her back. Although she cut back on her hours, she didn't really retire until she was 70 – and given her continued charity work, arguably not even then. She didn't feel she really needed to. She was still out and jogging every morning into her eighth decade. She died at 90 years old after a short illness.

If you had asked Sumita about her life, she would have said that she was grateful for the opportunities she had been offered, but even more so, thankful that she had grabbed them when they were, and that she had worked hard to take advantage of them. She had made a bit of a name for herself in her industry, she had contributed something, and she had left something for her children – not just money, she hoped, but an example and a legacy, if that wasn't putting it too strongly.

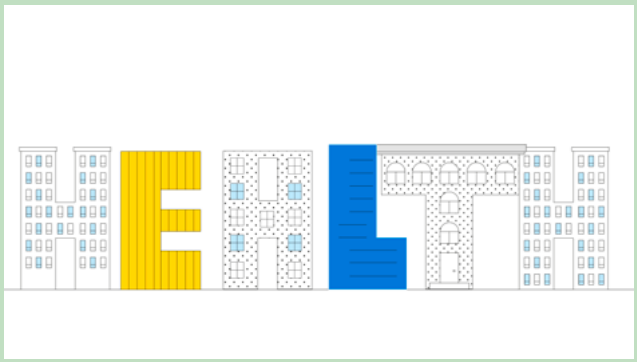


George and Sumita experienced very different trajectories through life. Neither came from a wealthy background, though neither was desperately poor either. In terms of life expectancy, Sumita had the advantage of being a woman, although women often live longer with worse health. Why was there such disparity in the lives they led?

Sumita had a better diet and a healthier lifestyle, but it is evident that George's poorer health choices were not simply a product of ignorance, laziness or apathy, but were shaped by his circumstances.

Governments, and the various arms of the state, also influenced their lives. Both had health problems, and both benefitted from NHS care. Yet we can see that the foundations of their health were laid long before they went to their GP or hospital. A higher minimum wage or increased statutory sick pay might have benefitted George, and health policy, housing policy, employment strategies and others all shaped the society in which they live. A different government, and different policies, might well have changed the inequalities they experienced, or reduced their importance for health.

No matter what the Government was doing, however, the private sector – the businesses for whom they worked, from whom they bought goods and services, and who also shaped the houses and communities in which they lived – had a huge influence for good and ill in the lives of these two people.



CHAPTER 1
INTRODUCTION

In all countries, rich and poor, the health of the population is strongly linked to the conditions in which people are born, grow, live, work and age. Access to high quality healthcare is essential but it is not lack of healthcare that leads people to become ill in the first place: it is the conditions in which people live and work. Inequalities in these social conditions account for a great deal of the inequalities in health that are a major feature of all societies. These inequalities were growing in the UK even before the pandemic, during a decade of austerity, and have been further amplified by the effects of COVID-19.

Until now, focus on these issues – the social determinants of health – has been for government and civil society. The private sector has not been involved in the discussion or, worse, has been seen as part of the problem. It is time this changed. Business has a vital role to play in shaping the conditions in which people live and work and, as a result, their health. Businesses can potentially play a key role in reducing health inequalities by improving equity in the social determinants.

Businesses have both positive and negative impacts on health: through employment practices; through goods, services and investments; and through their impacts on communities and the environment. This report shows concrete, practical ways through which focussing on these three domains can be a force for good in improving health and reducing health inequalities. Reducing harmful impacts of businesses and enhancing their positive contribution is vital for health and wellbeing.

Underlying this report is the recognition that business can and should be a partner for good in creating healthier societies. This report shows how and why 'H' for health can and should be added to ESG – environment, social and governance – as a core consideration for business (5).

We are calling on companies to act on the social determinants of health, not to gain competitive advantage, but because reducing health inequalities is the right thing to do. However, there are additional benefits that will accrue. In working to improve the health of their employees, employers will also reap the benefits of a healthier and more productive workforce. It has been estimated, for example, that 30% of the shortfall in productivity in the 'Northern Powerhouse' compared with the rest of England is due to ill health (6).

In increasing health equity and improving opportunities for disadvantaged groups, businesses can ensure they have access to the very best and brightest in recruitment and promotion. Businesses with a strong social purpose will also attract and retain the best employees, who increasingly seek more than just a paycheque. Within companies where a sense of collective purpose to address health inequality is cultivated there is also potential to benefit employee wellbeing. In one study of the five places in the world with the highest average life expectancy, a sense of purpose was identified as a key feature of the lifestyle and traits of people who lived to be over 100 (7). Where companies have their purpose at the heart of what they do, employees are more emotionally connected to the business and understand how they personally contribute (8).

ESHG monitoring would also enable consumers and investors to take account of who is doing something, doing more, or doing better, in support of health. Customers also seek out ethical companies, and the growing market for social impact investment funds shows that many investors feel the same way. This is not only altruism from their perspective, either, but includes a recognition that businesses making a positive contribution are well-placed to grow: protected from changes in legislative, policy and tax regimes; attracting driven and committed workers; and popular with informed and loyal customers and clients.

At the national and international level, the COVID-19 pandemic made clear the close interdependency of health and wealth. Despite opinions sometimes expressed in the media that at times suggested a need to balance the health of the population against the health of the economy, the real lesson was that neither could thrive without the other. The economy requires healthy workers and healthy customers, and a failing economy damages health.

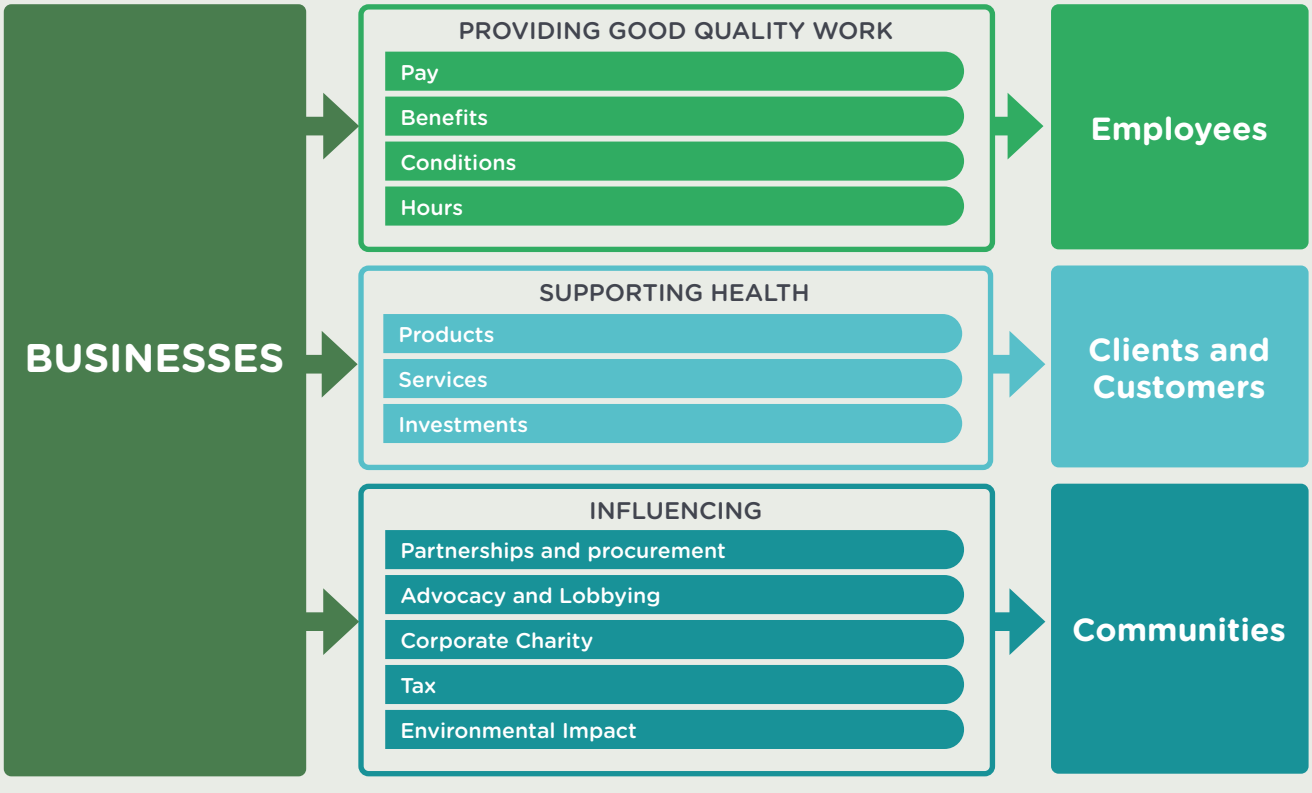
Many companies have already begun to take actions that improve health. Many, particularly larger employers, provide resources and services to improve employee health: for example, exercise facilities, healthy meals, or counselling for mental health issues. Other companies are concerned to improve the health impact of the products they produce, perhaps by ensuring that food is nutritious, or housing is good quality. Others support their local communities in a variety of ways, through local food banks, or funding community groups, for example. This work is valuable, but this report outlines how the private sector can maximise the effectiveness of such interventions and further extend action on health inequalities. This includes ensuring that all activities of businesses – investments, contracts, goods and services, working conditions and employment terms, as well as corporate social responsibility – are attuned to reducing inequalities in the social determinants of health.

This advice to do something, do more, do better echoes the advice offered to countries at different stages of development and action on the social determinants of health (9). Businesses that provide poor jobs or unhealthy products or function on a model of polluting manufacturing can do something to ameliorate their health impacts. Those that have worked to reduce harm can ask if there is something more they can do to support good health. Firms that already work to support health can extend their efforts through their investments and supply networks and more widely to disadvantaged groups and do better in supporting health equity.

This report covers the whole private sector and is of necessity general in its recommendations. It draws on evidence of positive action on health equity by businesses in the UK and around the world, and also from actions by communities, the voluntary, community, faith and social enterprise (VCFSE) sector, and local governments. The report is only the beginning of this movement to bring business into the world of health equity, and will be followed by the creation of a national network of local authorities, businesses and other partners committed to improving the health of the UK. Further work will look in more detail at specific industries, and begin to create metrics and tools for the assessment of health impact.

The social determinants of health comprise a huge sphere of action and so we have developed a framework to enable a systematic approach by businesses. Businesses affect the health of their employees and suppliers, through the pay and benefits they offer, through hours worked and job security, and through the conditions of work. Businesses affect the health of their clients and customers and shareholders through the products and services they provide and how their investments are held. Businesses can also affect the health of individuals in the communities in which they operate and in wider society, through local partnerships, through procurement and supply networks, and in the way they use their influence through advocacy and lobbying. The effects on wider society also encompass the environmental impacts of business operations, including carbon footprint and air pollution, as well as the taxes paid by businesses to local and national governments, which support policies for health. This is summarised in Figure 1.

Figure 1. How businesses shape health: the IHE framework



To tackle regional and local inequalities in health, businesses will need to make new connections with the public and voluntary sectors to take a place-based view of public health challenges and address them in concert. Companies should work with local systems that shape health: local authorities, Integrated Care Systems, healthcare providers, educators, housing associations, and the community and voluntary sector. Where connections between business and the public realm already exist, for example through Local Enterprise Partnerships, health equity should be at the top of the agenda, for the benefit of both the local economy and the health of the community.

In many cases, action on health might be easier for larger companies to take, with their greater resources and access to economies of scale. However, there is much that businesses of all sizes can do to improve health. Small and medium-sized enterprises (SMEs) are crucial to this work, as they provide more than half of the UK's private sector employment and turnover (10). While they may not have the same formal structures as large companies, they are just as able to adopt the ethos of health equity and pursue the same ends, and will accrue many of the same benefits in gaining a healthier, happier, more productive workforce, attracting customers and investment, and forging closer supportive ties with their local communities. SMEs can also work together to take action, forging new partnerships or using existing groups such as local Chambers of Commerce. Partnership working can also involve larger companies extending resources and expertise to SMEs, particularly those within their supply networks, to enable the sector as a whole to support health.

Any action to reduce health inequalities should consider the likely impacts of emerging drivers of inequality. New technologies have the potential to improve health, both through advances in healthcare and health education, and in widening access to services and resources. However, there is a danger that some individuals will be left behind if, for financial or other reasons, they are unable to access or use digital solutions. This problem was illustrated during the pandemic, when an increased reliance on virtual communication and distance learning for schools exacerbated social and economic inequalities. Equity needs to be a primary consideration in the rollout of new technologies, to ensure that they reduce, rather than worsen, inequalities.

The threat posed by climate change is a further challenge to reducing health inequalities. The direct and indirect impacts of climate change in the UK are likely to fall disproportionately on the already disadvantaged and worsen health inequalities. For example, increasing temperatures will disproportionately impact people not financially able to address overheating in their homes, while increasingly frequent and intense storms and floods are likely to disproportionately impact exposed households that cannot afford adequate insurance coverage. Those with lower incomes are likely to suffer more from rising food, water or energy prices that are likely to be indirect effects of climate change. Climate and sustainability concerns, therefore, are health equity concerns as well – in fact, ESHG is not four separate domains, but overlapping, intersecting and, properly considered, mutually supporting.

Our focus is on health, both preventing ill health and maintaining good health. This is only possible by considering the social determinants of health, factors that also constitute the building blocks of social, financial and emotional wellbeing. This report, then, is part of a movement for more responsible, socially impactful and health-generating business. It aims to provoke a shift in the culture of business towards defining success in terms of purpose as well as profit while meeting standards for equity in health, social and environmental performance, transparency and legal accountability.

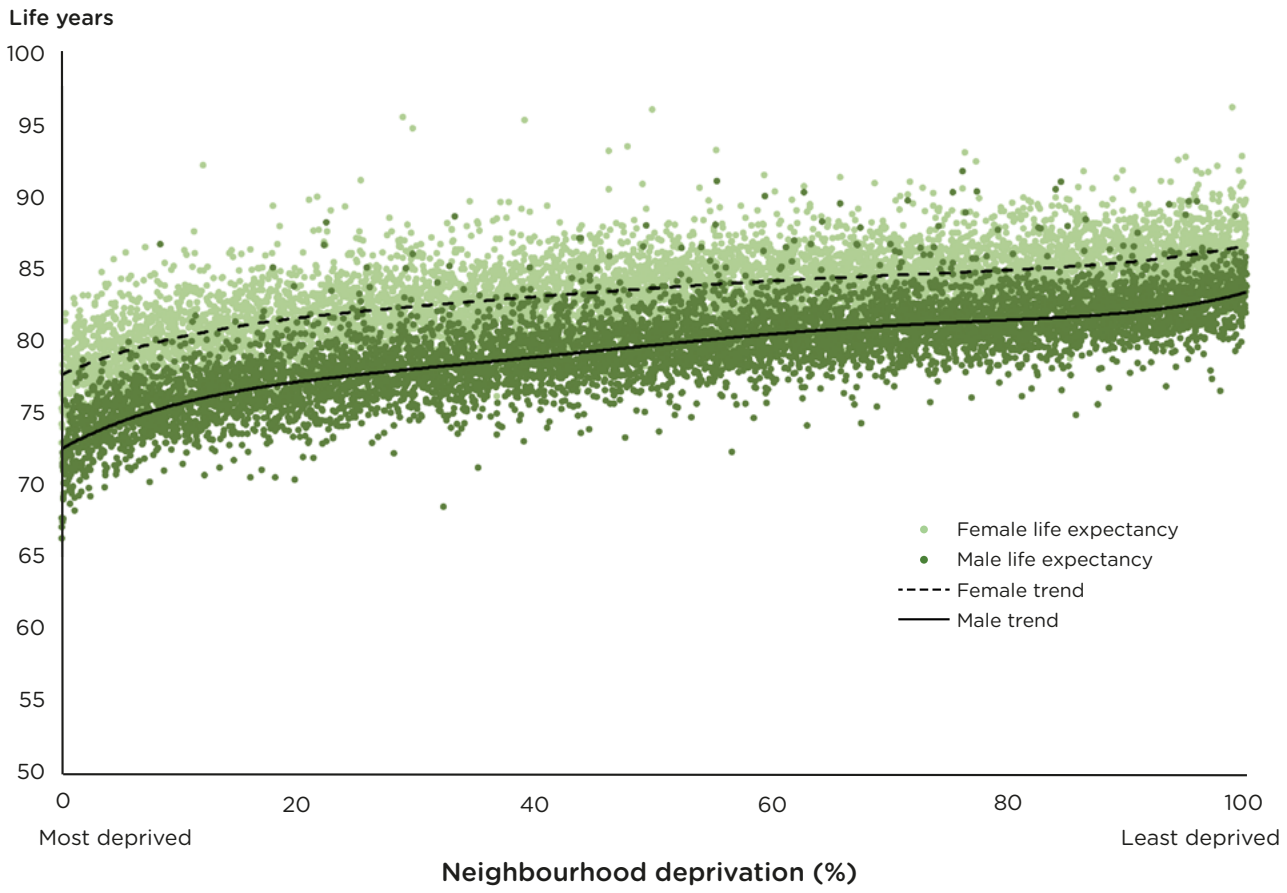
HEALTH INEQUALITIES IN THE UK

Across societies, the more advantaged enjoy better health and longer life spans than those who are more disadvantaged. This is true in poorer and in richer countries and health outcomes have been repeatedly found to be gradated up and down the social scale (11).

In 2020, just prior to the pandemic, IHE published *Health Equity in England: The Marmot Review 10 Years On*. It set out just how closely health and life expectancy relate to socioeconomic position in England, with these measures largely driven not by access to healthcare but by the social determinants of health – the conditions in which people are born, grow, live, work and age. Inequalities in experiences and outcomes in the early years, education, training, employment, income, housing and environmental conditions lead to unfair health inequalities, by affecting exposure and susceptibility to health risks, both physical and mental.

Figure 2 shows how life expectancy at birth correlates with the level of deprivation in the neighbourhoods in which we live, as measured by the Index of Multiple Deprivation (IMD). The health gradient is clear: the more deprived the area (represented as a dot on the graph), the lower the life expectancy. There is an even steeper gradient for healthy life expectancy – the number of years one can expect to live in good health. Inequality is costing years of healthy and productive life (2).

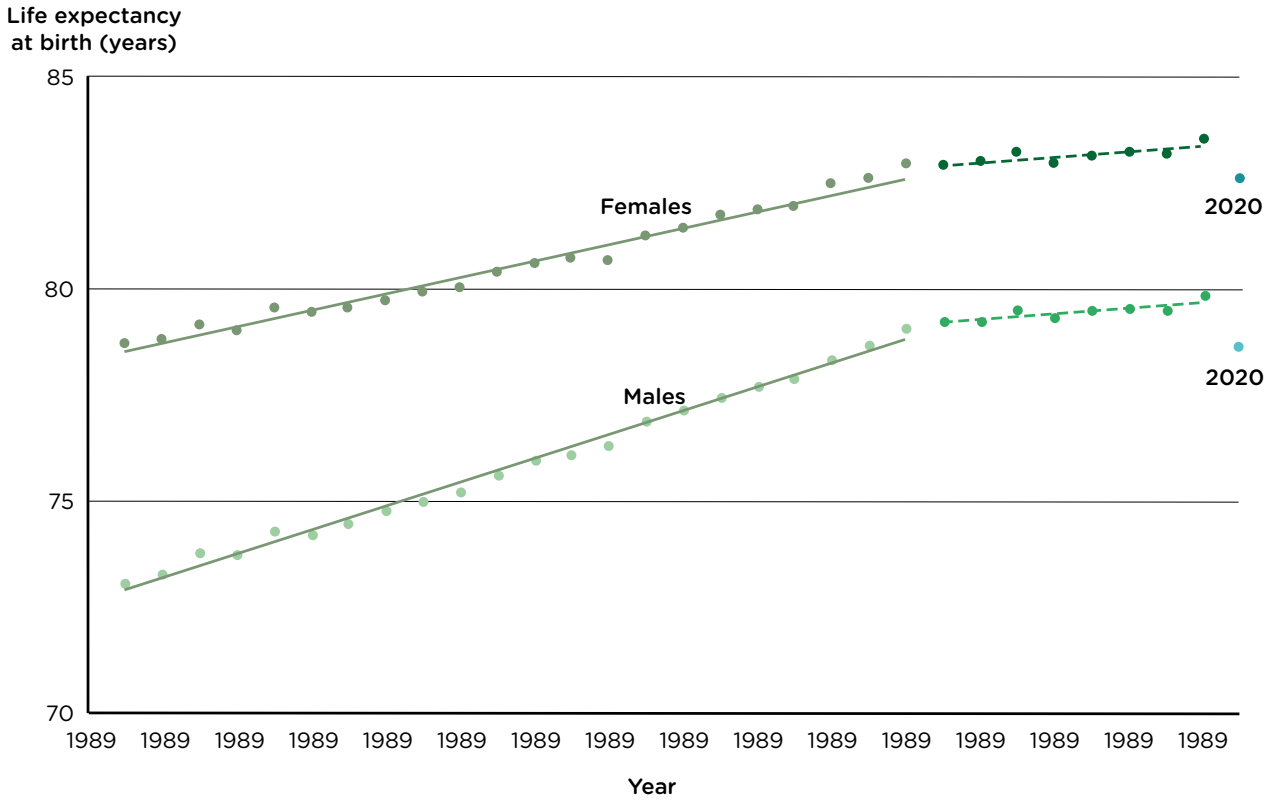
Figure 2. Life expectancy at birth for neighborhoods (MSOAs) in England, by sex and level of deprivation, 2016–20



Source: *ONS, 2021 (12)*
Notes: *Based on IMD, 2019. MSOA = middle layer super output area.*

The Marmot Review *10 Years On* report showed that in the decade from 2010, improvement in life expectancy had stalled, health inequalities had increased and life expectancy had declined for people in the most deprived 10% of neighbourhoods outside London. After the publication of that report, in the context of the COVID-19 pandemic, life expectancy in England declined for both men and women in 2020 (13). Figure 3 shows both the stagnating trend from 2010–19, and the sudden drop in 2020.

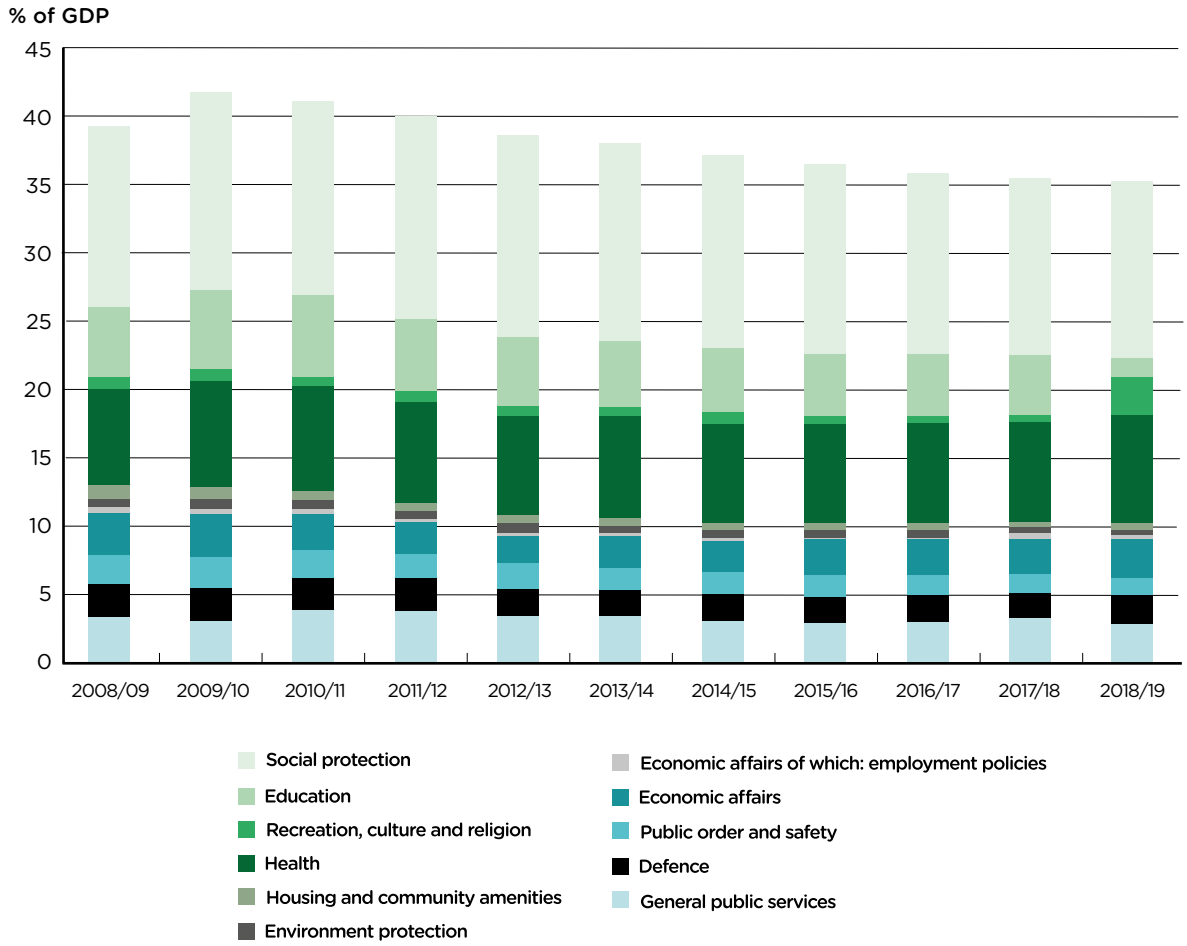
Figure 3. Life expectancy at birth, males and females, England and Wales, 1989–2020



Source: *ONS, 2021 (14)*

The impact of the 2008 financial crash, the subsequent recession and the policies of austerity that followed were experienced unequally across society and deepening social and economic inequalities manifested in worse health and more pronounced health inequalities between 2010 and 2020. Wages stagnated, job quality deteriorated and cuts to essential public services and benefits damaged health, particularly in poorer communities. As shown in Figure 4, public sector expenditure on services as a percentage of GDP declined from 42% to 35% between 2009/10 and 2018/19.

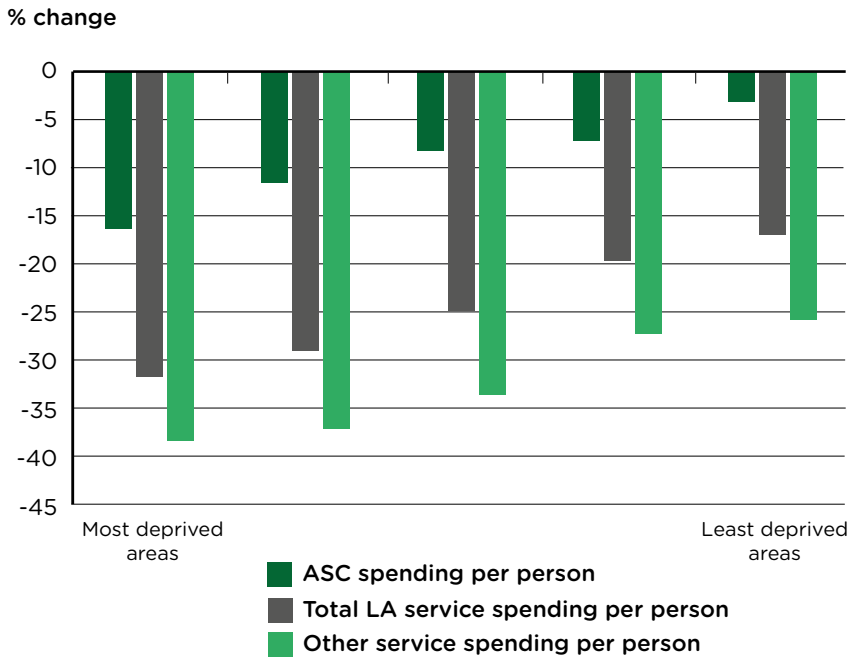
Figure 4. Public sector expenditure on services by function as a percentage of GDP, UK, 2008/09 to 2018/19



Source: *HMT National Statistics, 2019 (15)*

At a local level, funding cuts were deeper in more deprived areas, further disadvantaging those areas and leading to widening health inequalities prior to the pandemic (2). Figure 5 displays the relative cuts to local authority funding between more and less deprived areas, and shows that disproportionately large cuts fell on adult social care and other public services in more deprived areas, where there was already greatest need. In the 2010 Marmot Review we introduced the principle of proportionate universalism – universal programmes with effort proportionate to need. What Figure 5 shows is effort that is inversely proportional to need.

Figure 5. Average change in council service spending per person, by quintile of Index of Multiple Deprivation average score, 2009/10 to 2017/18



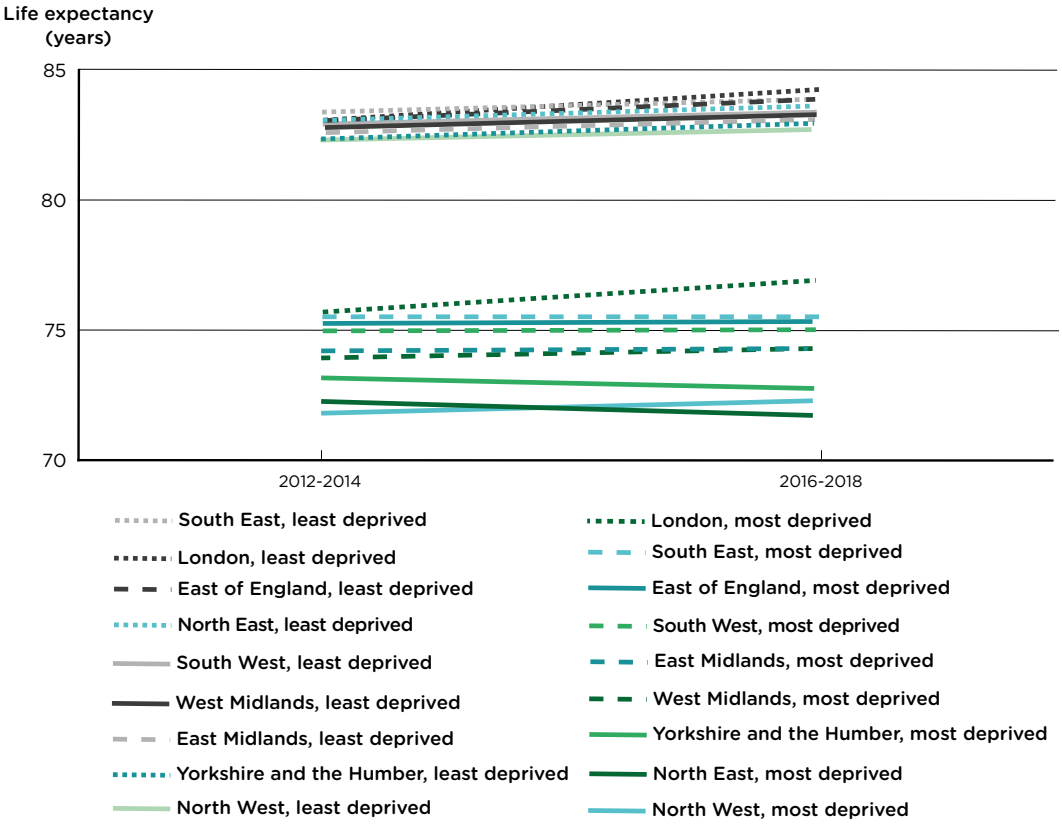
Source: *Institute for Fiscal Studies, 2018 (16)*

Notes: *LA = local authority; ASC = adult social care; Other services = all council services except adult social care.*

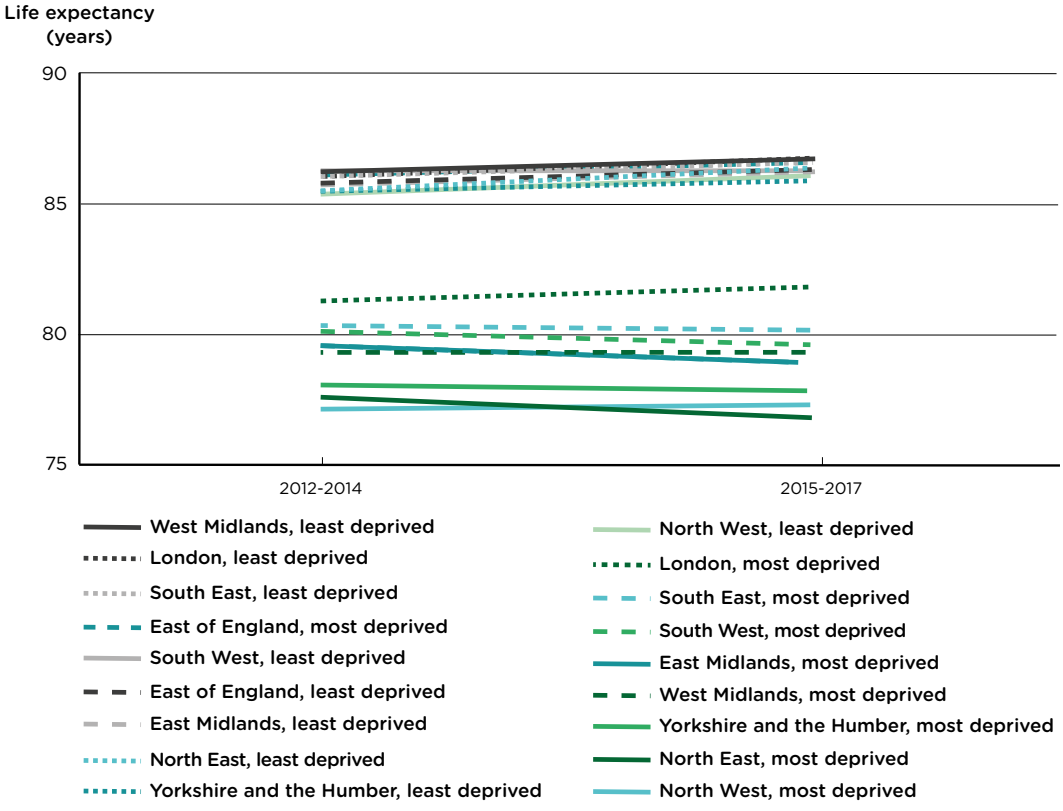
Figure 6 shows how regional and other inequalities interact to shape health inequalities. For those in the least deprived decile, there is little difference in life expectancy wherever in the country you live, and life expectancy rose slowly in the second decade of the 21st century. For those in the most deprived 10%, however, it matters enormously where you live, with those in London having a life expectancy on average five years longer than those in the North East. Outside of London and the South East, life expectancy for the most deprived decreased during 2010–20 and inequalities widened, even before the COVID-19 pandemic.

Figure 6. Life expectancy at birth by sex for the least and most deprived deciles in each region, England, 2010–12 and 2016–18

a) Males



b) Females



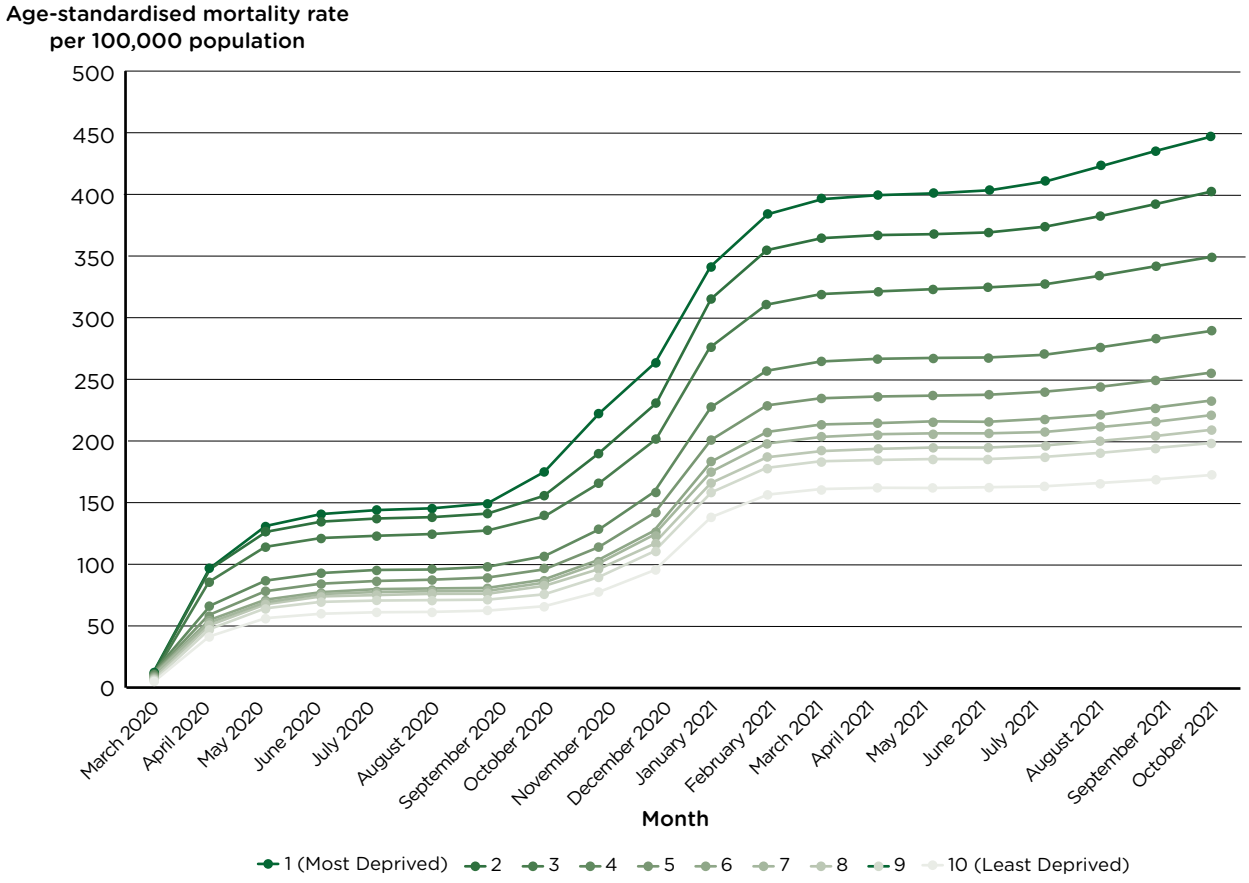
Source: *ONS, 2019 (17)*

In December 2020, IHE published Build Back Fairer: *The COVID-19 Marmot Review*, which showed that the pandemic and the response to it had exposed and amplified inequalities in health. These inequalities were themselves likely to be a legacy of the decade of austerity pursued by successive governments, leaving the UK in a poor and unhealthy state to handle the pandemic (18).

More deprived people were less likely than better-off people to be able to avoid infection, due to living in more crowded homes and neighbourhoods, and having a greater likelihood of working in service and frontline jobs which could not be done from home. More deprived people are also more likely to suffer from medical problems including obesity, respiratory problems, high blood pressure and diabetes, increasing their risk of serious illness or death from COVID-19.

Figure 7 shows the social gradient in health as exposed by COVID-19, with mortality for the most deprived being more than double that for the least deprived 10% of the population. This gradient is very similar to that for non-COVID mortality, suggesting that the same mechanisms of inequality are at work. We must also bear in mind other dimensions of inequality and exclusion that affect health, including ethnic inequalities: cumulative COVID-19 mortality rates for both Black/Black British and Asian/Asian British ethnic groups have been double that of the White ethnic group (19).

Figure 7. Cumulative mortality rate per 100,000 population for deaths involving COVID-19 in England, by deprivation decile, March 2020 to October 2021



Source: *CHIME, 2021 (19)*

It is in the context of these widening health inequalities and declining life expectancy that this report calls for businesses and industry to take a more active role in working for health equity. This is not to diminish the importance of government policy or wider civil society, nor is it to suggest that businesses should only play a role in health as a last resort, after government has failed. Businesses will always have a great deal of influence over health, whether intended or not. When businesses recognise this fact, they can then exercise that influence consciously in pursuit of better health for all. That includes interacting with the public sector, in support of good health policy. As noted above, investors looking for sustainable returns on their investments may well seek out businesses who are staying ahead of the Government, in anticipation of regulation to come. The fact that government policy over the last decade has failed to reduce inequalities only makes it more urgent for industry to join in the effort.

CHAPTER 2

BUSINESSES REDUCING HEALTH INEQUALITIES

Health equity should be a consideration across all industries, and across all departments within businesses, in the same way that environmental sustainability is becoming. However, in the past, increased action on environmental risks by businesses has not always led to sustainability considerations becoming embedded throughout these companies. One survey of 9,500 executives globally found that 45% of executive-level managers within a company said their organisation's sustainability strategy was about brand management and being viewed as socially responsible, while only 20% thought they were creating real value (20). Action taken merely for appearances' sake must be avoided as businesses try to embed health equity.

This report outlines ways in which companies can take action on the social determinants of health. No single intervention is the answer, but we recommend the re-orienting of a firm's culture to one that prioritises the reduction of inequalities and fostering positive social as well as economic impacts. This requires a root and branch examination of business practices, purpose and incentives. It requires a clear message from the top, and responsibility and autonomy in decision-making at every level. Pockets of good work, siloed into ethics or ESG teams, do not mean that a company is acting in the best interests of health in the way it conducts its business. Companies may be supporting health in some areas while hindering action elsewhere.

The following three sections of the report detail these areas for action, laid out according to our business for health equity framework illustrated in Figure 1 above. Section 2.1 describes some of the ways that employers can improve health with good quality work, available to all. Section 2.2 describes some of the effects on health that businesses have through their core operations, providing goods and services to clients and customers, and by making investments. Section 2.3 examines some of the effects that businesses have on the local communities in which they operate and on wider society.

2.1. BUSINESSES AS EMPLOYERS CREATING GOOD QUALITY WORK

Recommendations for creating good quality work

A) PROVIDE SUFFICIENT PAY AND IN-WORK BENEFITS	Ensure pay for all employees, contractors and workers throughout supply networks constitutes a minimum income for healthy living. Companies should make attempts to reduce disparities in pay across their organisation. In-work benefits should be comprehensive and larger companies should assist SMEs to achieve this.
B) ENSURE HEALTHY WORKING CONDITIONS	As well as ensuring safe working conditions, businesses must provide good quality employment, job security, flexible working practices and employee representation. Recruitment should ensure opportunities for underrepresented communities, and opportunities for training, progression and personal development should be offered to all staff.
C) ENSURE GOOD PHYSICAL AND MENTAL HEALTH	Employers should work with their entire workforce to support good physical and mental health. This includes providing advice and support for key drivers of health such as housing and financial management as well as healthy living and the maintenance of good mental health.

Employers have a great deal of influence over the health and wellbeing of their workforce. In this section we discuss the definition of good quality work, before going on to look in more detail at the impact of pay, benefits and conditions of work on health via the social determinants. Finally, we discuss ways in which employers can take direct action to support health in their workforce.

JOB QUALITY

Unemployment, particularly when it is long-term, contributes significantly to poor health, while good quality employment is protective of health (1). Poor quality work, which is characterised by adverse physical or psychosocial conditions, by poor pay and insufficient hours, by precarity, job insecurity and the risk of redundancy, can be actively harmful to physical and mental health (2) (21).

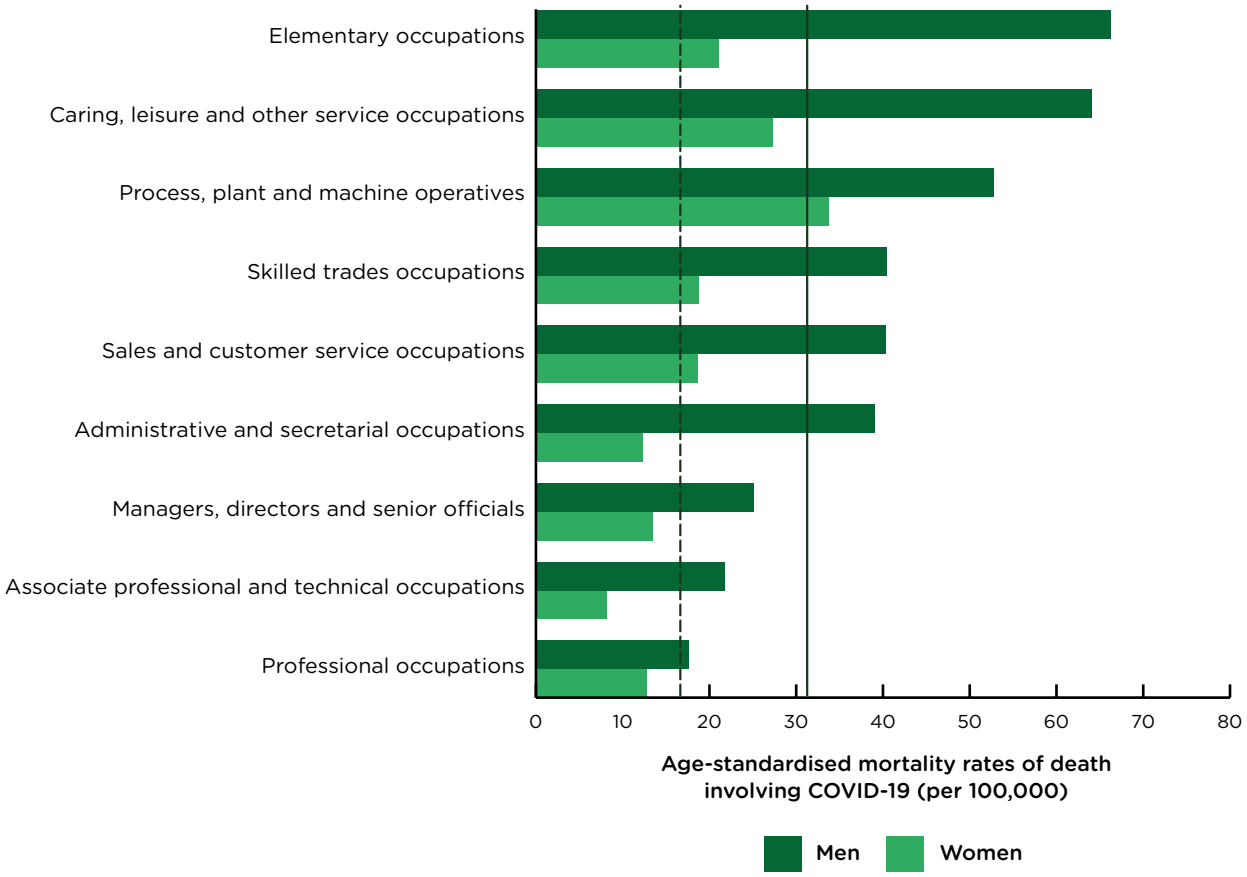
Safe working conditions extend beyond protecting against physical risks to health and safety. The UK economy has a large tertiary sector, where accidents are less common, and also relatively strong legal requirements for safe workplaces, although even here, and accounting for the pandemic keeping people at home, 142 workers died and 693,000 were injured in workplace accidents in 2019/20 (22). Good work includes having safe working conditions for both physical and mental health, and also fair progression, decent pay, job security and having some control and flexibility over tasks (23).

Hierarchy in the workplace plays a significant role in shaping health inequalities, as first established by the Whitehall studies of UK civil servants. The higher rates of disease, both physical and mental, among those lower in the civil service hierarchy were found not to be entirely explained by differences in lifestyle, like smoking and drinking alcohol, and these civil servants were not facing absolute poverty and deprivation. In fact, the the hierarchical and disempowering nature of the work that placed high demands on the worker while providing little control over work tasks was shown to play a key part in generating inequalities in health (11) (24).

Lower-skilled work is associated with higher mortality from all causes (25). Investment in recruitment, training and retraining, particularly in underserved regions, may help move people into higher-skilled, higher-paid jobs that protect their health, but we must also strive to improve the conditions of work in order to protect those in lower-skilled and lower-paying jobs, who must also have the chance of a long and healthy life.

The COVID-19 pandemic has highlighted inequalities in health related to occupation. As Figure 8 shows, mortality between different occupational groups has varied significantly.

Figure 8. Age-standardised mortality rates at ages 20 to 64, by sex, and major occupational group, for deaths involving COVID-19 registered in England and Wales between 9 March and 28 December 2020



Notes: *1. Elementary occupations are those that require the knowledge and experience necessary to perform mostly routine tasks. Most occupations in this group do not require formal educational qualifications but will usually have an associated short period of formal experience-related training.*

2. The vertical lines represent the average death rate involving COVID-19 at ages 20 to 64 in England and Wales for men and women, respectively.

Source: *ONS, 2021 (26)*

Below we examine the main features of good quality work that are affected by employers' policies, management approaches and conditions of employment.

PAY

Employers have significant influence on health via the wages they pay. While high incomes cannot guarantee good health, an insufficient income to be able to lead a healthy life leads to poor health: by increasing stress and reducing the sense of control over one's life; by reducing access to resources and a decent living environment; by making it harder to adopt and maintain healthy behaviours; and by removing the reassurance of a financial safety net (2) (27).

In the UK, the majority of those living in poverty are now in work and having a job does not guarantee a sufficient income (2). This can lead to a vicious cycle, as lower income can lead to poorer health, and poorer health can reduce the chance of being in employment and one's earning capacity (1). The cycle can even perpetuate into the next generation: forced to take multiple jobs and work unsociable hours to make ends meet, workers in precarious employment will spend less time with their families. Children who receive less attention at home from absent or exhausted and preoccupied parents are likely to have reduced cognitive development compared with their peers even before their formal education begins (28).

Established minimum wage levels, including the National Living Wage, do not provide a basis for healthy living, or even for avoiding poverty (23). The original 2010 Marmot Review described a minimum income for healthy living (MIHL), which included being able to afford the costs of a healthy diet and exercise (1). The Joseph Rowntree Foundation similarly set out a minimum income standard (MIS), which is an income sufficient to provide for a socially acceptable standard of living, and meets the criteria of the MIHL. This includes basic necessities like healthy food, good housing and clothing, but also the freedom and opportunity to participate fully in society, as determined by members of the public. It also takes into account not just income at a given time, but also what is required to achieve security and stability in an unstable labour market (29). The statutory National Living Wage by itself is insufficient for many to reach this standard.

Many companies already recognise the insufficiency of the statutory National Living Wage and are accredited Living Wage Employers, providing an income above the statutory minimum (30). **It is possible for companies to go beyond this, and ensure that they are offering a minimum income for healthy living to all contractors and other temporary employees, as well as using their influence to support companies in their supply networks, or those that they hold shares in, to makes similar commitments.** We encourage all companies to do this.

Ensuring the financial wellbeing of employees goes beyond paying sufficient wages, and employees may benefit from financial planning advice (31). Financial services firms like Legal & General are particularly well-placed to **encourage and support employees, temporary staff and associates throughout supply networks with financial planning, enabling them to make the most of their income and avoid financial stress. Assistance with financial planning should take advantage of research in behavioural science and systems to 'nudge' employees towards long-term decision-making, as with the introduction of opt-out pension schemes** (32).

INEQUALITY IN PAY

Action on pay that aims to reduce health inequalities may also include reining in excessive remuneration packages for senior figures. In the United States in 2020, by one calculation, the average CEO made over 350 times the earnings of the average worker, up from 21 times in 1965 and 61 times in 1989 (33). In the UK the situation looks a little better, but high levels of inequality remain: the median FTSE 100 CEO took home 86 times the median earnings of a UK full-time worker in 2020 (34). Remuneration decisions are already routinely assessed as part of responsible governance in the UK.

Companies should make a bold commitment on remuneration, prioritising fairness alongside market value and committing to bringing down pay inequality. There is a danger in setting concrete targets that can, for example, encourage companies to outsource their lower-paid workers or provide additional benefits to senior executives that are less visible, nor does addressing executive pay reduce inequalities between companies or between industries. However, **companies that make honest and transparent attempts to reduce the disparity in pay packets across their organisation should be applauded.**

IN-WORK BENEFITS

Pay for sickness absence is essential in enabling workers to take time off to access healthcare and recover from illness or injury. COVID-19 has also highlighted the importance of pay for sickness absence in slowing the spread of disease, by enabling people with infections to stay away from workplaces and avoid contact with colleagues and clients. Most workers in the UK receive some or all of their salary for a limited period of sickness absence, but it is estimated that about a quarter of workers, or 6.4 million employees, are only eligible for statutory sick pay (SSP) at £96.35 per week (35). The rate of SSP in the UK equates to less than 20 % of median weekly earnings, and is comparable to Malta's, which is the lowest of any EU member state. The equivalent in France,

by comparison, is 50%, in Germany 70%, and in Denmark 80% (36). Workers on low incomes are particularly likely to receive no further employment benefits beyond SSP, so that the already disadvantaged face the greatest income insecurity when they become unwell.

The support that is available to permanent workers is not always extended to contingent workers, or throughout supply chains. Analysis by the Trades Union Congress of the Labour Force Survey found that in 2019 about 1.87 million workers were not eligible for SSP due to not meeting the lower earnings limit of £118 per week (now £120), and that 70% of these were female, and many in insecure or zero-hour contracts (35). The TUC also found that about 34% of people on zero-hour contracts did not meet the earnings threshold.

The Workforce Disclosure Initiative, a coalition of investors that encourages companies to disclose their workforce and supply chain practices, received submissions from 141 companies in 2020, covering over 14 million direct employees, and many more in supply chains. It found that every company that provided data reported that permanent employees were covered by measures to ensure they took sick leave appropriately, but only 87% extended the same benefits to temporary workers, dropping to between 20% and 27% for workers on zero-hour contracts, agency workers, contractors and other contingent workers (37).

Beyond sick pay, other employee benefits also contribute to the social determinants of health and health inequalities. Workplace pensions significantly mitigate risks of low income in old age; and support for parental leave and childcare allow parents on lower incomes to remain in work, both maintaining income and avoiding de-skilling and damaging career progression. For many on lower incomes, childcare costs can be a huge burden: in a recent survey 33% of parents using childcare reported that childcare costs were bigger than their rent or mortgage payments, rising to 42% of parents receiving Universal Credit, and 47% of those with a Black ethnic background (38). This may make it economically unviable to work at all, which may in turn stall career progression and worsen inequalities. 82% of mothers and 56% of fathers reported to the same survey that they would have achieved a more senior or higher-paying position at work had they not had childcare considerations (38). Alternatively, parents may be forced to work excessive hours to cover childcare, reducing the amount of time they have to spend with their children, which can itself have knock-on effects that perpetuate disadvantage into the next generation (28).

Under what is often called the 'Nordic model', in some countries the state provides for extended parental leave and either provides or subsidises childcare. Businesses should support moves towards such a model in the UK, which could ameliorate the effects of socioeconomic inequalities and prevent the worsening of health inequalities for both parents and children. In addition, this increases the possibility for those who wish to work to remain in the workforce. In a report outlining the role of business, however, it is important that we consider where the private sector can contribute when

the state is unwilling or unable to provide such support. Companies can provide parental leave beyond the statutory minimum, and provide or subsidise childcare for employees. Forms of flexible working may also make it easier for parents to accommodate their parental responsibilities alongside remaining in work.

Companies should consider the benefits they offer, including sickness pay, parental leave and childcare, as a means of reducing health inequalities and use their influence over companies they contract with to ensure these benefits are available more widely. SMEs that lack the infrastructure and expertise to provide these independently may be able to collaborate with each other and with larger companies to pool risk and ensure all employees receive the support they need.

LOW-CONTROL WORK ENVIRONMENTS AND JOB INSECURITY

Working environments that generate psychosocial stress harm health. To support health, jobs need to be stable and provide a good degree of autonomy and control, combined with support from fellow employees and managers. This kind of work can improve wellbeing by meeting the psychological needs of self-efficacy, self-esteem, a sense of belonging and meaningfulness (21).

Stressful jobs are particularly damaging to health, and these can be conceptualised either as jobs that make high demands of employees but offer little control, or as those that ask for a great deal of effort but provide little reward in the form of pay, recognition or status (39) (11). These jobs are associated with worse physical and mental health, including higher risks of obesity, heart disease and diabetes, aspects of 'metabolic syndrome' (40) (11). Worse jobs tend to be clustered at the lower end of the socioeconomic gradient, thus worsening the inequalities in health across society (21).

In the last 10 years, while unemployment has decreased, there has been an increase in precarious employment: jobs that are low-paid, unskilled and offer insecure contracts (2). Insecure employment can include self-employment or employment on temporary or zero-hour contracts (41). Workers on zero-hour contracts may lack a reliable income and endure a very unbalanced power dynamic with an employer who expects them to be available at short notice. Job insecurity has been found to be associated with self-reported poor health more than other characteristics of low-quality jobs (42).

People in lower-skilled and lower-paid occupations and people from minority ethnic groups are more likely to be on zero-hour contracts than those in higher-skilled occupations and people from White backgrounds (2). To protect workers on these contracts, the Living Wage Foundation has produced a Living Hours standard, covering accurate contracts that reflect the reality of the work, decent notice periods for shifts and a guaranteed minimum of 16 hours' work a week (43).

Management practices for all staff should be based on principles of good working conditions, including allowing all employees to have some control over their working hours and environment where possible, variation in tasks, and systems for recognition and reward for work, that are purposeful and health-promoting, at every level of the organisation. Companies must ensure that workers are not falsely classified as self-employed and are on secure contracts and terms of employment that meet the Living Hours standard.

WORKING HOURS

Working 'long hours', which is defined as 48 hours or more per week, increases the risk of experiencing fatigue and of accidents. There is some evidence that it can lead to stress, depression or mental ill health. The World Health Organization has found that working 55 hours or more over a week is the occupational risk factor most associated with increased mortality, responsible for around 750,000 deaths per year globally due to an associated increased incidence of stroke and ischaemic heart disease (44). In the UK approximately one in eight workers works more than 48 hours per week, rising to one in six in London (21). One in four of all sick days taken in the UK is directly attributed to workload problems (45).

A study of UK firms that adopted a four-day working week found that over three quarters of staff were happier, 70% were less stressed and 62% took fewer days off due to sickness (46). One of the main criticisms of a four-day week is the compromise in terms of productivity. However, research consistently shows that the most productive and wealthy countries are ones that work fewer hours (47). It may be that as nations become more productive, they free up more time for workers; or that, at least past a certain point, excessive work hours lead to a drop in productivity. In France the working week has been capped at 35 hours since 2000, with no repercussions for its productivity. Productivity as measured in gross domestic product (GDP) per hour worked in 2017 found France's productivity was £69.60 per hour, while in the UK it was £61.10 (48).

Shift working is associated with a number of negative health outcomes, including disrupted sleep patterns, symptoms of anxiety and depression, and increased risk of cardiovascular disease (49). While shift working cannot be eliminated entirely, particularly in the healthcare and transportation industries, efforts should be made to limit this kind of work where possible and to protect the mental and physical health of shift workers by avoiding excessive hours and providing support where necessary.

The COVID-19 pandemic has seen a huge increase in working from home. Most of those who have begun working from home, across the socioeconomic gradient, want to continue working from home at least some of the time, and a smaller number want to remain at home all of the time (50). Flexible working should be encouraged as it can promote a good work–life balance and a degree of control over one's life while also enabling social interaction at work, which is supportive of good mental health. Flexible working can be particularly beneficial for working families with children, or those with caring responsibilities, who might not be able to continue in the workplace if their on-site presence were required full-time.

Employers should regulate working hours and promote a work–life balance that supports physical and mental health, taking into consideration options for creating a four-day week.

EMPLOYEE REPRESENTATION

In addition to pay and benefits, there are other aspects of 'good jobs'. The Good Business Charter, a UK accreditation scheme for responsible businesses, recognises employee representation as a crucial component of a good business (51). The Taylor Review of Modern Working Practices (2017) similarly noted that consultative participation and collective representation, and the ability to actively engage with decisions affecting people's working lives, are indicators of healthy employment practices (52). Employee representation may involve recognition of and support for union membership, and a commitment to engage with workers' representatives (51).

Businesses should seek opportunities to increase employee engagement and to support worker-owned cooperatives in supply chains. Larger companies must commit to worker representation at the decision-making level, including on corporate boards. SMEs may not have the same formal structures but should engage with employees on a regular basis, and see that all employees have a chance to have their voices heard.

RECRUITMENT, TRAINING AND PROGRESSION

A company that provides good jobs and the health benefits that come with those must also take care not to perpetuate inequalities. This necessitates an approach to recruitment, retention and promotion that is supportive of individuals with recognised protected characteristics who may face barriers to employment, and barriers to career progression once in employment. As well as the benefits this will bring for social justice, and for the company in terms of widening the pool of available talent, measures to address unequal opportunities can contribute to health equity by making good jobs available to disadvantaged groups.

For example, within the fund management industry only 1% of people identify as Black, in comparison to 3.3% of the UK population and 13.3% of the population of London, where the majority of fund managers are based (53). Projects like 10,000 Black Interns are working to increase representation in sectors including the financial sector by working with companies to offer 2,000 internships a year for five years (54).

EXAMPLES OF TRAINING AND RECRUITMENT PRACTICES FOR GREATER WORKFORCE EQUITY

The Wates group in the UK sets commitments on employment for disadvantaged groups, including ex-offenders, care leavers, disabled people, those not in employment, education or training, homeless people and veterans (55). In a construction project at Gibside Special Educational Needs School in Gateshead, 11 prisoners gained qualifications and insight into the profession, one of whom went on to secure paid work experience there after his release and gain further qualifications and entry into a career path (55).

Redemption Roasters trains offenders in coffee-making skills in 10 prisons, including at its roastery at HMP The Mount, and provides employment opportunities for ex-offenders on release (56). Second Shot Coffee trains, employs and supports people affected by homelessness (57).

Nairn's Oatcakes has partnered with a social enterprise, Haven, to provide employment to people with disabilities or other disadvantages in the labour market (58).

Improving equity in recruitment may involve working with partners. Applied is a recruitment platform aiming to reduce bias in hiring, and has managed to increase the rate of placing ethnically diverse candidates into science, technology, engineering and mathematics (STEM) positions by two to three times. 60% of its successful hires would not have been placed by a traditional CV review process (59). It is worth noting, however, that others have raised concerns about tech-based 'race-blind' hiring, which may be less effective than race- and gender-conscious hiring with the aim of actively increasing diversity (60).

Legal & General has developed a digital 'Best Team' toolkit aimed at challenging thought patterns and behaviours when decisions are being made on hiring, promotion and development, to encourage diversity throughout the group (3). At the highest level, Legal & General has pledged to oppose all-male boards and non-ethnically diverse boards of large US and UK investee companies (3).

Provision of apprenticeships and other training schemes, as well as within-work training and progression, are beneficial to reducing inequalities in health and in the social determinants of health. **Apprenticeships** and other 'non-traditional' routes that favour those with fewer advantages are particularly important for social mobility and reducing health inequalities, and bring benefits to companies by providing hard-working motivated employees with a wide range of skills and life experiences.

Closure of early years services and schools and disruption to universities, further education and apprenticeships during the pandemic risk having widened inequalities in children and young people's development and education and in post-18 training and employment. During the first two quarters of the 2020/21 academic year the number of apprenticeships dropped by 18% in England from the same period in 2019/20 (61).

During the two years of the COVID-19 pandemic unemployment increased among all age groups, but young workers aged 18–24 and older workers were the most likely to have left employment, and the most likely to have become economically inactive as opposed to being registered as unemployed (62) (63). Unemployment in young adulthood is particularly scarring for long-term earnings and employment prospects and damaging for health and wellbeing. **Businesses have a central role to play in working in partnership with youth and adult education providers, to increase availability of mentoring, internships, training and school holiday training schemes.**

One survey found that 43% of people from a Bangladeshi ethnic background and 38% of people from a Black Caribbean ethnic background had experienced loss of income as a result of the pandemic by June 2020, compared with 22% of White British people (64). This loss of income could represent the loss of a job, or a reduction in pay or hours, which during the pandemic lockdowns happened more commonly in jobs without secure contracts. Tackling inequalities like these requires companies to **proactively seek out opportunities for recruitment to good quality jobs in underrepresented communities.**

Companies must commit to achieving equal pay for equal work, as well as to monitoring equality and inclusivity at all levels of recruitment, promotion, pay and seniority, with the aim of encouraging diversity throughout their organisation.

Once again, SMEs may lack the structures to take these actions systematically, and larger companies may be able to support SMEs in their supply networks to adopt positive recruitment strategies and could open their training schemes to SMEs in their supply chains, facilitating the upskilling of workers throughout the system. Local business organisations, perhaps working with local government, may be able to provide a support network for SMEs to ensure fair recruitment in a local area.

MENTAL HEALTH SUPPORT

Having to undertake stressful work can be more detrimental to health than being unemployed (65). Chronic stress at work is related to poor mental health, coronary heart disease and metabolic syndrome (66) (67) (68). In 2018/19 there were 602,000 workers in the UK who reported themselves to be suffering from work-related stress, depression or anxiety (1,800 per 100,000 workers) and a total loss of 12.8 million working days as a result (an average of 21.2 days lost per case) (69). More people suffer from poor mental health in the workplace than from work-related musculoskeletal disorders (70).

Businesses have a statutory requirement to look after the health and safety of workers, and in recent years, particularly in the context of the COVID-19 pandemic, employers have started to recognise and acknowledge how work can influence mental as well as physical health (71). Some have called for parity between the management of physical health and safety and mental health and safety within the corporate world (71).

Companies should prioritise mental health at work, including protection of good mental health with good quality jobs and consideration of working hours and pressures. Companies should provide effective signposting to mental health services and counselling services when appropriate. There should be parity between physical and mental health conditions, including in all sickness pay, leave and other benefits. Large companies may also be able to extend some of their support services to SMEs in their supply networks.

EXAMPLES OF CORPORATE MENTAL HEALTH APPROACHES

Procter & Gamble responded to the pandemic by overhauling its Mental Health and Wellbeing Strategy, elevating it from constituting pockets of work and one-off events, with variable commitment from managers, to become a thread woven throughout its business. P&G's approach incorporated important elements including buy-in and direction from senior leadership, and provision of multiple, varied and easily accessed avenues of support for employees (72).

Anglian Water has also responded to changes in working brought about by the pandemic. Describing safety as its number one concern, it has incorporated 'psychological safety' into that established focus and created a Health and Safety Strategy that guides action across its business and supply chain. It has recognised that the increase in working from home necessitated by the pandemic has improved work–life balance for many of their employees and has committed to a more flexible approach in the future that will retain home working as a viable option (73). Flexible working is one way in which employees can be given more control over their working lives.

Deloitte has similarly credited the pandemic with prompting the company to rethink its approach to mental wellbeing. Its CEO encouraged staff to put their wellbeing and that of their families first from the start of the pandemic. The company has committed to flexible, hybrid working in the longer term, which is encouraged and role-modelled by leaders (74).

PHYSICAL HEALTH AND HEALTH BEHAVIOURS

Employers can support and encourage healthy behaviours among their employees: for example, encouraging active travel to work by providing bike lockers and showers at work for those who walk or cycle in. They can subsidise bicycle purchase or hire schemes, or travel on public transport for a hybrid journey that involves at least some active component. Larger companies should give consideration to physical health when designing offices, including provision of green spaces where possible and encouragement of active travel. Workplaces that provide food can prioritise healthy options. Companies may provide services to assist with smoking cessation or alcohol reduction. This is far from an exhaustive list.

While these actions can support employees' healthy decision-making, it must be noted that initiatives like these should not replace action by business on the social determinants of health: the causes of the causes. Higher-risk health behaviour is more common further down the social gradient: there is evidence that stressful lives, while damaging health directly through physical stress responses, also bring a cognitive load that reduces the 'mental bandwidth' available for making decisions; and stress reduces capacity to make difficult health behaviour changes, such as giving up smoking, resulting in behaviour that worsens health in the long term (75) (76) (40).

Healthy workplaces should support physical health by encouraging and facilitating good diet and exercise, without neglecting action on the social determinants of health.

WORKFORCE CONTRIBUTIONS

Companies can also support their employees, at all levels, to undertake philanthropic or purpose-driven work to act on the social determinants of health and health inequalities. This may be as simple as matching donations. Going further, companies could support employees to volunteer. For example, employees' contracts could specify a number of days of employment to be spent volunteering. **Employees should be encouraged to engage with the local community and support community activities**, and in turn they should be supported by their employer to do so.

Companies should identify employees who are already furthering health equity and sustainability goals and retain, develop and incentivise them to drive cultural change. Health equity considerations should be incorporated into the frameworks of how leaders are selected, promoted, rewarded and developed.

EXAMPLES OF WORKFORCE CONTRIBUTION PROGRAMMES

Google offers an array of programmes aimed at supporting workforce contributions. In terms of monetary contributions, Google Give matches any charitable donation by an employee, up to $10,000 a year; while the Google Giving Campaign provides every employee with $400 at Christmas to donate to charities of their choice, encouraging local, small-scale community action. The Google Serve programme allows employees to spend up to 1% of work time on a charitable cause of their choice, for which Google will also donate $10 for every hour spent, up to $2,500 a year: this can involve whole teams engaging in community projects (77). The Google.org fellowship programme loans out employees to specified charities for longer periods (78).

On a smaller scale, Barkers Commercial Consultancy in the UK is a procurement consultancy of 20 people who have committed to working for social benefit. From 2017, senior staff moved from billing an average of five days a week to three, freeing up time to contribute to pro bono advisory work for charities, be members of advisory boards, and create their own social enterprise, Life-Scape, a landscaping business employing ex-offenders. In 2021 the firm invested the equivalent of 220 days of Partner time, for a financial value of £328,900 (55).

2.2. BUSINESSES SUPPORTING GOOD HEALTH FOR CLIENTS AND CUSTOMERS

Recommendations for supporting good health for clients and customers

A) ENSURE CONSUMER PRODUCTS SUPPORT GOOD HEALTH	Businesses have a key role to play in supplying consumer products, including affordable and nutritious food, that enable people to live a healthy lifestyle. They must also act to limit the harm done by products that damage health and the social determinants of health. Financial products and services should be designed to expand access and support good health.
B) ENSURE HOUSING, INFRASTRUCTURE AND REGENERATION SCHEMES ARE HEALTHY AND EQUITABLE	These should support good health in their design and construction, particularly for lower-income communities, and adhere to sustainability principles. Health equity impact assessments must be used and responded to.
C) INVEST FOR HEALTH EQUITY	Businesses must give priority and visibility to the impact of their investments on health and the social determinants. Potential investors should assess the environmental, social, health and governance (ESHG) impact of companies when making investment decisions, and encourage and incentivise health-supporting action where they do invest.

In this section we set out the ways in which businesses can support good health through their core activities – producing products, providing services and making investment decisions. The initial focus is on certain key industries but the analysis is intended to illuminate the approach across the business world. We encourage each company and industry to examine the impacts that it currently makes, and the changes that it could make.

First, we discuss businesses that market products directly to consumers, using the food industry as an illustration. We then refer to financial services and construction, including both housing and infrastructure projects, industries that are critical to the UK economy and that greatly influence social determinants of health such as income, housing quality and the built environment.

The section then looks at some of the ways in which investors can consider health equity in their decision-making. Investors can invest in companies that are working to support health, and can also encourage and incentivise the companies in which they are already invested to do so. In addition to the health impacts of products and services, investors must consider employment practices, as covered in the preceding section, and other impacts, including environmental impacts, discussed in Section 3.3.

BUSINESSES AS PROVIDERS OF CONSUMER PRODUCTS

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

The food industry has an enormous influence on health and on health inequalities. Consumption of fruit and vegetables is lower among low-income groups than among high-income groups, and consumption of foods high in fat, salt and sugar higher, driving diet-related health inequalities (79) (80). The food industry spends 27 times more on advertising than the UK government spends on promoting healthy eating (81). Food producers can reformulate their products and change marketing strategies to promote healthier options, particularly to children and young people. Producers can work with public health authorities to ensure that they offer affordable healthy foods, sensible portion sizes and clear, useful nutritional information. Retailers also have a role, and should apply knowledge about behaviour, such as removing 'impulse buy' products from checkouts and stopping deals that encourage overconsumption of sugary drinks and unhealthy snacks.

Investors and shareholders can encourage companies to assess decisions on a health equity basis. If healthier options are more expensive, then the less well-off are pushed towards less healthy options, exacerbating inequalities. This also needs to consider that those working in lower-paying jobs are often time-poor as well. Many supermarkets provide recipes and guide purchases through these – these should take into account people on a reduced monetary or time budget, and, to avoid exacerbating ethnic inequalities in health, people from different cultural backgrounds. Online retailers have the option of 'nudging' consumers towards healthier options at the virtual checkout, while bricks-and-mortar stores can ensure healthier options are prominently displayed on shelves.

Unaffordability of healthy food can be a major barrier to healthy eating. Families who are in the lowest decile of household income would have to spend nearly three quarters of their income after housing costs on food to afford the recommended NHS Eatwell plate (82). When prices rise, they do not affect all groups equally, especially if cheaper options see price increases that exceed more expensive items proportionally. Poorer people may lack the ready funds necessary to take advantage of cheaper bulk buying, or the time to shop around for the very cheapest items. Following a campaign by food writer and campaigner Jack Monroe, the Office for National Statistics recently acknowledged these differences in the way inflation is felt (83). This is in the context of a cost-of-living crisis in the UK, as the prices of consumer products rise across the board (84). In particular, energy prices are being pushed up, with the potential to leave poor families in a situation where they have to choose whether to 'heat or eat' (85) (86).

These are only a few ways in which the food industry can influence health equity, and future industry-specific work may draw out more. There is a wide range of research examining global food systems from a health equity perspective, from the conditions of the workers who produce the food, all the way down to how social determinants affect what ends up on the plates of consumers (87) (88) (89).

It is critical to note that the poor and socially disadvantaged are often less likely to make healthy decisions due to an abundance of pressures and lack of support and resources. Tackling the root causes of poverty, deprivation and disadvantage works to improve nutrition. When businesses in the food industry ensure that employees, suppliers and contractors throughout their supply networks are well-paid and provided with good work, they are perhaps having their greatest effect on health.

Where a firm considers it anti-competitive to take significant steps to reduce the impact of their services or products on health they should advocate for system-wide agreed standards that can ensure all products support health. In the food industry and elsewhere government regulation may be both more effective and more productive than voluntary industry agreements in creating a level playing field for competition (see the section below on advocacy and lobbying for more on supporting such regulation).

BUSINESSES AS PROVIDERS OF FINANCIAL SERVICES

Financial products such as pensions, annuities and life assurance can also ensure financial stability in older age and maintain health. Legal & General and other pension providers have an important role to play in supporting older people to live healthy and socially engaged lives. However, these services, if available primarily to those higher up the socioeconomic scale, may have the potential to widen inequalities. Those with greater wealth are often more able to access advice and services to better manage their wealth and plan for their financial future, while here, as elsewhere, it is more expensive to be poor.

Financial services companies can help redress this inequality by making services and products available more widely. This may take the form of providing advice to employees within their own organisations, as mentioned in the preceding section, and throughout their supply networks, especially with SMEs. Such companies could also lend support, expertise and capacity to charitable organisations that provide financial planning assistance to the public, like Citizens Advice.

The economic impact of the COVID-19 pandemic also fell hardest on the already disadvantaged, and borrowing was the most frequently used coping strategy by people whose finances were adversely affected. The availability of credit is crucial to enable financial planning, but there is a high risk of exploitation from predatory payday lenders and loan sharks. Investors could consider supporting the likes of Fair For You, a social enterprise providing loans at fairer rates (90). Other businesses could follow suit in providing credit responsibly, perhaps in the form of low-interest loans to staff and to companies and individuals within their supply networks.

An extensive look at the health equity impacts of the financial sector lies outside the remit of this report. However, it is important to understand that products and services that do not directly hinder health may yet have a negative impact on health if they perpetuate and worsen inequalities in the social determinants of health. **A ready supply of financial advice and credit at reasonable rates, made available to those on lower incomes or who are otherwise disadvantaged, could do much to improve health equity.**

THE CONSTRUCTION INDUSTRY

HOUSING

A supply of good quality and affordable housing is essential for health. Poor quality housing which is in disrepair, overcrowded, damp or cold increases mortality and ill health. Poor housing conditions increase the risk of severe ill-health or disability by up to 25% during childhood and early adulthood, increasing the risk of developing respiratory problems, slowed physical growth, delayed cognitive development and mental health problems like anxiety and depression (91) (92). Children living in precarious housing conditions have lower rates of enrolment, attendance and performance at school (93). If the homes they live in are overcrowded, they also have increased risks of respiratory problems and other infections (92) (94). It has been estimated that it costs the NHS £1.4 billion per year to treat ill health resulting from poor housing conditions for first year treatments alone, not including the costs for treatment that continues past one year (95).

The UK has a major problem with poor quality, poorly insulated housing that is damaging to health and contributes to excess winter deaths each year. The lower a person's socioeconomic position, the more likely it is that they will live in a poor quality, cold home, and those living in cold homes experience higher mortality and worse physical and mental health than those who do not (96). It has been estimated that over 20% of excess winter deaths are attributable to cold homes, a situation that is only likely to worsen with rising energy bills (97). It is therefore important that new housing stock, and the retrofitting of older stock, target improved energy efficiency, which has co-benefits for addressing climate change concerns. Adequate ventilation is also important for indoor environment and health (98).

As climate change is expected to increase heat-related deaths, in the UK and worldwide, it is also important that cooling is taken into account (99). Heat-related

deaths also interact with other inequalities, as many at-risk groups are more likely to be of lower socioeconomic status: those with chronic disease, outdoor and manual workers, the displaced and homeless, and those living in overcrowded homes without adequate cooling (100).

Affordable housing is essential for reducing health inequalities. The cost of housing drives many families into poverty and impacts their ability to lead a healthy life, in addition to the mental health impacts associated with stress and anxiety. Not being able to find housing near work increases commuting times, contributing to pollution, and worsening work–life balance. Not being able to afford decent housing has been linked to raised blood pressure, depression and anxiety (101).

There is a lack of affordable housing in the UK, and increasing housing costs over the last decade have fallen hardest on renters and the more economically deprived. More than one third of households privately renting in 2017/18 were living in poverty after housing costs, and nearly half of those in the social rented sector were on relative low incomes after housing costs, as rents have increased faster than wages (2). The private rental sector has the poorest quality housing in the UK (18). 23% of all homes in the private rental sector, well over a million homes, are considered 'non-decent', not reaching minimum standards of quality (102). Developers must not attempt to evade Section 106 or other commitments to providing affordable housing through viability loopholes (103).

Security and type of tenure are also vital for health (104). Private rental housing can be the most insecure form of housing, as landlords have greater freedom to refuse tenancy or evict tenants. Nearly one in five private landlords will not rent to families with children. Two in five refuse to rent to those on housing benefit, disproportionately affecting women and people with disabilities, who are more likely to be in receipt of housing benefit (2) (105) (106). This makes clear the need for new affordable and social housing, not just new homes for private rental.

The emerging build-to-rent sector offers longer, secure tenures, with a single responsible landlord. These projects also often provide amenities, including facilities for co-working and for exercise. These are therefore potentially health-supportive. However, they are frequently expensive developments, and the risk is that they create exclusive rather than mixed communities. **Build-to-rent projects, and other housing projects, should aim where possible to construct blended communities, including those in receipt of universal credit or other benefits, and a proportion of affordable housing, with affordability determined by local incomes.** Projects should also consider offering reduced rents to carers and key workers.

Beyond the houses themselves, housebuilding has to take into account the neighbourhoods that are being created or shaped. Access to community facilities, green spaces, healthy retail and opportunities for active travel are important for both physical and mental health. Similarly, there must be consideration of how amenities are made accessible for older people and those with disabilities, to enable them to engage with the local community. Although this section does not deal in great detail with

environmental impacts, developments should also aim to be carbon-neutral, to avoid worsening the climate crisis and the damage to health that it is bringing.

Housing projects that support health and health equity must begin with a health equity impact assessment that examines the entire project through a social determinants lens, much as environmental impact assessments are currently used. Further work with the industry and other stakeholders is needed to develop these in detail. These may include ongoing assessment that lasts beyond the construction phase and measures the health equity impacts of the housing and the neighbourhoods that are created as people come to live in them.

Projects must address need: local authority housing plans can identify where need is greatest, and for what kind of housing. Homes must be good quality, of suitable size and affordable, including heating and maintenance costs. Housebuilders should also engage with the local healthcare system to enable the provision or adaptation of homes that can meet a range of supported housing needs.

INFRASTRUCTURE

Improved infrastructure, including local roads and decent housing, can not only contribute to economic prosperity, which brings a health dividend, but also tackle health directly. Regeneration and new infrastructure projects can provide good jobs that provide income and support health as well as improving the physical quality of homes and neighbourhoods and their environmental sustainability. All of these will improve health. It has been suggested that now is the ideal time to invest in infrastructure regeneration, to contribute to levelling up British regions in the wake of widening regional inequalities and the economic shock of the pandemic. Up to £190 billion is available from the pension market to invest in UK infrastructure over the next decade (107).

Companies should work with local and central government to identify underserved regions and ensure infrastructure development reaches more deprived areas, both urban and rural. They should then seek to engage communities in establishing the aspirations of the community and to build on existing local assets that support health, in partnership with local public and voluntary sector organisations.

The Rebuilding Britain Index is one tool to identify areas in need of investment, combining data on deprivation, including life expectancy, average earnings and unemployment, alongside qualitative survey data (108). These considerations can help ensure that investment is directed to better support health equity by addressing areas with significant disadvantage in the social determinants of health.

Health equity should be a priority consideration in both where and how infrastructure development takes place. Key equity concerns include sustainability, with a need to focus on 'green' rather than 'grey' infrastructure; the provision of transport infrastructure that supports active and hybrid travel and restricts traffic, particularly in deprived areas; and reducing digital exclusion, particularly in rural areas (109).

Regeneration programmes must also take account of changing social structures in the wake of the COVID-19 pandemic. A poll by think tank Demos found that the pandemic, lockdown and changes to working habits had strengthened people's relationship with 'place' and made local amenities more important (50). Its report, Post Pandemic Places, examines the impact on regeneration plans of the rise in homeworking and flexible working. Many workers who began working from home during the pandemic wish to remain doing so at least part of the time, but many of the more economically disadvantaged are likely to work either in service jobs that cannot be done remotely – and may lose out, at least initially, from reduced commuter footfall – or in jobs that can be done remotely but without sufficient space to work comfortably from home. Incorporating shared remote-working office facilities into regeneration schemes may help solve both of these issues and avoid worsening inequalities. **These development schemes may adopt the principles of the 15-minute city, providing a mix of amenities and places to meet and work within a local area, encouraging active travel and reducing transport pollution as well as improving social capital and fostering a sense of community among residents (110).**

INVESTMENTS FOR HEALTH EQUITY

The assets companies hold and where they are invested have important impacts on health and health inequalities. Beyond avoiding investment in companies that produce products and services actively harmful to health, investment funds can invest explicitly in ventures with a positive social impact. The social impact investment market is growing rapidly, increasing six-fold between 2011 and 2019, from £830 million to £3.4 billion (111). However, there is enormous room to expand and to increase focus on health equity: a total of £2.6 trillion is invested in UK pensions, which could be mobilised to bring social impacts as well as a return on investment (112).

Investing for social impact can create financial value as well as social value, as it involves mitigating the risks of investing in companies vulnerable to changing attitudes, law and policy, while taking opportunities to invest in companies well-placed to benefit from more sustainable economies (113). **The United Nations-backed Principles for Responsible Investment (PRI) offer one set of principles for institutional investors around ESG issues – these could be extended to include health as 'ESHG'** (114).

Some industries are inherently harmful to health, perhaps most obviously tobacco, but also the alcohol, gaming and arms industries, and heavily polluting energy sources, among others. Investors who are prioritising

health may well wish to divest completely from these industries. However, divestment is not always the best option, or indeed an option at all. Index funds, and other forms of passive investment, may be compelled to possess holdings in particular industries. In other cases, there can be unintended consequences from responsible investors divesting from health-damaging industries, leaving the market open only to investors with more short-term extractive strategies and little concern for the level of harm done (115). Responsible stewardship may in these cases involve taking an active role in guiding the companies in which one is invested.

Investing for health equity is not only about where an investor puts their money, but also about how they then use their influence over that business. Holding investments in care homes is not necessarily more beneficial for society than investing in a cigarette company if one investor is pushing the cigarette company to develop safer products without tobacco, and the other is encouraging cost-cutting and poor quality care for the sake of a quick profit. **Investors should always seek to use their influence to move companies towards a business model that supports health equity.**

Firms within health-damaging industries can take action to mitigate some of their health impacts. These include producing less harmful product lines; restraining aggressive marketing and especially not marketing to children and young people; and supporting the introduction of fair regulatory frameworks and not lobbying against public health measures, in every jurisdiction in which they operate. Investors should encourage these strategies, or more fundamental changes to the way these businesses operate, as necessary, to reduce harm to health. Cigarette companies can be pushed to plan for a future business model not dependent on tobacco, and may find this more attractive to long-term investors.

Many institutional investors already use their influence to push firms to behave responsibly (116) (117). These large investors should report explicitly on the health equity impact of companies, in the same way that they report on the climate impact of companies. They should use sanctions, including divestment and voting against company boards, against businesses acting in a way that is detrimental to public health or health equity. This could make health equity a priority for firms worldwide.

Responsibility for investment decisions should not be displaced entirely onto the consumer. An investor that offers consumers a responsible investment product alongside another products that potentially damages health cannot reassure itself that it has put the responsibility onto the market. **All investments should aim to be at least health-neutral, and default plans should aim to have some beneficial health equity impact**.

It can be a difficult decision for investors whether to divest entirely or to engage and use their influence to shift the business towards a more health-supporting business model. The case study below details how one bank made the decision to divest because they believed that tobacco manufacturers simply could not become a positive influence for health. In other industries, including energy and transport, there may be more room to push forward a health-supporting agenda. Such decisions should be made with an honest and transparent assessment of the health equity impacts, and the potential for change, of a given industry or firm.

CASE STUDY: A BANK EXCLUDING TOBACCO MANUFACTURERS FROM ITS INVESTMENTS (118)

ABN AMRO is a full-service bank in the Netherlands with operations in selected corporate and private banking sectors globally. It has a pledge to be a 'better bank' and a mantra that people should not be disadvantaged by the way in which the bank or its clients make money. If shareholder engagement fails, it has a publicly available Exclusion List which, since 2017, has included tobacco manufacturers. This means that ABN AMRO will respect existing contractual commitments but these will not be expanded or renewed.

CEO Kees van Dijkhuizen said: "Respecting the right to health in a meaningful way would require tobacco manufacturers to cease their primary business. A safe level of consumption is impossible. Our decision is more than a logical consequence of our sustainability ambitions. Dutch public health NGOs are campaigning for a 'smoke-free generation'. Children should be protected against the temptation to start smoking: at home, at school, and at their sports club. As a sponsor of youth sports clubs and activities, we couldn't agree more with this position. Every individual and organisation can contribute to making a smoke-free generation a reality. For us as a bank, this means that we will no longer finance the companies that lie at the heart of the problem. We hope that other financial institutions will follow suit."

CASE STUDY: FINANCIAL SERVICES AND HEALTHY ESG

In the Netherlands, the Butcher's Pension Fund, a fund managing €2.5 billion of assets, created its own environmental, social and governance policy in 2015, with advice from Kempen Capital Management. The Fund added ESG as a fourth point to its pension 'triangle' considerations of risk, return and fees. A board member noted that "we were in fact not restricting performance ... you run less risk in the long term with sustainable investment." Its investment has, among other impacts, reached 397,000 people underserved by healthcare services, avoided 12,000 tonnes of carbon dioxide emissions, and supported 3,400 people into employment (113). All of these impacts can positively affect health equity.

Investing in a socially responsible way may involve investing in social enterprises, worker-owned or cooperative companies, or purpose-driven companies that balance profit and social good (59). Greenwich Leisure Ltd, which trades as Better, operates more than 270 leisure centres in the UK. It is a Community Benefit Society that generates income through membership fees and other charges, and initially raised capital via the Rathbones Charity Bond Support Fund, providing sustainable growth for investors. It supports mental and physical health by providing access to affordable exercise facilities and classes, and acts on inequalities by discounting memberships for people with disabilities or in receipt of benefits (111) (55).

Targeted investing can also play its part in tackling the UK's regional inequalities, a priority for the Government, as outlined in its 'Levelling Up' agenda. Its recent White Paper on this subject noted that "only a small fraction of UK pension money is invested directly in the UK in ways that could drive more inclusive and sustainable development, in sectors like affordable housing, small and medium-enterprise (SME) finance, clean energy, infrastructure and regeneration" (119). A place-based approach to investing involves investing to yield financial returns alongside positive local impacts, encouraging local and regional sustainable development and resilience (119).

CASE STUDY: LONG-TERM INVESTORS IN PEOPLE'S HEALTH (120)

Long-term Investors in People's Health is a growing global coalition of responsible investors, led by Share Action, who recognise the multiple determinants of health, and who are willing to develop and adopt solutions to systemic issues. The LIPH coalition acts on some of the most pressing public health issues by setting investor standards, running corporate campaigns, and promoting public policy that supports investors and companies to go further on health. This initiative grew out of a recognition of the unequal impacts of the COVID-19 pandemic. The coalition has recognised that the 'S' in ESG encompasses many of the determinants of health, and that poor health threatens long-term investors both due to direct effects on employees, and via wider effects on society, including the financial and personal costs of rising demand for health and care.

Companies should be transparent about their investments and investment policies and give the same visibility to health as they do to other ESG factors, in an extended ESHG model. Assessing the range of health impacts of a potential investment involves assessing all of the factors discussed elsewhere in this report, and should be done using a structured approach that reflects the full range of determinants of health. This warrants the same level of assiduity and thoroughness with which ESG is currently assessed. Developing assessment tools for the health equity impact of investments, including the current impact of an investment and the potential for impact if guided by responsible shareholders, is one aspect of future work to be done by this partnership.

2.3. BUSINESSES INFLUENCING THE WIDER COMMUNITY

Recommendations for influencing the wider community

A) OPERATE SUSTAINABLY TO PROTECT THE NATURAL ENVIRONMENT, INCLUDING THROUGH ACTION TO PROTECT BIODIVERSITY AND REDUCE AIR, SOIL AND WATER POLLUTION; AND BY TACKLING CLIMATE CHANGE THROUGH REDUCING CARBON EMISSIONS	Businesses, working with local and national planning systems, must ensure that disadvantaged neighbourhoods and communities do not bear the brunt of polluting industrial activity or climate change impacts.
B) WORK IN PARTNERSHIP WITH LOCAL COMMUNITIES	Businesses should partner with VCFSE organisations, the public sector, including healthcare providers, and local communities to identify areas of concern and inequality, and to plan and provide support. Businesses should act as anchor institutions for local communities, and use social value procurement to ensure spending pays health dividends.
C) ADVOCATE FOR HEALTH EQUITY	Companies can advocate nationally and locally for health equity and for policies that act on the social determinants of health, and ensure taxation arrangements are fair and support a public realm that can undertake these policies.

In this section we look at some of the ways in which businesses influence communities. These include their effects on the environment: given the already extensive literature and focus on environmental issues, we concentrate specifically on the health equity issues raised. We then discuss ways in which businesses can work locally, as anchor institutions and through social value procurement, to benefit the communities in which they operate. Finally, we look at the national impact that businesses can have, as advocates for health equity and as corporate taxpayers.

ENVIRONMENTAL IMPACT

The environment in which people live is a major determinant of their health. Many companies, particularly those in the agricultural, extractive, construction, automotive and aerospace industries, produce health-damaging pollution and significantly contribute to the climate and environmental crises. Others may produce air pollution, plastic pollution, destroy natural environments and damage biodiversity, or deplete or contaminate water supplies. It is critical that all industries work to ensure that they preserve the natural world: clean air, adequate water, a stable climate and access to green spaces are pre-requisites for good health (121).

24% of deaths globally are associated with living or working in an unhealthy environment (122). WHO attributes an estimated 4.2 million deaths a year worldwide to ambient air pollution, and a further 3.8 million premature deaths to indoor household pollution (136). In particular, compared with wealthier people, less affluent and more socially deprived groups are more likely to be exposed to environmental health risks, whether in their homes, including via biological and chemical contamination, tobacco smoke, noise, and extremes of temperature, or in their neighbourhoods, including as a result of air pollution and hazardous waste sites (123). **Action on mitigating environmental damage and protecting the natural world must take into account issues of health equity and ensure that the likes of polluting industrial sites or transport links are not simply moved into lower-income or otherwise disadvantaged neighbourhoods, worsening health inequality.**

In global terms, many businesses have already come to appreciate the necessity of reducing carbon emissions and are taking action in that direction. Businesses that wish to improve health equity will find alignment with action and motivation to combat climate change. However, there are also health equity considerations in the choice of strategies for sustainability: the costs should not fall unfairly on the more disadvantaged, but should aim to advance sustainability and equity at the same time. For example, reducing transport-related emissions can involve the promotion of electric vehicles, but these remain prohibitively expensive for the majority. An alternative strategy that promotes shared or active transport will be more inclusive and accessible, with the additional health benefits associated with being active. Similarly, improved home insulation can reduce the health risks associated with cold and damp homes, while also reducing the need for active heating, improving sustainability and reducing costs for vulnerable families. IHE has produced a report on sustainable health equity that lays out in greater detail how these priorities can be mutually supporting (124).

The principle of equity should underpin the strategy of any business adopting a net-zero or equivalent target.

PARTNERSHIP WORKING TO STRENGTHEN LOCAL COMMUNITIES

Firms should develop and contribute to local partnerships with other stakeholders and consider what they have to offer to these. While they may not have the knowledge of the local population and its health needs that a local authority may have, or the trusted relationships of the health sector, they can provide expertise, finance, equipment, buildings, infrastructure, goods and services and partner with community partners who do have the insights and expertise. Place based partners in health include businesses, the community and voluntary sector, public services and local government. Collaborations between all these sectors are vital to tackling local deprivation and improving health equity. Legal & General has experience forming these kinds of partnerships: for example, partnering with the University of Oxford to provide housing and facilities to benefit the local economy; and in Birmingham where Bruntwood SciTech is partnering with the University, two NHS Trusts and the City Council, among others, to deliver a Health Innovation Campus (125) (126).

Firms may be able to provide low-interest loans or grants directly to local community groups, or support other community investment. Child Dynamix in Hull and Grimsby received £280,000 of investment from Social and Sustainable Capital's Community Investment Fund to refurbish nurseries providing for 53 nursery places in deprived communities (111). London Luton Airport provides a fund of £150,000 every year to local charities, administered by the Bedfordshire and Luton Community Foundation, allowing the local VCFSE sector to address priority local issues in a coordinated way (127).

Large businesses should look to partner with communities, VCFSE and public sector organisations wherever they operate, identifying priority public health areas of concern, health inequalities, and inequalities in the social determinants, and to plan support for the community from this basis.

BUSINESSES AS ANCHOR INSTITUTIONS

The concept of anchor institutions is widely used in the public sector in the UK. These are institutions like hospitals, universities and councils that are physically rooted in communities and can directly and indirectly shape the health and wellbeing of the local population. They can leverage their position as an employer, a purchaser of goods and services, a provider of services, an owner of local buildings, land and other assets and as leaders in the community to effect change. Some anchors are seeking to develop relationships with local businesses, understanding their shared role in the health and wellbeing of the community.

Businesses themselves can also function as anchor institutions (128). They can provide good jobs (as outlined in Section 2.1); recruit locally, especially in low-income areas; mobilise their supply networks to support the local economy; support local charitable and not-for-profit enterprises; lend expertise to local partnerships; and share use of land and property. Providing training and employment preferentially based on location can help address inequalities in the social determinants of health if the benefits reach communities and/or areas that have a below-average amount of training opportunities and rates of educational attainment.

In short, to be an anchor institution is to be a good corporate citizen, part of the local community and benefitting the health of that community. Even though businesses often operate in multiple locations, and may lack the firm rootedness of public anchor institutions, they can still pursue anchor strategies (129).

CASE STUDY: THE WEST BAR DEVELOPMENT

The West Bar development in Sheffield, UK, in which Legal & General is a partner, illustrates the level of impact that companies with an interest in development can have. This development will provide office space, retail units, housing and green spaces, including a nature park (130). By providing good jobs, quality affordable housing, local amenities and accessible green spaces, projects like these can have a salutary effect on community health. However, if locals and the disadvantaged are priced out, if tenancies are insecure, if exploitative businesses are housed, if public transport links are absent, or other health impacts are not taken into consideration, then these opportunities can be squandered.

CASE STUDY: CAMPBELL'S SOUP

Campbell's Soup was under pressure to move from its hometown in Camden, New Jersey, due to the economic and social struggles of the area. However, it remained and in 2011 committed to improving the health of young people in Camden in partnership with community initiatives. This has included providing better access to affordable, nutritious food via food distribution programmes, community gardens and a partnership with the Healthy Corner Store Initiative; as well as increasing access to green spaces, including renovating public parks in partnerships with Big Green and The Trust for Public Land (131) (132).

CASE STUDY: WEST SIDE UNITED (220)

The West Side of Chicago has some of the poorest health outcomes in the city, which are accompanied by high rates of poverty and unemployment. West Side United (WSU) is a partnership between healthcare institutions, businesses, residents, education providers, non-profits, government agencies and faith-based institutions that have a connection to the West Side and which are seeking to make their neighbourhoods "stronger, healthier and more vibrant places to live".

The partnership has a goal to reduce the gap in life expectancy, which is up to 14 years between some communities, in the West Side and Downtown area by 50% by 2030. It covers four strategic impact areas that span social and environmental determinants of health as well as healthcare:

- Health and healthcare
- Economic vitality
- Education
- Neighbourhood and physical environment

Its activities are a combination of partnership work to maximise the value of partners' routine activities; direct grants to community-based businesses and organisations; and impact investing. It works with anchor healthcare institutions to increase recruitment of local residents and procures from local businesses, which has resulted in the anchor partners having spent US$90 million at local West Side businesses since 2018.

To build the capacity of businesses in turn, WSU distributes small grants, amounting to US$1 million to 70 businesses since 2018. On a larger scale the partnership performs impact investing as a collective with Illinois Medical District, Northern Trust Bank and the American Medical Association. These fund community-based projects spanning housing, community spaces and job development, amounting to over US$8 million in investment since 2018.

The partnership is young and the impacts on population health are yet to emerge but are being tracked and monitored, with a set of 14 metrics covering all four impact areas.

SOCIAL VALUE PROCUREMENT

Companies can use their purchasing power to support enterprises that further the ends of health equity. The Social Value Act of 2013 requires public sector commissioners to consider economic, social and environmental wellbeing in the procurement of services contracts, with the aim of maximising value for money in public spending. By taking social value into account, those in charge of spending public money can pursue their primary aims while adding supplemental benefits in the local community, including on the social determinants of health, like employment and housing (133). For-profit businesses can also generate social value while pursuing a profit-making course, by considering employment, subcontracting, procurement and other opportunities to generate ancillary health and equity benefits.

While social value as a concept is more widely used within the public sector than the private, although not exclusively, there are similar ideas that have gained more traction in the business world. One of these is the 'triple bottom line', a commitment to people and planet alongside profit (134). Another is the 'purpose-driven business', a business that exists to benefit society and sees generating profits and growth not as the only aim, nor as opposed to that purpose, but as an integral part of it (59).

CASE STUDY: GREENER NHS REDUCING EMISSIONS IN THE SUPPLY CHAIN (135)

Greener NHS has integrated the consideration of climate risk into procurement decisions that will impact more than 80,000 suppliers to the NHS, covering medical equipment, food, business and office goods, which is understood to be essential to reaching net-zero greenhouse gas emissions by 2045. To do this it has announced a plan to publish a Supplier Framework for benchmarking and reporting progress on a Roadmap that involves incremental increases to requirements over time. For example, all suppliers with new contracts above £5 million will be required to publish a carbon reduction plan for their direct emissions from April 2023, while from 2027 this will apply to all direct and indirect emissions of suppliers of contracts of any value; beyond that date suppliers will need to demonstrate progress. The procurement plans will also adopt the Government's Social Value Model, which will include a minimum of 10% weighting given to how suppliers will contribute to the NHS's net-zero targets and social value in contract delivery.

CASE STUDY: THE BUY SOCIAL CORPORATE CHALLENGE

The Buy Social Corporate Challenge involves a group of high-profile businesses in the UK with an aim to spend £1 billion collectively with social enterprises through their procurement activity. In the first five years it spent close to £165 million and created over 2,000 jobs. Of its partners, 95%, including companies in the financial sector like Zurich, Barclays and NFU Mutual, report that social enterprises are cost-neutral and deliver comparable or higher quality compared with other suppliers (136). Suppliers cover a wide range of products and services, from tea (NEMI Teas, which supports refugees to gain work experience and skills to enter the UK workforce), to stationery (Ethstat Ethical Stationery CIC, which donates all its profits to projects including Nightwatch, supporting homeless people during the pandemic with food, clothing, PPE and more), to pest control and cleaning services (Tarem Services, focussed on tackling in-work poverty in an often low-paid industry) (137) (138) (139).

CASE STUDIES: DEVELOPMENTS FOR SOCIAL VALUE

The project that won the Social Value Project Award in 2021 was 245 Hammersmith Road, a London project in which Legal & General was a partner, and where it maintains an office. The project provided social value in its construction by providing work for locals, bringing those not in employment, education or training ('NEETs') into employment, and providing mentoring and training. It has given social value throughout the pandemic by providing socially-distanced spaces for charitable and educational activities; and it continues to provide value as a mixed public and private space (55).

Sir Robert McAlpine Ltd monitors and quantifies the economic contribution made to the local community on the projects it undertakes. When it was constructing the Emirates Arena and Sir Chris Hoy Velodrome for the 2014 Commonwealth Games in Glasgow, it awarded tenders to local SMEs or social enterprises totalling £6.4 million in value, and recruited 107 new entrants and 44 apprentices. The company calculates that for every £1 invested, an additional 64p of value was generated in the local area, to a total of £60 million for the local economy (58).

Large companies should explicitly consider social value when subcontracting or seeking suppliers for large projects, to maximise the impact of every pound spent. SMEs may need to develop strategies on how to deliver and evidence social value in order to build the market of smaller businesses able to deliver social value.

ADVOCACY FOR HEALTH EQUITY

Companies can advocate to the public, persuade other firms, and lobby local and national government to take action to reduce health inequalities. By articulating their support and committing to action to tackle health inequalities they can signal to the public, politicians and other businesses that health inequity is a serious issue, and one where action can be taken now. Large corporations, and representative bodies such as the Institute of Directors, the Confederation of British Industry (CBI) or local Chambers of Commerce have significant influence over government. If they were to signal that action on the social determinants of health and health inequalities is a priority not just for the public sector and the charitable sector but also for the private sector, that could change policy and public understanding of the role of business in society.

The welfare state and other public services can ameliorate economic inequality, and also break the link between economic inequality and health inequality, by providing universal services. The rolling back of state services and protection in the UK in the 2010s contributed to stalling life expectancy and widening health inequalities (2). **Companies should advocate publicly, and lobby where they have influence, for a comprehensive welfare state that supports good health, including the provision of adequate social care.**

Individual companies and senior figures can also lobby other firms in their industry and the wider business world. They have access and know the language in a way that health professionals or activists may not. **Other companies can be encouraged to sign up to be a Living Wage employer, to be a purpose-driven company, to invest for social value, to commit to a fair tax programme, or to explicitly consider ESHG in their dealings. Ensuring these are requirements for qualifying to tender for contracts and to supply goods and services is an even more impactful way of achieving changes.**

All firms should lend support to initiatives for more responsible business, an example being the proposed Better Business Act, which would make it easier legally for a company to balance the interests of shareholders with other stakeholders (140). The Better Business Act would amend Section 172 of the Companies Act 2006. At present, this section lays out the duty of company directors to act to promote the success of the company, with 'regard' given to the interests of wider stakeholders, including customers, employees, society and the environment (141).

However, the wording of the legislation as currently written can give rise to uncertainty for company directors, who may find that the interests of wider society conflict with their fiduciary duty to maximise value for

shareholders. The Better Business Act would change the default position of 'shareholder primacy', rebalance the interests of stakeholders, and free company directors to pursue socially and environmentally positive ends while continuing to create value for shareholders.

The significance of such changes can be seen in the United States, where, in September 2021, Republican senator Marco Rubio proposed a bill that would allow shareholders to sue directors who take socially progressive actions perceived as 'woke' and force them to prove that these were in the shareholders' financial interests (142).

There may be areas where companies feel that commercial considerations are preventing them from acting in a way that supports good health – the 'first mover' problem. In those circumstances, advocating publicly and lobbying government for an effective regulatory framework can ensure that action is taken while maintaining a level playing field for competition in that market. For example, the Soft Drinks Industry Levy introduced in 2018 has led to the reformulation of soft drink products to reduce their sugar content, and an overall reduction of 30% in sugars sold in soft drinks in the UK (143). Responsible food industry producers, manufacturers and retailers that want a level playing field with competitors can support calls for government-led interventions that apply across the market, such as minimum standards, levies or restrictions on promotions that will help shift consumption away from foods high in fat, salt and sugar and improve standards of basic nutrition. **Firms should support and lobby for clear regulatory frameworks that do not put companies at a competitive disadvantage when they choose to do the right thing.**

In general, companies should lend their vocal support to policies that enhance health equity and reduce inequalities in the social determinants of health. The private sector is well placed to make the argument that a generous welfare state represents not just action for social justice, but also a long-term investment in the health of the UK and a healthy and productive workforce of the future.

TAX ARRANGEMENTS

The state has a crucial role to play in reducing inequalities in health, and in the social determinants of health, via a progressive taxation system and provision of welfare and public services. Welfare policies should follow the principle of 'proportionate universalism', whereby services are available to all, but allowing for greater targeting of resources where there is greatest need. The NHS is a good example of what proportionate universalist policies look like when supported by progressive taxation to pay for them. It has been correctly said that services designed only for the poor can very quickly become poor services.

Beyond welfare, well-funded and comprehensive services can improve health by breaking the causal link between low income and actual deprivation. If the public sector provides healthcare, public transport and education, then the relatively income-poor need not be deprived of these benefits and their positive impacts on health.

It is essential that businesses that have the ear of government support a robust welfare state and good public services. I**t is also critical that businesses, and individuals associated with them, pay a fair rate of tax which provides government with the necessary resources to promote and protect health and take action on the social determinants.** We would like to see businesses give support to efforts for a fairer tax system and articulate the reasons why taxation is necessary for health equity and other social as well as economic benefits. While acting unilaterally to ensure that they pay their fair share is laudable, greater impact may come from businesses working together to lobby the Government for a more progressive taxation system. This would also have the effect of putting competitors in the same position, and not penalising companies that take their tax responsibilities more seriously.

Corporate tax arrangements should be developed with a view to addressing the social determinants of health and the impact of tax receipts in jurisdictions globally. Large companies should publish their tax strategies in full and pay tax on their operations in the jurisdictions where the majority of those operations are located.

NEXT STEPS

This report accompanies the launch of a nationwide network that will bring together local authorities, businesses and other stakeholders, including the public and VCSFE sectors, in places across the UK to share knowledge and best practice for improving health equity.

Further work from the partnership between Legal & General and UCL IHE will draw on the expertise and insights of this network, and the framework and context provided by this report to develop:

1. **A set of metrics for measuring the health equity impact of businesses, enabling a consistent and accurate ESHG approach.**
2. **Further overarching recommendations tied to those metrics, generated in consultation with businesses.**
3. **Industry-specific work that will provide more detailed and practical steps that businesses in those industries can take for health equity.**
4. **Guidance specifically for SMEs on actions they can take to further health equity, and how that can benefit their business.**
5. **Health equity impact assessment tools for projects, which may be incorporated into a wider social value framework.**
6. **Further recommendations for businesses internationally, taking into account differing health priorities around the world.**

This report, then, is a call to action for industry, and an invitation to businesses of all sizes to contribute to the ongoing work and join the movement for health equity.

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