

Health, Wellbeing and Sustainable Development

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Nazmeen kauser

2313167

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1. Introduction

Health, wellbeing and sustainable development is one of the biggest policy challenges of the 21st Century (Henderson and Loreau, 2022). In 2015 the UN produced a blueprint for action known as the 2030 Agenda for Sustainable Development and there are 17 Sustainable Development Goals which have three interwoven elements: environmental, social and economic. This paper analyses, for the first time, the link between and the implications of Sustainable Development Goal 3 'Good Health and Wellbeing' and Sustainable Development Goal 10 'Reduced Inequalities' for the citizen at global, national and local levels within the United Kingdom (Gavurova and Megyesiova, 2022). Health inequalities are some of the most persistent and intractable problems in our modern health and care systems (Marmot, 2010). The bio psycho-social model of health (Engel, 1977) and the holistic model of health (Huber et al., 2011) present an invaluable theoretical framework for explaining why health can't be disconnected from the social, economic and environmental determinants of health. Looking at national and local initiatives such as the NHS Long Term Plan and Making Every Contact Count (MECC) will show current strengths and weakness in policy and offer a evidence-based recommendations to improve sustainable health and wellbeing outcomes in the UK.

2. Good Health and Wellbeing A Global and National Perspective

2.1 Overview and Global Significance

To ensure healthy lives and promote wellbeing for all at all ages' (United Nations, 2023), is the broad target of SDG3, which comprises of seventeen specific targets covering communicable and non-communicable diseases, maternal and child mortality, mental health, substance abuse, universal health coverage and development of the health workforce. Progress globally is highly uneven. Between 2000 and 2020 maternal mortality rates reduced by 34%, but an estimated 287,000 women still died from preventable causes related to pregnancy and childbirth in 2020 (WHO, 2023). Non-communicable diseases (NCDs) are now the leading cause of death worldwide the range of NCDs (including cardiovascular disease, cancer, diabetes and chronic respiratory diseases) are attributed to 74% of all deaths globally. It is this data that illustrates why SDG 3 is so significant not simply as a declaration, but as a request for real systemic change.

At the core of SDG 3 is the world Health Organisation's (1986) Ottawa Charter for Health Promotion, which argues that health promotion cannot simply refer to providing health care services (Sallaway-Costello, Magistretti and Lindström, 2025). Instead it requires an advocacy

for social, economic and environmental determinants that enhance health. This can be viewed in line with the holistic concept of health defined by (Huber et al. 2011) as, 'the ability to adapt and self-manage in the face of social, physical and emotional challenges.' This is a significant step away from the more limited biomedical perspective of health which views health as, 'the absence of disease or pathological processes' (Dubos, 1965) in that it includes social determinants of health.

2.2 SDG 3 in the United Kingdom Context

The NHS Long Term Plan (NHS England, 2019) is the main national policy mechanism aligned to SDG 3. It aims to reduce strokes, heart attacks and cases of dementia by 150,000 over ten years via better screening for cardiovascular disease, increased diagnoses for cancer and greater availability of mental health services. Investing at least £4.5 billion into primary and community care, the Plan outlines a move from hospital centred reactive care towards a proactive community centred population health approach, fully congruent with the population health objectives of SDG 3. The effectiveness of the NHS Long Term Plan, however, is compromised by the strain of COVID-19. Between March 2020 and January 2023, a backlog of over 7 million patients accumulated in the NHS, the highest the organisation has ever experienced, leading not only to prolonged waiting times for existing medical conditions but to increased mental health challenges; one in six children between five and 16 in England met criteria for a probable mental health disorder in 2021 (NHS Digital, 2022), a rise from one in nine in 2017. Making Every Contact Count (MECC) is another intervention which is widely employed in both health and social care settings and aims to integrate brief health behaviour conversations into every encounter, integrating well with SDG 3 as it enables health and social care professionals to address lifestyle related risk factors such as lack of physical activity, poor diet, smoking and drinking alcohol, at both individual and community level. Evidence from (Public Health England 2016) demonstrated MECC had a positive influence on physical activity uptake and smoking cessation, with the persistence of these changes relating to the adequacy of training and organisational support for staff.

3. Reduced Inequalities, The Intersect with Health and Wellbeing

3.1 Rationale for Selecting SDG 10

SDG 10 aims to reduce inequalities within and between countries in terms of income equality, social exclusion and discrimination (and so on and so forth). SDG 10 was chosen as the SDG to complement this report as health and inequality are inextricably linked. We now know unequivocally that in England health outcomes operate on a gradient in accordance with socio-

economic position for example The lower your position, the more ill health you have-a gradient confirmed by (Marmot 2010) in Fair Society, Healthy Lives (Marmot, 2010). This trend can be observed across a wide range of indices including life expectancy, prevalence of chronic disease, mental health and infant mortality. As noted in (Marmot 2010), people in the most deprived areas of England died on average 7 years earlier than their richest counterparts, while experiencing significantly greater years of their lives living with chronic illness and disability. The relationship can be illustrated by an examination of the biopsychosocial model (Engel, 1977). This model states that health is influenced not only by biological factors but by psychology and social determinants including poverty, housing, education, employment and social connectivity. It has since been adapted into a more operationalized concept of well-being as being a balance between resources and challenges (Dodge et al, 2012), thus the inextricably linked nature of socioeconomic inequality and the improvement of well-being becomes clear and shows SDG 10 as a pre-requisite condition for SDG 3.

3.2 Health Inequalities in the UK: Global and Local Dimensions

SDG 10 has various links with health internationally. (Labont and Schrecker 2007) outline how health inequalities between rich and poor countries have been exacerbated by globalization because of the centralization of power, access to health-promoting materials and services, and medicines. (Lee 2004) discusses similar global governance structure issues and claims that these processes tend to reinforce existing health inequalities, as economy is favoured over health equity in trade and intellectual property agreements. Health inequalities are apparent and enduring in the UK. In NHS England, The Core20PLUS5 framework (NHS England, 2021), to reduce health inequalities, suggests the poorest 20% of population suffers from worse health outcomes than others in five priority clinical areas- maternity, mental health, cancer, chronic respiratory disease and elective recovery. Life expectancies in the Handsworth and Ladywood regions of Birmingham are 8 years shorter than in Sutton Coldfield according to the Public Health England data (PHE, 2021). In Wales, the Well-being of Future Generations Act 2015 provides the Welsh Government with a statutory framework to embed sustainable development and health equity in decision-making by public bodies – it has become an internationally recognized example of aligning SDG 3 and SDG 10 legally (Bevan Commission 2021). However, the research found health inequalities have actually increased in Wales since 2010. Poverty and social deprivation remain the primary causes for ill health in Wales. In the UK, and also other developed countries the role of inequality in health was particularly visible during COVID-19. According to (Public Health England 2020) BAME individuals were much

more likely to suffer from COVID-19, mainly due to living in crowded conditions, having public-facing jobs, lower socioeconomic status and these are all compounding factors to the biological risk. This finding links back to the 'social production of disease' phenomenon explained by (Kickbusch 2000).

4. Evaluation of National and Local Initiatives

4.1 NHS Long Term Plan and Core20PLUS5

In its recognition and plans to reduce health inequalities the NHS Long Term Plan is a credible and welcome commitment to address such issues. Core20PLUS5 provides an organised, evidence based method of targeting resource towards those communities who require them most, although (Marmot et al 2020) report that after the 10 year follow up of the original Marmot Review, health inequalities had increased between 2010 and 2020, and life expectancy had stagnated in England for the first time in over a century due to an overall reduction in public health spending of 24% in real terms between 2015/16 and 2020/21 as a result of austerity measures (The Health Foundation, 2021). These results highlight that as much as NHS clinical services may be important, health benefits depend upon sustained cross-sectoral spending on the determinants of health such as housing, education, welfare provision and local community infrastructure, which are largely outside of the direct control of the NHS.

4.2 Making Every Contact Count (MECC)

MECC is low cost and practical. Health promotion through a "Making Every Contact Count" (MECC) approach has been identified as a cost-effective and pragmatic approach to health promotion and aligns well with both SDG 3 and SDG 10. By incorporating brief conversations on health, such as through a routine GP visit, community health services, in a social care setting or by local council staff in housing offices, MECC seeks to reach the public who would not normally make an active decision to ask about health. According to (NHS SCW 2024), tens of thousands of staff across all health and social care professions in England have received MECC training. Studies suggest that MECC is effective at signposting to smoking cessation, weight management and mental health services. Crucially, MECC could reduce inequalities, as it focuses on those in deprivation who encounter most structural barriers when seeking health support. However, there are limited data on the long-term population level effects of MECC; a reliance on self-reporting data and the lack of clear national evaluation frameworks limits the ability to attribute specific SDG3 effects to MECC (NHS England, 2017). However, MECC relies on adequate capacity among staff, a factor which has been impacted most heavily by the pandemic and ongoing staffing shortages in the NHS.

4.3 Well-being of Future Generations Act (Wales)

The Welsh Government's Well-being of Future Generations Act (2015) is probably the most ambitious legislative framework anywhere in the world to incorporate sustainable development in public health governance. It requires all public bodies in Wales to enhance the economic, social, environmental and cultural well-being of the nation and directly embeds sustainability in the duties of public institutions. The Public Services Boards (PSBs) established by the Act represent an innovative mechanism for intersectoral work on health and well-being, yet critical analyses argue that it has been implemented inconsistently, and that whilst it forms a sound normative framework, the Act has yet to enable the system-level change required to reduce health inequalities due to limitations imposed by finance, departmental silo working and accountability mechanisms (Bevan Commission 2021).

5. Recommendations for Improvement

In light of the previous discussion, the following evidence-based recommendations to improve congruence between current health policy and the vision and goals of SDG 3 and SDG 10 are proposed: The UK Government should reinstate and increase ring-fenced public health funding to local authorities. (The Health Foundation 2021) has provided clear evidence that cuts to the prevention budget have resulted in the widening of health inequalities. Investment into housing, education, income security and community services, which constitute the social determinants highlighted by (Marmot 2010) and the ecological model of health (Dubos, 1965) will lead to improvements in population health and wellbeing in the long-term. Moreover, support MECC through a national evaluation framework with standard outcome metrics to enable an evidence base for the population level impact. Funds should be used to implement MECC training within non-traditional contexts such as schools, housing associations, and community food banks, so as to target populations of most profound social disadvantage, which directly addresses Marmot's health inequality gradient (Marmot, 2010).

Furthermore, support the Core20PLUS5 approach by implementing 'place-based' investment plans in the most deprived areas. Modelled on the US's 'Healthy Places' scheme, these 'place-based' initiatives are likely to address simultaneously both the clinical and environmental determinants of health. Investigate the implementation of health equity impact assessments, as used in Wales, into all major policy decisions across England and Scotland. Also, Increase national health literacy programmes. (Kickbusch 2000) argues health literacy is a key mediator of the link between social position and health status. Providing people with the tools to

understand health information and systems enables those experiencing the most health inequality (under SDG 10) to increase control over their health.

6. Conclusion

This report has critically considered both SDG 3 'Good Health and Wellbeing' and SDG 10 'Reduced Inequalities' and demonstrated how there cannot be lasting health gains for populations without the parallel consideration of social and economic structural determinants of ill-health. Using the biopsychosocial and whole model of health, the Marmot Review and up to date policy evidence it is clear that even the UK is struggling to meet its own SDG promises and ensure equitable health outcomes for all citizens. The NHS long term plan, MECC and Well-being of future generations act (Wales) are welcome policy initiatives however they all encounter systemic barriers that are intrinsically linked to political decision making around finances, workforces and the social gradient of health. This report's recommendations for a sustained investment in social determinants, strong evaluation, place based action and health literacy, is an attempt to develop policy in to a lived experience. For the success of SDG 3 and 10 it will take not only clinical, but political, will, cross sectoral partnership, and a commitment to social justice in health for years to come.

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