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

THE LEGAL & GENERAL AND UCL IHE PARTNERSHIP

The Institute of Health Equity (IHE) at University College London (UCL) is led by 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. Since then, IHE has been at the forefront of the social determinants and health equity movement nationally and internationally. All the IHE reports and further information about the Institute's work can be found at **instituteofhealthequity.org**.

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' (2). 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 entering into a four-year partnership with IHE to further the role of businesses in reducing inequalities in health in the UK and to establish a UK-wide health equity network.

ACKNOWLEDGEMENTS

Authors: Professor Sir Michael Marmot, Dr Michael Alexander, Dr Jessica Allen, Dr Alice Munro.
Peter Goldblatt and Michael Alexander coordinated production and analysis of tables and charts.

Thanks to Pete Gladwell, Social Impact & Investment Director, L&G Group and Matilda Allen, Harkness Fellow in Healthcare Policy and Practice, UCSF.

Thanks also to John Alker, Dan Batterton, Richard Booth, Simon Century, Ben Denton, Jo Elphick, John Godfrey, Bill Hughes, Kurt Morrieson, Maria Ortino, David Reid, Sam Roberts, Daniel Shakhani and Sir Nigel Wilson for reviewing the draft report and providing useful comments.

Suggested citation: Marmot M, Alexander M, Allen J, Munro A (2022), The Business of Health Equity: The Marmot Review for Industry: Institute of Health Equity.

This report was funded by Legal & General, who also provided expert input and advice. Editorial control remained with the UCL Institute of Health Equity.

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. Businesses have not been involved in the discussion or, worse, have 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. Business can and should be a partner for good in creating healthier societies.

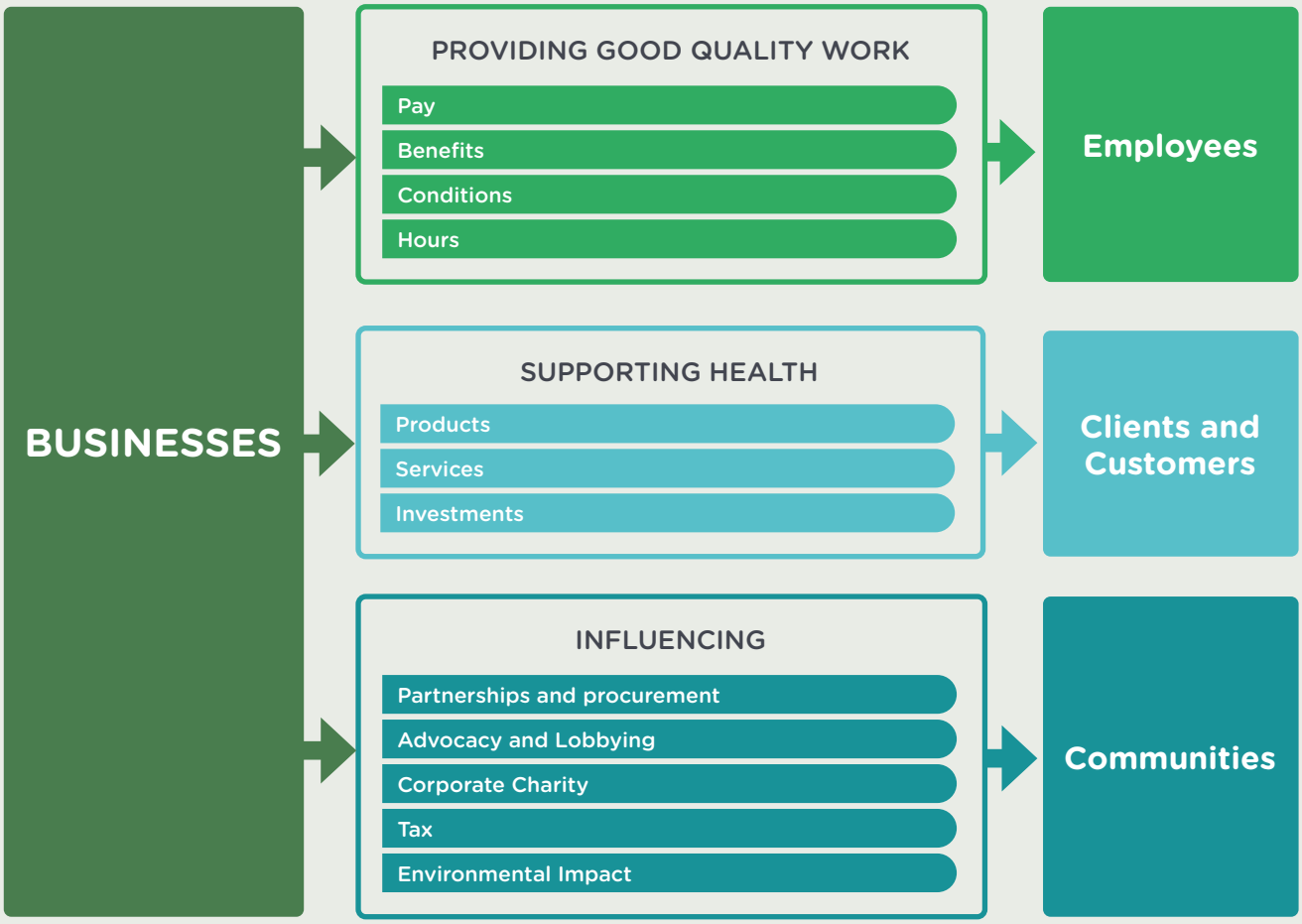
In all countries, rich and poor, the health of the population is strongly linked to the conditions in which people are born, grow, live, work and age. Access to high quality healthcare is essential but it is not lack of healthcare that leads people to become ill in the first place: it is the conditions 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. Businesses have not been involved in the discussion or, worse, have 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. 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 (3). If this were to happen, businesses would improve the societies in which we all live, and would also accrue benefits to themselves: in a healthier, happier and more productive workforce; in recruitment and development practices that attract the best and brightest; and in a purpose-driven business that inspires employees, retains customers and attracts investment.

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. Reducing the harmful impact of business and enhancing the positive contribution is vital for health and wellbeing. Businesses affect the health of their employees and suppliers, through the pay and benefits they offer, through hours and job security, and through the conditions of work. Businesses affect the health of their clients, customers and shareholders through the products and services they provide and how their investments are held. And businesses can 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 include environmental impacts of business operations, including carbon footprint and air pollution, as well as the taxes paid by businesses to local and national governments that support policies for health. This is summarised in Figure 1.

Figure 1. How businesses shape health: the IHE framework



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. Pockets of good work, siloed into ethics or ESG teams, do not translate into a company that is acting in the best interests of health in the way it does business. Companies may be supporting health in some areas, but hindering action elsewhere.

To tackle regional and local inequalities in health, businesses will also need to make new connections with the public and voluntary sectors to take a place-based view, working with local systems that shape health: local authorities, Integrated Care Systems, healthcare providers, educators, housing associations, and the community and voluntary sector.

In many cases, action on health seems easier for larger companies. However, there is much that businesses of all sizes can do to improve health. While SMEs may not have the same formal structures, 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 healthier, happier, more productive workforces, attracting customers and investment, and forging closer supportive ties with their local communities. SMEs can also work together and in partnership with larger companies in their supply networks to take action.

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, shifting the culture of business towards defining success in terms of purpose as well as profit and meeting standards for equity in health, social and environmental performance.

CHAPTER 2: 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. Unemployment, particularly when it is long-term, contributes significantly to poor health, while good quality employment is protective of health (1).

Poor quality work, 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 (4). Good work incorporates safe working conditions for both physical and mental health, fair progression, decent pay, job security and having some control over and flexibility with tasks. Lower-skilled work is associated with higher mortality (5). 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 improve the conditions of work in order to protect those in lower-skilled and lower-paying jobs.

PAY AND BENEFITS

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 of 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 (6) (7). In the UK, the majority of those living in poverty are in paid work (6).

The statutory **minimum wage** is often insufficient for many to live a healthy life (8). Companies should commit to offering all employees, including contractors and temporary staff, the Joseph Rowntree Foundation's minimum income standard (MIS), an income sufficient to provide for a socially acceptable standard of living, including basic necessities like healthy food, good housing and clothing, but also full participation in society, security and stability (9).

Companies should also 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 (10). Reducing pay inequalities

can also help: companies should prioritise fairness alongside market value for executive pay and reduce the disparity in pay packets across their organisations.

Pay for sickness absence is essential. While most workers in the UK receive some or all of their salary for a limited period of **sickness absence**, about a quarter of workers, mostly with lower incomes, are only eligible for statutory sick pay (SSP) of £96.35 per week, comparable to the lowest in the EU (11) (12). The lowest earners, including temporary workers and those on insecure contracts, are often not even eligible for SSP (11).

Other **employee benefits** also contribute to the social determinants of health and health inequalities. These include workplace pensions, parental leave and childcare. Companies should use their influence over companies they contract with to ensure these benefits are available more widely. SMEs that lack infrastructure and expertise could collaborate with each other and with larger corporations to pool risk and ensure all employees receive the support they need.

WORKING CONDITIONS

Health-supporting jobs need to be stable and provide a good degree of autonomy and control, combined with support from fellow employees and managers, variation in tasks, and systems for recognition and reward (4). Stressful jobs are associated with worse physical and mental health (13).

Job insecurity has also been found to be associated with poor health (14). Precarious employment is more common for lower-paid and ethnic minority employees (6). Companies should commit to the Living Hours standard of accurate contracts, decent notice periods and a guaranteed 16-hour week (15).

Excessive **working hours** are responsible for around 750,000 deaths per year globally from stroke and heart disease and negatively impact physical and mental health (16). In the UK approximately one in eight workers works more than 48 hours per week, rising to one in six in London (4). One in four of all sick days taken in the UK is directly attributed to workload problems (17). Research suggests countries whose citizens work fewer hours have higher productivity (18). Flexible working should be encouraged.

Employee representation and engagement is a crucial component of good business, including consultative participation and collective representation (19). Larger companies must commit to worker representation at decision-making level, including on corporate boards. Businesses of all sizes should engage with employees on a regular basis, and see that all employees have a chance to have their voices heard.

A company that provides good jobs can extend their contribution to equity through proactive **recruitment, training and promotion for disadvantaged and underrepresented groups**. Companies must commit to achieving equal pay for equal work. Businesses should work in partnership with youth and adult education providers to increase the availability of mentoring, internships, training and school holiday training schemes, and particularly routes such as apprenticeships that favour those with fewer advantages. Where **SMEs** lack the necessary structures, larger corporations, local business organisations and government can support them to adopt positive local recruitment strategies. Larger companies could open their training schemes to SMEs in their supply chains.

SUPPORTING PHYSICAL AND MENTAL HEALTH

The statutory requirement for businesses to look after the health and safety of workers should incorporate mental as well as physical health (20). This includes protection of good mental health with good quality jobs and working hours, counselling and effective signposting to mental health services, as well as parity between physical and mental health in all sickness benefits. Large companies may also be able to extend some of their support services to SMEs in their supply networks.

Employers can support and encourage **healthy behaviours** among their employees, including encouraging or subsidising active or hybrid travel to work, providing green spaces, healthy food options, or smoking cessation and alcohol reduction support. These actions can support healthy decision-making, but must not replace action on the social determinants of health and the provision of jobs that support health.

Companies can also support their employees to undertake **philanthropic or purpose-driven work**. This may be as simple as matching donations, but can go beyond this to support employees to volunteer. Employees should be encouraged to support local community activities. Health equity considerations should be incorporated into the frameworks of how leaders are selected, promoted, rewarded and developed.

CHAPTER 3: 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.

PRODUCTS AND SERVICES

Many companies affect health and health inequalities through the **commodities** they produce. 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 (21). The food industry spends 27 times more on advertising than the UK government spends on promoting healthy eating (22). Affordability 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 (23). The poor and socially disadvantaged are also often less likely to make healthy decisions, due to an abundance of pressures and lack of support and resources. This is why tackling the root causes of poverty, deprivation and disadvantage works to improve nutrition.

The food industry should reformulate products; change marketing strategies to promote healthier options, particularly to children and young people; and offer affordable healthy foods, sensible portion sizes and clear, useful nutritional information. 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.

Financial products such as pensions, annuities and life assurance can also ensure financial stability in older age and maintain health. However, 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 it remains more expensive to be poor. Financial services companies should make services and products available more widely, providing advice to employees within their own organisations and throughout their supply networks; lending support, expertise and capacity to charitable organisations that provide financial planning assistance; and providing

credit responsibly, perhaps in the form of low-interest loans to staff and to companies and individuals within their supply networks. 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.

HOUSING AND INFRASTRUCTURE

A supply of good quality, affordable and secure **housing** is essential for health (24). Poor quality housing which is in disrepair, overcrowded, damp, poorly ventilated, poorly insulated or prone to overheating increases mortality and ill-health, including respiratory problems, infections, delayed physical and cognitive development in children, and mental health problems (25) (26). More than one third of households privately renting in 2017/18 were living in poverty after housing costs, and this sector has the poorest quality housing (6) (27).

Housing projects should aim 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. Developers must not attempt to evade Section 106 or other commitments to providing affordable housing through viability loopholes (28). Projects must begin with a health equity impact assessment that examines the entire project through a health equity lens, much as environmental impact assessments are currently used.

Improved **infrastructure** 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. Health equity should be a key 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 (29). Neighbourhoods should provide a mix of amenities and places to meet and work, encouraging active travel and reducing transport pollution as well as improving social capital and fostering a sense of community among residents, based on the principles of the 15-minute city (30).

INVESTMENTS

The **investments** companies make 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. 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 (31).

Some industries are, by their nature, inherently harmful to health. Investors who are prioritising health should consider divesting completely from these industries where possible. Where this is not possible, or health impacts are more balanced, investors should engage actively and use their influence to shift the business towards a more health-supporting business model. Such decisions should be made with an honest and transparent assessment of the health equity impacts of a given industry or firm.

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 using a structured approach that reflects the full range of social determinants of health. Investors should use all of their influence and sanctions to discourage business models that worsen health or health inequalities. All investments should aim to be at least health-neutral, and default plans should aim to have some beneficial health equity impact.

CHAPTER 4: 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.

THE NATURAL ENVIRONMENT

The **environment** in which people live is a major determinant of their health. Many companies produce health-damaging pollution and significantly contribute to the climate and environmental crises. Clean air, adequate water, a stable climate and access to green spaces are pre-requisites for good health (32). 24% of deaths globally are associated with living or working in an unhealthy environment (33). Compared with wealthier people, less affluent and more socially deprived groups are more likely to be exposed to environmental health risks (34). Action on mitigating environmental damage must take into account issues of health equity and ensure that polluting industrial sites or transport are not simply moved into lower-income or otherwise disadvantaged neighbourhoods.

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

WORKING IN PARTNERSHIP

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

Anchor institutions like hospitals, universities and councils that are physically rooted in communities can shape the health and wellbeing of the local population, leveraging their position as employers, purchasers, service providers, landowners, asset holders and as leaders to effect change. Businesses can also function as anchor institutions (35). These businesses can provide good jobs; recruit locally, especially in low-income areas; mobilise their supply networks to support the local economy; support local charitable and not-for-profit enterprises; advocate with communities; lend expertise to local partnerships; and share use of land and property.

Companies can use their **purchasing power** to support enterprises that further the ends of health equity, generating social value while pursuing profit, by considering employment, subcontracting, procurement and other opportunities to generate ancillary health and equity benefits.

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

Companies can **advocate** to the public, **persuade** other firms, and **lobby** local and national government to take action to reduce health inequalities. They can also lobby other firms to support health equity, including by requiring ESHG criteria for qualifying to tender for contracts and supply goods and services.

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 and should support policies that enhance health equity and reduce inequalities in the social determinants of health. This represents not just action for social justice, but also a long-term investment in the health of the UK and a healthy and a healthy and productive workforce of the future.

Finally, it is critical that corporations, and individuals associated with them, pay a **fair rate of tax** that provides governments 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 a fairer and more progressive tax system, which would also avoid penalising companies that take their tax responsibilities seriously.

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.

REFERENCES

1. Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M. Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010, 2010.
2. Legal & General Group. Making a difference through inclusive capitalism: Legal & General Group Plc Annual Report and Accounts 2020.
3. Wilson N. It's time for ESG to incorporate health. Fortune, 2021. fortune.com/2021/08/25/esg-companies-health-reporting-legal-general/
4. Durcan D. Local action on health inequalities: Promoting good quality jobs to reduce health inequalities. Public Health England/UCL Institute of Health Equity, 2015.
5. P Katikireddi SV, Leyland AH, McKee M, Ralston K, Stuckler D. Patterns of mortality by occupation in the UK, 1991-2011: a comparative analysis of linked census and mortality records. The Lancet Public Health, 2017. Vol. 2(11). doi.org/10.1016/S2468-2667(17)30193-7
6. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. Health Equity in England: The Marmot Review ten years on. UCL Institute of Health Equity, 2020.
7. Lawson S. Poverty and health. The Health Foundation, 2018. health.org.uk/infographic/poverty-and-health
8. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. Building Back Fairer in Greater Manchester: Health Equity and Dignified Lives. UCL Institute of Health Equity, 2021.
9. Davis A, Hirsch D, Padley M, Shepherd C. A Minimum Income Standard for the United Kingdom in 2021. Joseph Rowntree Foundation, 2021.
10. Cox A, Rickard C, Spiegelhalter K, Brown D. Employee financial well-being: Why it's important. Institute for Employment Studies/Chartered Institute of Personnel and Development, 2017.
11. Trades Union Congress. Sick Pay for All: How the Corona Virus has shown we need urgent reform of the sick pay system, 2020. tuc.org.uk/research-analysis/reports/sick-pay-all
12. Vanhercke B, Bouget D, Spasova S. Sick pay and sickness benefit schemes in the European Union: background report for the Social Protection Committee's in-depth review on sickness benefits. European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2017. data.europa.eu/doi/10.2767/531076
13. Bell R. Psychosocial pathways and health outcomes: Informing action on health inequalities. UCL Institute of Health Equity, 2017.
14. Tinson A. The quality of work and what it means for health. The Health Foundation, 2020. health.org.uk/publications/long-reads/the-quality-of-work-and-what-it-means-for-health
15. The Living Wage Foundation. Living Hours. livingwage.org.uk/living-hours
16. World Health Organization and International Labour Organization. WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury, 2000–2016. 2021.
17. Health and Safety Executive. Work related stress, depression or anxiety in Great Britain, 2018. hse.gov.uk/statistics/causdis/stress/index.htm
18. Ashford NA, Kallis GA. Fourday Workweek: a Policy for Improving Employment and Environmental Conditions in Europe. Nicholas Ashford, 2013. dspace.mit.edu/handle/1721.1/85017
19. Taylor M, Marsh G, Nicol D, Broadbent P. Good Work: The Taylor Review of Modern Working Practices. 2017.
20. Business in the Community. What if your job was good for you? A once-in-a-lifetime opportunity to transform mental health and wellbeing at work. 2021.
21. Public Health England. National Diet and Nutrition Survey time-trend and income-analyses for years 1-to-9. 2019. gov.uk/government/statistics/ndnstime-trend-and-income-analyses-foryears-1-to-9
22. Obesity Health Alliance. Health costs of obesity soaring as junk food companies pours millions into advertising. 2017. obesityhealthalliance.org.uk/2017/10/11/press-release-health-costs-obesity-soaring-junk-food-companies-pour-millions-advertising/

23. Scott C, Sutherland J, Taylor A. Affordability of the UK's Eatwell Guide. The Food Foundation, 2018.

24. Judge L, Rahman F. Lockdown living: Housing quality across the generations. Resolution Foundation, 2020.

25. Building Research Establishment. Good housing leads to good health: A toolkit for environmental health practitioners. Chartered Institute of Environmental Health, 2008.

26. Marmot Review Team. The Health Impacts of Cold Homes and Fuel Poverty. Friends of the Earth/ Marmot Review Team, 2011. ISBN: 978–1–85750–343–2.

27. Marmot M, Allen J, Goldblatt P, Herd E, Morrison J. Build Back Fairer: The Covid-19 Marmot Review. UCL Institute of Health Equity, 2020.

28. Wilson W, Barton C. Research Briefing: Tackling the under-supply of housing. House of Commons Library, 2022.

29. UCL Institute of Health Equity/Health Foundation. Health Foundation and Institute for Health Equity response: Health Equity as a Vital Component of Good Infrastructure. 2017.

30. The 15-Minute City. 15minutecity.com

31. Pizzey M, Brown H, Boyd E. Helping purpose-driven business thrive. ReGenerate, 2021.

32. Prüss-Ustün A, Wolf J, Corvalán C, Bos R, Neira M. Preventing disease through healthy environments: A global assessment of the burden of disease from environmental risks. World Health Organization, 2016. ISBN: 978 92 4 156519 6.

33. World Health Organization: The Global Health Observatory. Public health and environment. 2022. who.int/data/gho/data/themes/public-health-and-environment

34. World Health Organization European Centre for Environment and Health. Environment and health risks: a review of the influence and effects of social inequalities. 2010. www.euro.who.int/__data/assets/pdf_file/0003/78069/E93670.pdf

35. Denison N, Newby L. Harnessing the power of anchor institutions – a Progressive Framework. Joseph Rowntree Foundation, 2018.


INSTITUTE of
HEALTH EQUITY