

## Written evidence submitted **International Longevity Centre UK (ILC)**

I am responding to the Committee's call for evidence on behalf of the [International Longevity Centre UK \(ILC\)](#), the UK's specialist think tank on the impact of longevity on society. We are responding to this consultation to encourage the Government to learn the lessons of the COVID-19 pandemic in order to better protect and enhance the longevity of our population against the threat of infectious diseases.

UK governments have been complacent about the threat of infectious diseases

In 2018, ILC expressed concern "that we need to tackle the growing complacency about infectious diseases".<sup>i</sup> This was echoed by the fact that in 2019, three of the World Health Organisation's ten biggest threats to global health related to infectious diseases.<sup>ii</sup> In 2016, the Exercise Alice report, commissioned by the then-Chief Medical Officer, even warned of the threat of a coronavirus pandemic specifically.<sup>iii</sup> Several factors have contributed to the increased risk of infectious disease epidemics and pandemics:

- **Globalisation** and the increasing ease of international travel has meant that infectious diseases can spread globally more easily
- **Urbanisation** has meant that more people are now living in overcrowded living environments in which infectious diseases can spread more easily
- **Climate change** has caused significant human displacement, often leading people to expand into new environments and therefore come into contact more with animals that typically carry infectious diseases
- **Ageing populations** have increased the number of people at greater risk of poor health outcomes from infectious diseases

Over the past decades alone, we have seen a number of infectious disease outbreaks, including the 2009 H1N1 Pandemic, which caused between 150,000 and 500,000 deaths globally,<sup>iv</sup> and the 2014-2016 Ebola outbreak, which caused over 11,000 deaths in Guinea, Sierra Leone, and Liberia.<sup>v</sup>

However, despite this, we have seen complacency leading to falling investment in prevention since the 2008 financial crisis. This is not unique to the UK – between 2009 and 2014, OECD countries' public spending on prevention fell by 2%. However, compared to the other G7 countries, UK health spending per capita is the second lowest, and fell as a percentage of GDP from 9.8% in 2013 to 9.6% in 2017, while it rose for four of the other G7 countries.<sup>vi</sup> Likewise, while Canada invests 6% of its health budget into prevention, the UK's spend is only around 5.2%.<sup>vii</sup>

### **We should have invested in a healthier population**

The lack of investment in prevention has meant that while the UK population is living longer, people are also spending more of their remaining lives with disabilities and care needs. From 1990-2016, while life expectancy at age 65 increased for both men (by 4.4 years) and women (by 3 years), the proportion of years lived independently declined.<sup>viii</sup> At the start of the pandemic, 2.2 million people in the UK (more than 1 in 30 people) were classed as clinically extremely vulnerable,<sup>ix</sup> undoubtedly contributing to the UK seeing more deaths per 100,000 COVID-19 cases than France, Spain, Ireland and Germany.<sup>x</sup>

Investing in public and preventative health earlier could have lowered the burden of underlying health conditions, which in turn could have reduced the health impact of the pandemic. For example, since increasing its spending on prevention to 6% in 2000, Canada has seen a decrease in avoidable

mortality and an increase in life expectancy. Moreover, Canada saw a mortality rate that was less than half that of the UK (797 deaths per million cases in Canada compared to 2,184 per million cases in the UK).<sup>xi</sup>

### **We should have addressed health inequalities**

The inequalities exposed by the COVID-19 pandemic have been apparent and entrenched in the UK for decades. The gap in life expectancy between people in the top and bottom 1% of the UK population socioeconomically is 12 years.<sup>xii</sup> As well as living shorter lives, people in areas with the lowest life expectancy spend on average 10% more of their lives in poor health than those areas with higher life expectancy.<sup>xiii</sup> There is also a lack of access to preventative interventions, especially in rural areas or for those with limited mobility.

Specifically looking at the BAME population:

- Older BAME people are more likely to be in poor health<sup>xiv</sup> and more likely to have age-related conditions, such as hypertension, diabetes, and being overweight, that increase the risk of experiencing severe symptoms and complications from COVID-19<sup>xv</sup>
- BAME people are highly likely to be employed in frontline and essential sectors, such as health and care, transport, and hospitality, making them unable to work from home and therefore putting them at greater risk of being infected with COVID-19<sup>xvi</sup>
- BAME communities are more likely to live in overcrowded and/or multigenerational households, which enable infectious diseases to spread more easily<sup>xvii</sup>

It should not therefore have come as a surprise that we have seen inequalities in the health impact of COVID-19 pandemic. For example, in the first wave of the pandemic people with Black African ethnicity were nearly four times more likely to die from COVID-19 than those with White ethnicity.<sup>xviii</sup> The Government should have recognised that the conditions in which BAME communities live and work, their health status and the barriers they face accessing public health services would make them more likely to be exposed to the virus and responded accordingly.

### **We should have improved the data infrastructure of our healthcare system**

Back in 2016, the UK Health Secretary Jeremy Hunt promised that every patient in England would have online access to their medical records by the end of the year<sup>xix</sup>. Likewise, when he was appointed Health Secretary, Matt Hancock listed improving the NHS' use of technology as one of his three key priorities.<sup>xx</sup> Despite these promises, there has been a lack of coordinated information recording and record sharing between health professionals.

There are currently several health data systems in operation across the UK, many of which aren't interoperable with each other. According to research from Imperial College London, NHS Trusts use at least 21 different electronic medical record systems, and nearly a quarter (23%) still use paper records.<sup>xxi</sup> This lack of interoperability meant that between April 2017 and April 2018, there were more than 11 million cases where a hospital was unable to access medical data recorded in another hospital.<sup>xxii</sup>

The Government has built an expansive data infrastructure to respond to the COVID-19 pandemic, but had to do so almost from scratch when it should have already existed. And the current system of data collection is also far from perfect. Despite COVID-19 having a disproportionately worse impact on people with underlying health conditions, data on vaccine uptake among these groups does not specify per condition. For example, the category "Chronic Respiratory Disease" doesn't diverge between asthma, COPD, emphysema and other related conditions. This needs to be far more tailored to monitor uptake more closely among individual patient populations and respond in a targeted manner, rather than taking a one-size-fits all approach.

## **What needs to happen next**

COVID-19 has shown us the devastating impact of infectious diseases on our population's health and the economy. The Government now needs to heed the lessons from this experience to ensure we do not return to the same levels of complacency seen before the pandemic. As a start, the Government should match Canada's investment of 6% of its health budget in prevention, which we estimate would require a £2.687 billion investment – that is just 4.5% of the £60 billion the Department of Health and Social Care received for COVID-19 measures.<sup>xxiii</sup> This sustained investment in prevention would improve the resilience of our population's health to the threat of infectious diseases and help contribute to the Government's target of adding five additional healthy years to life expectancy by 2025.

The Government should also place addressing health inequalities at the core of the levelling up agenda through taking a local and personalised approach to the rollout of preventative health interventions to ensure no one is left behind. Bringing prevention to people, rather than vice versa, through delivering preventative interventions in convenient locations rather than expecting people to travel to them would help reach those otherwise excluded. Likewise, collaboration and consultation with local actors and community leaders is key to understanding the barriers faced by minorities in the UK to accessing preventative health interventions.

Finally, the Government must build on the data infrastructure created during the COVID-19 pandemic to finally deliver on the promise to improve the use of data for the delivery of healthcare in the UK. Improving the interoperability of health data and increasing access to digital health records would allow better monitoring of infectious diseases and enable a swifter, more effective response should a future outbreak occur.

The case for prevention is clear, we now urge the Government to look beyond short-term electoral gains and focus on protecting the health and wellbeing of our population throughout the life course.

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