COMMON SENSE POLICY GROUP

# Transforming public health

## Common Sense Principles for Radical Prevention Funds

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# Contents

# A Common Sense Radical Prevention Fund in 5 minutes

The North East Devolution Deal which underpinned the establishment of the North East Combined Authority (NECA) set out a remit to establish a Radical Prevention Fund (RPF) to tackle long-standing health disparities to improve quality of life and reduce health and care costs. The region has the worst health outcomes in England, with life expectancy some three years lower than London and the South East. It also has among the worst rates of poverty in the UK, including the highest before-housing-costs child poverty. But many regions with similarly bad outcomes could benefit from such an approach.

Preventive health interventions are far more cost-effective than reactive services. But health and care systems under both NHS and local authority control are under intense financial pressure and are unlikely to be able to shift resources upstream. A separate RPF that supports such upstream interventions is, therefore, greatly needed. Given the breadth of Combined Authorities' geographic, policy and public service innovation remits, organisations like NECA are in a strong position to administer an RPF.

Building on research examining the underpinning drivers of effective, impactful public policy that address the social determinants of health, RPFs should be developed in line with the following principles:

**Principle 1:** Equality Principle
**Principle 2:** Freedom from domination
**Principle 3:** Tackle the social determinants of health directly or on a stepping stone basis downstream where it is not
**Principle 4:** Build up community wealth
**Principle 5:** Level up places
**Principle 6:** Modern problems require ambitious, experimental and innovative solutions
**Principle 7:** Interventions should be scalable unless they address the cause directly for the whole population affected
**Principle 8:** Work across policy areas and between institutions where it is more effective
**Principle 9:** Transfer decision-making power to citizens where possible
**Principle 10:** Value expertise, but hold it accountable

The most essential principle for an RPF is perhaps '3: Tackle the social determinants of health directly or on a stepping stone basis downstream where it is not'. This may well mean providing money directly to those who need it rather than a more politically palatable, but less effective, service. For example, the NHS' Healthy Start scheme provides money via a card to purchase healthy food and formula milk, while South Tyneside Council provides payments to pregnant women who quit smoking. The test, here, is that if an issue is identified as the cause of a health problem downstream, it should be addressed directly rather than its effects being partially mitigated over an extended period. This may not always be possible within the scope of a Combined Authority, and in these cases, the next step down should be targeted. The point, though, is that intervening at the highest points upstream is most impactful and cost-effective.

Given the likely initial size of an RPF, and in line with Principle 7, innovative approaches that are scalable should be prioritised, unless they address the cause directly for the whole population affected. Based on a very rough estimate, £100 million could end the two-child benefit cap in the NECA area. If an RPF is in the order of single or low double-figure millions, then scalable solutions could be trialled for, for example, a portion of the group affected by poverty driven by the cap. If an RPF reaches a sufficient level to bring the entire group affected by the cap out of poverty through cash transfers, then this would be the solution in line with Principle 3. Mitigating the negative effects of poverty will never be as effective as eliminating that poverty.

Policymakers may feel unable to risk political capital on such interventions where they differ substantially from inherited approaches, even though those approaches have, demonstrably, failed. A solution is for an RPF to transfer decision-making power to citizens to provide democratic backing. This approach builds community wealth and assets, helps prevent clientelism in the funding and provide greater opportunity for equity of access for both applicants and those involved in the assessment of proposals.

The report proposes a structure for an RPF in the North East that incorporates substantial citizen decision making and which should be subject to consultation with stakeholders, particularly citizens. Any final structure should adhere to the 10 Principles.

It is essential that an RPF be viewed not solely as a funding mechanism, but also as part of an approach that builds on examples like the Preston Model, creating community wealth and establishing the North East, and other areas facing similar issues, as a true trailblazer, reflecting the devolution deal implemented in 2024.

# Our Common Sense Recommendations

**1:** Radical Prevention Funds (RPFs) should be established by Combined Authorities such as NECA in order to address health inequalities in the worst-affected regions. Combined Authorities' broad geographic, policy and public service innovation remits put them in a strong position to administer RPFs.

**2:** RPFs should be designed in alignment with the 10 Principles outlined in the report to ensure that they most effectively address health inequalities.

**3:** RPFs should address social determinants of health inequalities directly if possible, and on a stepping stone basis down from that if not.

**4:** RPFs should prioritise innovative approaches that are scalable, unless they address the cause directly for the whole population affected.

**5:** RPFs should transfer decision-making power to citizens to provide democratic backing to approaches that may otherwise be deemed 'too radical' for policymakers to enact. This helps build community wealth and assets while preventing clientelism, reducing bias in the process and providing greater opportunity for equity of access for both applicants and those involved in assessment of proposals.

**6:** RPFs should be developed further through consultation with stakeholders, particularly local people, to decide on the final structure in line with the 10 Principles.

# 1. Introduction

Since the Global Financial Crisis, there has been a context of extreme budgetary constraint, falling central government funding and rising debt in the UK public sector, including among local authorities[1] and with knock-on effects for even recently established Mayoral Combined Authorities.[2] Spending on health and social care was provisionally estimated by the Office for National Statistics[3] at £239 billion in 2023 across the NHS, local government and other public bodies, and at 8.2% of national income in 2022/23 by the Institute for Fiscal Studies.[4] Given the significant strain on public spending and the contribution of health and social care inequalities to it,[5] there is growing recognition that budgetary sustainability requires that upstream interventions which address social determinants of health be funded in order to save the public purse on service provision downstream. The context makes this both more difficult, as budgets are forced to focus on immediate, reactive services, and more essential, as savings become necessary.

That necessity is evident in declining outcomes of critical social importance: health,[6] education inequalities,[7] employment and crime,[8] among many others. There is a pandemic in anxiety and depression[9,10] and, for the first time since records began, an increase in infant mortality in Britain.[11] Young people see little hope of a pathway from education and work to property, family and success. Many are quiet quitting their jobs as a consequence.[12] This is all at odds with the lived experience of older generations, whose outcomes from work and accumulation of wealth exceeded both those of their parents and children, adding an intergenerational dimension to inequality[13] that is historically unprecedented.

Throughout the period, the underpinning cause of crisis has been concealed by numerous identitarian, cultural and ideological discourses pitting often equally vulnerable communities against one another.[11] The challenges humans face are material in nature: resources are finite and unequally distributed.[11,14] An ever-growing body of evidence demonstrates the impact of not dealing with those challenges effectively. However, there is increased recognition at various levels of government that addressing the material social determinants of strains on public resources is key to resolving budgetary crises. Levelling Up sets out the relationship between poverty, inequality and health and social outcomes,[15] while devolution deals have focused on investment mechanisms to address those determinants.[16,17]

In both West Yorkshire and the North East, the national prevention agenda[18,19] has been formalised through funds with commitments to investing in young people in the former, and a 'Radical Prevention Fund' (RPF) in the latter. The RPF is outlined as follows:

> Population health and prevention – commitment by the Department for Health and Social Care and NHS England to work alongside North East and North Cumbria Integrated Care Board to develop a Radical Prevention Fund reshaping existing funding away from acute services and into preventative action. Building on regional population-based prevention work this would aim to develop new

models of prevention to tackle long-standing health disparities to improve quality of life and reduce health and care costs. There is potential to use the Dormant Assets Act 2022 to support community and voluntary sector organisations to make a difference in their places.[16]

The North East's RPF would likely include using resources to tackle the material bases of health inequalities. It would be radical, insofar as it would be concerned with new and innovative interventions, preventive, by focusing on social determinants, and have a ring-fenced budget that needs to be spent. These early outlines leave open a large number of questions about the size and scope of RPFs, alongside processes involved in running such scheme and delivering funding in the most effective and equitable manner possible. Given the trend of politics toward devolution and prevention, it is likely that such approaches will be adopted more broadly. However, they lack underpinning sets of principles by which to guide their development, implementation and delivery. The lack of principles reduces, rather than aids, the possibility of pragmatic, effective interventions, since their absence means that policymakers are more likely to default toward tested and uncontroversial approaches that have failed to deliver improvement.

In this article, we use RPFs as a case study by which to develop principles to underpin policy. We outline the context of an RPF in the North East Combined Authority, before interrogating the distributive principles that have shaped policy for the past five decades. This provides a basis for developing 10 principles that can be used pragmatically to shape policy to suit local conditions.

# 2. The need for a Radical Prevention Fund

There is widespread recognition that Britain is in an extended period of crisis, with politicians increasingly appearing hapless in their attempts to make the country function. Part of the reason that politicians have failed to deliver is because the democratic system as it stands promotes bad outcomes.

The case for prevention being better than cure has become a rhetorical consensus across the political spectrum in recent years.[20,21] The devolution deal makes clear that the RPF is intended to 'tackle long-standing health disparities' and given the ambiguity otherwise in the policy, this must be taken as a concrete starting point. The Labour Government's election manifesto also prioritised reducing health inequalities and there is, therefore, national support for policy that contributes to that end.[21]

The North East faces particular, and extreme, challenges with regard to population health and health inequalities. Health Equity North[22] found that it had the lowest life expectancy of any English region for baby boys and girls, around three years less than London and the South East. The region also has the lowest proportion of people (78.3%, 3.4 percentage points below the English average) reporting their health to be 'good' or 'very good', and the highest proportion (6.9%, 1.6 points above average) reporting 'bad' or 'very bad'. It also has the highest rates of people reporting that their day-to-day activities are limited a lot by disability (9.8%, 2.3 points above average) and of being

economically inactive due to disability or ill-health (5.7%, 1.6 points above average). The North East has the highest percentage of people providing unpaid care (10.1%, 1.2 points above average). Family Resources Survey 2022/23 data shows that 31% of all people in the region are disabled, 5 points more than any other English region.[23] Three of Health Equity North's 10 recommendations in its 2023 report include prevention, with one being that 'Research funders should give increased priority to research that helps to address health inequalities including a place-based focus on prevention'[22]

There is considerable and growing evidence that socioeconomic inequality is the ultimate upstream social determinant of both health and other social outcomes. Observational and experimental associations between income disparities and health have been established in studies and reviews examining: self-rated health; mortality; biomarkers; child health and wellbeing outcomes; mental health among children and young people; and adult mental health[24] Supporting Pickett & Wilkinson's causal review,[25] Adeline and Delattre's analysis[26] supports the claim that higher income is associated with better health outcomes (the Absolute Income Hypothesis) and that health inequalities affect the health and wellbeing of nearly all members of a society (the strong version of the Income Inequality Hypothesis).

In 1980, the *Black Report*[27] highlighted the need to address health inequalities by affecting social determinants through tax-benefit policy, and those inequalities have only worsened since. In 2010, the Marmot Review found that 1.3–2.5 million extra years of life and 2.8 million free of illness or disability were being lost annually in England due to health inequalities,[28] with worsening trends in Marmot's 10 years on report.[29] IPPR analysis[19] comparing trends before and after austerity measures indicated that 130,000 preventable deaths between 2012 and 2017 could have been the result of such policies. The balance of evidence suggests that increases in quantity, security and predictability of income are the 'ultimate "multipurpose" policy instrument'.[30]

The North East context makes this particularly relevant. The rate of poverty is 25% in the North East compared to a national average of 22%, 19% in the South East and South West, and just 16% in Northern Ireland.[31] The North East had the highest share of people living in households where nobody was in work, at 30%, compared with 21% in the South East. The North East also has a higher-than-average percentage of people on Universal Credit and legacy benefits and in private rented accommodation.

Child poverty is an inter-regional inequality issue, with every local authority in the North East reporting a rate higher than the UK average.[31] As the 2021 Child of the North report highlighted,[32] the North East has the highest before-housing-costs child poverty rate (30%), and second-highest after housing costs (37%) after only Inner London. North East children are most likely to be eligible for Free School Meals (27.5%) compared with 16% in the South East. Pre-pandemic, the prevalence of low and very low household food security was 11% in the North East compared to 6% in the South East and 8% in England as a whole.

Cuts to local authority spending have been significantly higher in deprived areas and in the North compared with the South, leading to worsening health outcomes. The North saw larger cuts to Sure Start children's centres, with funding cut by £412 per eligible

child compared with £283 in the rest of England. Schools in London receive almost 10% more funding per pupil than schools in the North.[11]

The Child of the North's *Children in Care*[33] report found that the region has the country's highest overall care rates. The report also found that poverty is a causal factor in child maltreatment, including due to affecting parents' own stress and mental health and their ability to invest in their children, with poverty also increasing the likelihood that children will be taken into care, and making it harder for them to be reunited with parents. This places huge social and financial costs on society, including children, parents, communities and local authorities. For example, in 2022-23, residential placement costs per capita were highest in the North East at £334 per child, followed by £271 in the North West and contrasting with just £114 in Outer London.[34] The North East has particularly suffered over time, with a 33.8% increase in child poverty between 2014/15 and 2021/22 and Middlesbrough's rate rising from 29% to 41%, the largest increase of any local authority.[35]

Being born into poverty sets individuals off on a path from which the prospects of escape are bleak. Even using data from almost a decade before, a 2014 government review found that 50% of the relative difference in parents' incomes was 'transmitted' to their children.[36] Meanwhile, teenagers experiencing poverty in the mid-1980s were four times as likely to be in poverty as adults compared to those who had not experienced poverty as children. This is more than double the increased risk than for those who were teenagers in the mid-1970s.[36] Given deterioration in social mobility since,[37] it is reasonable to speculate that this will have worsened significantly.

Unfortunately, the capacity to catch such individuals in the 'midstream', once they are already somewhat at increased risk, has been weakened substantially in recent years. Research for the Health Foundation[38] has found that the public health grant paid by the Department of Health and Social Care has reduced by 28% per person in real terms since 2015/16, or 21% if time-limited funding for drug and alcohol treatment are included.[39] These cuts have been even greater in the most deprived areas, where public health activity is most needed.

Crucially, the study also found that each additional year in good health resulting from public health interventions cost just £3,800, compared with £13,500 from reactive NHS services. Excluding the time-limited additional funding, the grant is just £3.6 billion in 2024/25, a tiny proportion of overall health spending. Given worsening inequalities based on socioeconomic determinants, the Health Foundation called for increased investment in the public health grant.[38]

Successive Conservative-led governments committed to a 'prevention agenda'[40] in order to reduce pressure on the NHS and secure better health upstream. However, investment has failed to match this intention. Instead, NHS Providers[41] reported in July 2023 that 16 (38%) health systems ended the 2022/23 financial year in deficit, with 14 forecast to do the same in 2023/24. NHS Providers summarised the results from a survey with systems at the time, saying:

> Trusts are increasingly aware of the value they can add as anchor institutions supporting better population health, of their role in systems to address the

wider determinants of health and in supporting more preventative activity to keep people well. However tight financial envelopes across public services and severe cuts to local authority public health funding mean funds to invest in new and preventative approaches which could potentially deliver better outcomes and save funds down the line, can be challenging to deliver.[41]

There is, then, a context of primarily reactive services already having little or no money available for preventive health even if they themselves agree that the ultimate solution is to focus on prevention.[42] This is compounded by the fact that, as Mayes and Oliver put it, public health prevention benefits are 'dispersed and delayed'.[43] An under-pressure hospital trust cannot divert money from meeting the urgent needs of the patients of today to an early life intervention that would prevent the urgent health needs of hypothetical patients of the future, even if that is what would ultimately best serve that hospital and the public.

There is, therefore, a strong case for the establishment of a separate fund to support innovation and upstream intervention that relieves pressure on downstream services over time.

# 3. What does radical mean and why is it important?

In Newcastle, Social Impact Bonds (SIBs),[44] have been implemented through, for example, Ways to Wellness' programmes,[45] with payments from the NHS (and other commissioners) only made once outcomes have been evidenced (Outcomes Based Commissioning [OCB]). However, in line with the fundamentally 'radical' nature of the prevention fund approach, there may be the need to fund projects for which success is not guaranteed or where impacts are likely to be so far in the future that a social investor is unwilling to wait for a return. Public funding fills this gap.

Evaluation of a Radical Prevention Fund (RPF) intervention must seek to capture return on investment in its broadest sense and, if possible, model longer-term outcomes, such as quality-adjusted life years gained over a 10+ year period. In addition, by virtue of the central concern for prevention, interventions must be given sufficient time and space to achieve impact in order to accrue sufficient evidence of impact. Pragmatic concerns around electoral cycles and budgeting may limit the length of initial funding, but short-term or one-off interventions in population health cannot be expected to provide long-term or permanent benefits. A *Radical* Prevention Fund must, therefore, reshape expectations and focus on long-term change.

The means of establishing returns on investment from public health interventions are relatively well-established. National Institute for Health and Care Excellence (NICE) guidelines provide useful means of assessing the cost-effectiveness of interventions.[46] Whereas in NICE guidelines, the Willingness to Pay (WTP) threshold for an intervention being cost-effective is £20-30k per quality-adjusted life year (QALY) gained, in HM Treasury's Green Book, the figure is £70k in 2020/21 prices.[47]

The North East Combined Authority (NECA) has a remit to engage with Public Service Innovation (PSI) across the region. The OECD defines public-sector innovation as involving significant improvements in the services that government has a responsibility to provide, including those delivered by third parties. It covers both the content of these services and the instruments used to deliver them.[48]

This is, therefore, a very broad remit that facilitates experimentation in delivering the outcomes required within the region. With regard to addressing health disparities, this provides a platform for innovation and experimentation that other bodies may not feel resourced or empowered to deliver. Given the level of ambiguity in discussion of upstream and downstream health, there is a need to make clear, here, that a *Radical* Prevention Fund is one that seeks new, innovative and experimental approaches to prevent health problems from developing as early as possible in the process.

However, given political and practical pressures within local government, a useful point to start in the design of a truly Radical Prevention Fund is in setting out underpinning principles to guide development and from which deviation in design should be minimised.

# 4. Choosing the wrong principles is disastrous

The breakdown of society in the 1970s can be attributed to various causes.[11] The most significant was the strain on finances caused by cost-push inflation associated with ongoing geopolitical conflict among fossil-fuel-rich states. This contributed to intergenerational tensions as younger people who had grown up with unprecedented social security and opportunity and basic assumptions of continual improvement in their standards of living faced their first obstacles to development. Having not experienced war or the threat of death from lack of healthcare and social security, they had expectations around continuous improvements in circumstances that were stifled by inflation in prices and a militant, and at times, short-termist approach by trade unions to alleviating cost-of-living pressures through strikes against the Labour Government.

The likes of Friedrich Hayek[49] provided an alternative set of policies that had long been regarded as having failed historically, but which could serve as clear reference points for a radical Conservative Government from 1979 onwards capable of redistributing wealth through privatisation and heavily constrained public spending on housing and production. This channelled wealth, particularly through rising house prices, to the baby boomer generation more than others and changed voting preferences rightward long-term.[50]

While Hayek and other neoliberal policy entrepreneurs have been presented as inspiring the transformation that took place, it is the influence of John Rawls, a figure often regarded as the philosopher of social democratic renewal that has proven most long-standing and pernicious. Rawls' reputation as an opponent of inequality is understandable, given that much of *A Theory of Justice*[51] is devoted to discussion of equality. However, his formulation of the difference principle within his principles of justice[52] creates a caveat that undermines that work: that social and economic

inequalities are permissible if they benefit the worst off. This concern for 'maximin' – maximising the interests of the minimum level of society – served to entrench the fundamental case made by Hayek: that material inequality is consistent with justice and produces good outcomes. This rests on two are assumptions: 1) that material differences do not affect formal equality between citizens and abstract equality of opportunity; 2) that inequality benefits the worst off. Both of these positions sound plausible, since we often assume that people only reluctantly take on senior, apparently stressful roles in return for enhanced remuneration. However, when we understand the outcomes that the difference principle produces, it is apparent that it is consistent with the neoliberal settlement in ways that have distorted policymaking in disastrous directions.

Modern policymakers, with Conservative Prime Minister Liz Truss at the most extreme end but also effectively all who have held high office in recent decades, have followed the Thatcherite intuition that reducing the tax burden on the wealthy stimulates economic activity that 'trickles down' to improve the welfare of those in all subsequent strata.[53] 'The resulting inequality between rich and poor' does 'not matter since the concern of the poor' is 'their absolute position and... inequality' is 'distinct from poverty'.[54] In this account, those with low incomes remain equal as citizens to those with high incomes from wealth since they have the same voting rights and formal opportunities for advancement. In addition, they see their material condition improve by virtue of the absolute gains produced by the activity of the wealthy. Any marginal improvement in the material condition of those in the lower and middle part of the income distribution, however small, justifies the increase in material condition among the wealthy, however large. The outcomes are apparent in figure 1. It shows that between 1977 and 2014, both economic conditions and tax-benefit policy actually left the lowest income decile very substantially worse off. The second decile received a marginal overall increase between a gain through economic change and a loss through tax-benefit change. The third to eighth deciles of approximate middle earners all saw a gain or loss at the margin through increases from tax-benefit policy and losses through economic change. Only the ninth decile gained through both economic and tax-benefit changes, but at a relatively small scale. The richest, however, saw an enormous increase of almost a third on their already substantially larger incomes from economic change, with only a marginal loss through tax-benefit policy.

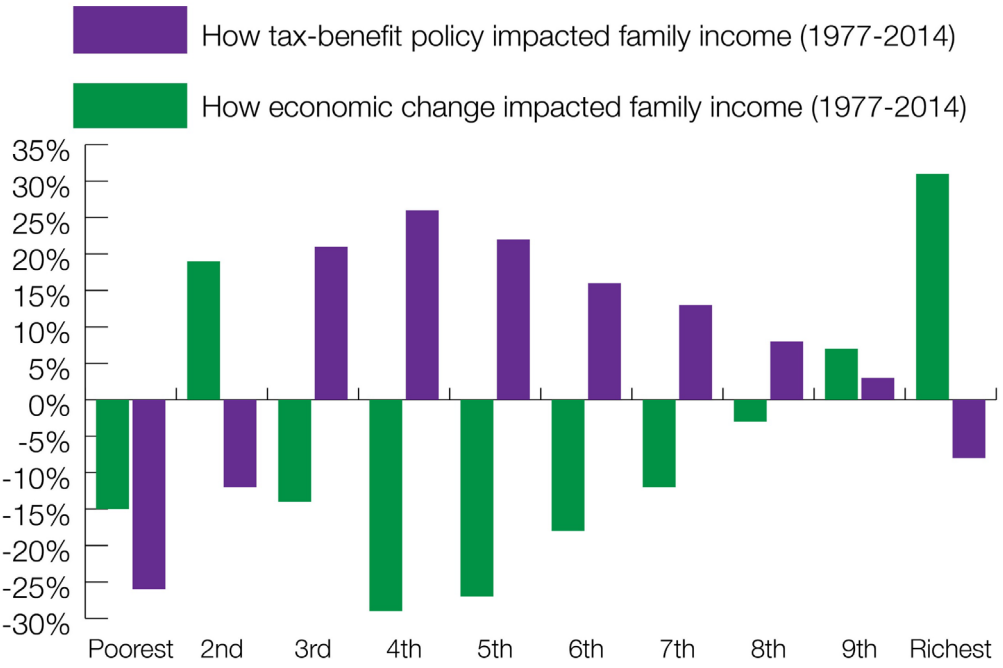


Figure 1. Comparison of tax-benefit and economic change on family income by decile (1977-2014). Source: Authors' analysis of Office for National Statistics data.[55]

The shift in post-War concern for relative gains in promoting equality to absolute gains in increasing aggregate wealth requires endorsement of growth.[56] If individuals are to gain without redistribution of resources, it is essential that there be a net increase in resources, specifically through free markets that foster global economic growth.[49,57] Rather than sharing the pie equally, policymakers are committed to making an ever-larger pie so that there are means of improving resource quantity for those with the smallest share without increasing their proportion. The contrast between the notion of infinite growth on a finite planet has contributed to climate change and social challenges related to migration without necessarily reducing poverty and in many cases increasing it.[58]

When surveyed, the general public are willing to consider inequalities of pay to facilitate socially valuable roles but believe that they should be much lower than they currently are.[59] Current inequalities in pay exceed those socially permissible amounts by huge margins, with those in the financial sector and other wealth-based occupations often exceeding ratios of tens or hundreds of times the lowest paid. An associated problem is that the assumption that some professions are inherently more stressful by virtue of seniority and therefore deserve higher pay, is fundamentally wrong. Often, the opposite is true: the more senior, the less stressful, since senior positions in hierarchies are subject to far fewer arbitrary decisions' being imposed by those higher in the pyramid.[60–63]

Justifications for incentives in pay are actually associated with circumstances under which the worst off are most likely to be exposed to risk. The most socially valuable professions are generally those performed by the worst off and regarded as being of lower value as a consequence.[64] Under non-emergency conditions, cleaners are perhaps the most significant arm in sustaining public health.[65] Under emergency conditions, the work of the lowest paid becomes even more critical. During the COVID-19 pandemic,

cleaners, nurses, shop workers and delivery drivers were key workers. These are also the citizens whose health, social and economic outcomes are targeted by RPFs. To improve the interests of the worst off, we need to increase the material interests of those with the lowest incomes. This means that the difference principle is either tautological, misleading or socially damaging. In the UK, the effects are profoundly harmful

Put simply, poverty and inequality have become fundamentally entwined because reforms to facilitate the latter justified as a means of reducing the former end up increasing the former and fostering a series of social problems that can only be addressed by reducing the latter. As Wilkinson and Pickett have demonstrated,[14] the more unequal a society, the worse its outcomes in health, education, social cohesion and criminality. To succeed, an RPF must fundamentally break from the difference principle.

# 5. Good principles for good outcomes

Principles matter and their influence ought to extend both to the interventions that are funded and processes within an RPF. The first five principles derive from the work of the Common Sense Policy Group in *Act Now*,[11] and apply to all public policy. However, those below rework the first five for an RPF specifically and add a further five.

## 5.1 Principle 1: Equality Principle

In place of the difference principle, we need an equality principle: *every* policy ought to be informed by commitment to reducing the material basis of inequality. Doing this necessarily reduces the inequalities attached to race, gender and disability, since discrimination on that basis fundamentally intersects with material processes and outcomes. While there have been previous attempts at such a formulation,[66] there has been insufficient understanding of the fundamental processes by which that might be borne out. Wealth from the richest ought to be redistributed to fund transformative policies to improve the material conditions of paid and unpaid workers and those who cannot work, gradually and irreversibly eliminating poverty and reducing inequality. This principle is consistent with provision of material incentives for provision of public service, such as cleaning, driving and fighting, that others are unable or unwilling to provide, since this itself consists in reduction of poverty and inequality. However, in line with principle 3 below, the broader tax-benefit system should support greater redistribution through income. Ironically, the current 'targeted' system fails to do this effectively. As figure 2 shows, the poorest 10% of households paid 43.5% of their income in taxes in 2017-18, 10 points more than the rest of households who pay an average tax rate of 32.7%.

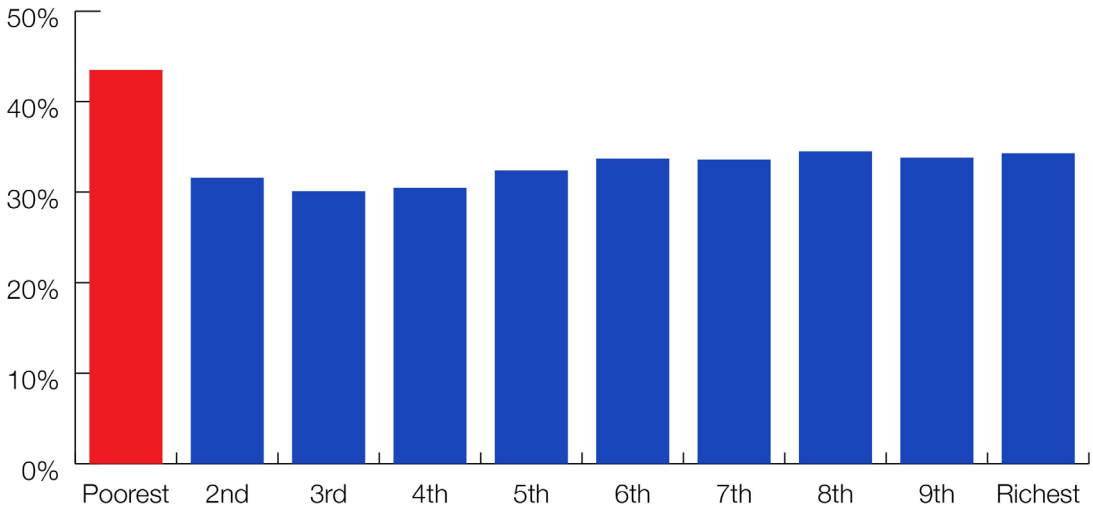


Figure 2. Proportion of tax paid by household by income decile (2017-18). Source: Authors' analysis of Office for National Statistics data.[67]

The result, as figure 3 shows, is that, in 2017-18, the poorest 30% received little more in benefits than they paid out in taxes. The total real cost of benefits was £14.9 billion or 0.7% of GDP. The vast majority of taxes fund public sector salaries and services that benefit society as a whole.

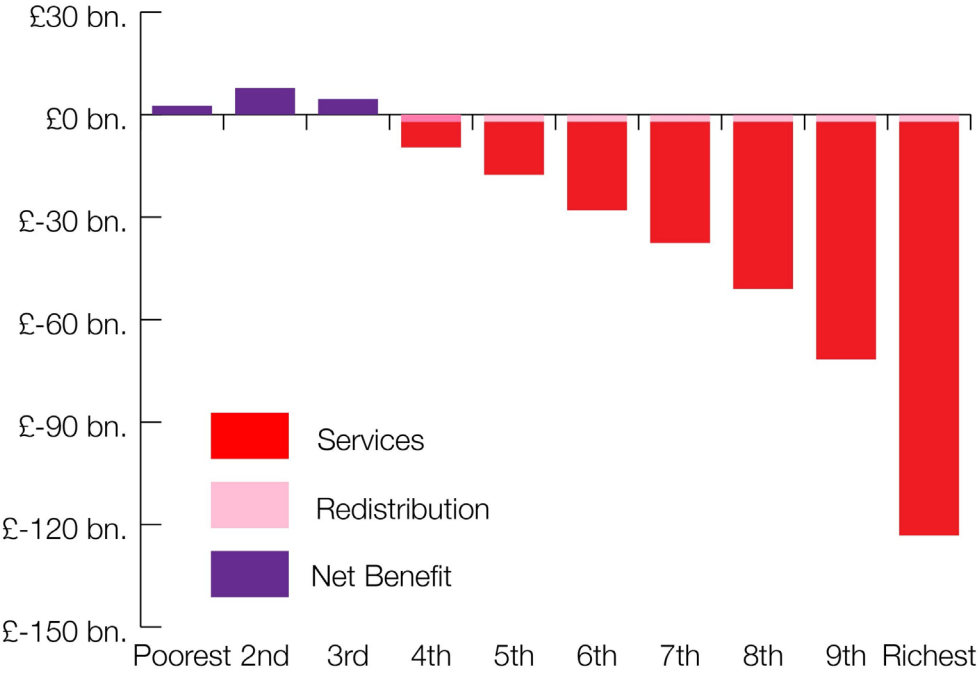


Figure 3. Effects of taxes and benefits on household income by decile (2017-18). Source: Authors' analysis of Office for National Statistics data.[67]

## 5.2 Principle 2: Freedom from domination

Equality is of importance in increasing the resources of the worst off. It is also important in reducing an associated source of ill-health: domination. This arises

> where people have to accede to the wishes of others, through desperation: they cannot say no and cannot walk away. A world of desperate poverty and insecurity is one where people have to accept bad jobs, bad relationships or bad housing

> because they have no alternative but to starve or freeze. People who are dominated cannot relax their guard; they must always adopt tactics to protect their interests, no matter how demeaning or unnatural those tactics may appear.[11]

Principles 1 and 2 are fundamental to addressing the long-term health problems that afflict modern Britain, and the North East in particular. As detailed above, there is considerable and growing evidence that socioeconomic inequality is harmful to health[25] and that exposure to domination is a core determinant in this.[62] Put simply, by supporting the material security of people, domination is reduced and better health-promoting behaviour is possible.[68–70]

## 5.3 Principle 3: Tackle the social determinants of health directly or on a stepping stone basis downstream where it is not

This is perhaps the most essential principle for the purposes of the RPF. Tackling the social determinants of health directly naturally complements the previous two principles. However, it must be made clear that the bucket of health funding will continue to leak if the causes are not addressed at their earliest point. This may well mean providing money directly to those who need it rather than a more politically palatable, but less effective, service.

For example, the NHS' Healthy Start scheme[71] provides money via a card to purchase healthy food and formula milk, while South Tyneside Council provides payments to pregnant women who quit smoking.[72] The test, here, should be that if an issue is identified as the cause of a health problem downstream, it should, in the first instance, be addressed directly rather than its effects being ameliorated. This may not always be possible within the scope of a Combined Authority, and where this is the case, the next step down should be addressed. The point, though, is that addressing the determinants at the highest points upstream is likely to be most impactful and most cost-effective, since it eliminates the issue rather than partially mitigating its effects over an extended period. Compared with *Act Now*,[11] which emphasised tackling determinants directly (which remains the ideal), an adapted principle for an RPF is therefore necessary.

## 5.4 Principle 4: Build up community wealth

Building up community wealth[11] is already an approach taken in local government in the UK under the 'Preston Model'.[73] In Preston, 'anchor institutions' like local government bodies and educational and health institutions which were responsible for a large share of local spending (£750m), were spending only £38.3m in Preston and £288.7m in Lancashire in 2012/13, meaning that £458m was leaving the region. They were also holding assets that were providing no community benefit. These anchor institutions changed their procurement to make it easy for smaller local enterprises to compete, encouraged the formation of social enterprises and cooperatives, including local pension schemes and mutual financial institutions. They improved the jobs they provided, encouraged the widest possible use of the assets they held, and in some cases democratised the ownership and control of those resources. This meant that that

by 2016/17, just four years later, £112.3m was being retained in Preston and £488.7m in Lancashire. In designing any funding mechanism, it is absolutely essential that the economic impact of that spending be felt within the region, both as a principle of good devolution and because it may result in further benefit to regional health.

## 5.5 Principle 5: Level up places

Principle 5 builds on recent governments' approach, including the Levelling Up white paper,[15] and in this context is the place-based counterpart to Principle 1. A devolved government context and an objective of reducing health inequalities provides key means of providing levelling up within Combined Authority areas like NECA's.

While these principles provide a platform on which to build most policy, it is likely that additional principles will be needed in the specific context of Combined Authorities and RPFs. The following five principles seek to meet that need.

## 5.6 Principle 6: Modern problems require ambitious, experimental and innovative solutions

The ambition of 1942's Beveridge Report,[74] which sought to address the Five Giant Evils of the age, has been lost in public policymaking over the last several decades. The solutions presented since the Global Financial Crisis over 15 years ago have failed to make significant inroads in areas relating to socioeconomic inequality, poverty and public health. Indeed, as the evidence above shows, many outcomes have got very substantially worse.[11] If a Radical Prevention Fund is to have any major impact, it must take seriously the 'Radical' part of its name and seek to fund interventions that are not given sufficient consideration otherwise.

## 5.7 Principle 7: Interventions should be scalable unless they address the cause directly for the whole population affected

The size of an RPF is likely to be relatively limited, at least initially, in comparison to the size and impact of social determinants of health inequalities. There is, therefore, a case for pursuing the ambition of Principle 6 by piloting approaches that are scalable with further funding. Indeed, if ambition of scale is not included in proposals, it is unlikely that the RPF will have the impact that the devolution deal envisaged. For example, using End Child Poverty Coalition figures[75] for the number of households affected in the NECA area (2.96%) as a proportion of the UK as a whole and IFS analysis[76] of the overall annual cost of removing the policy (£3.4 billion), a very rough estimate of the cost to end the two-child cap in the NECA area is around £100 million.

It is unlikely that an RPF will reach this kind of level of funding in the short to medium term, and, as such, support for piloting interventions and research that could result in much broader population impacts should be prioritised. This is essential to securing further funding from Westminster. Were an RPF to reach levels of funding of around £100m, Principle 3 suggests that it may well be best directed towards alleviating poverty directly. This Principle has been designed to accommodate such a scenario.

## 5.8 Principle 8: Work across policy areas and between institutions where it is more effective

There are two clear reasons to commit to collaboration and avoid traditional silos. First, the RPF currently proposed is situated within NECA, which serves institutionally to work across local government bodies. Second, NECA's Public Service Innovation function covers a broad range of policy areas and requires integration. Addressing the social determinants of health means there must be a willingness to support local communities across all aspects of their life. This requires collaboration between institutions and services responsible for, among others, welfare and employment support, early years education, childcare and public health services, such as smoking cessation for parents.

## 5.9 Principle 9: Transfer decision-making power to citizens where possible

The new Westminster Government's approach in relation to the two-child benefit cap[77] on Universal Credit and Child Tax Credit illustrates the challenges that policymakers face in pursuing impactful policy. The Institute for Fiscal Studies estimates[76] that scrapping the policy would immediately lift approximately 360,000 children out of child poverty – 500,000 were the policy fully rolled out – at a low up-front cost of £3.4 billion. Given that the Child Poverty Action Group estimated conservatively that the cost of child poverty in 2023 had hit £39 billion, up from £25 billion (in 2023 prices) in 2008, there is good reason to believe that there would be both large long-term health and social benefits from doing so and returns on investment that would more than pay for the up-front cost. There are indications that the decision not to scrap the policy may have been driven by public opinion in addition to that upfront financial cost.[78] However, recent survey evidence suggests that there are in fact high levels of support for measures that reduce child poverty, including by removing the two-child cap.[11]

A potential solution is to involve the public, supported by academic and policymaking expertise, more directly in decision-making, deferring to deliberative democratic processes where electoral calculation means that politicians are unwilling outright to support interventions. A recent example at the more ambitious end of such approaches is the *Guter Rat* (Good Council)[79] formed by Austrian heiress Marlene Engelhorn to distribute €25 million (around 90%) of her inheritance which resulted from the sale of Boehringer Mannheim company in 1996/97. 50 members of the public were selected to reflect Austria's demographic profile as closely as possible and met over six weekends while receiving input from experts before deciding how the money should be redistributed. Senior Labour Party officials now in key Westminster Government positions have expressed interest in using Citizens Assemblies to address a range of issues where representative democratic processes have failed.[80] The recommendations of Citizen Assemblies in Ireland ultimately led to marriage equality and abortion legislation.[81]

The Local Government Association (LGA) has cited Citizens' Assemblies and Citizens

Juries as a public service reform tool, including in preparation for devolution deals.[82,83] Former Secretary of State for Communities and Local Government Jon Denham and Jessica Studdert of the New Local think tank recently called for place-based public service budgets inspired by New Labour's *Total Place* pilots highlighted the prospective benefits of ensuring both public service provider collaboration and public involvement in such a system.

In terms of incorporating public opinion and community priorities in policymaking, the direct benefit of Citizen Assemblies is clear. However, there are additional benefits.[84] Assemblies are discursive and participants' preferences may change as a result of their participation and the arguments and evidence they see. Work on 'adversarial co-production', in which opponents of evidence-based policy create narratives designed to persuade people like them to support such policies, demonstrates that the concept of a relatively fixed 'Overton Window' of policies that are acceptable to the public which changes only very slowly over time is incorrect.[85] Instead, people are aware of their material interests and those of their communities and the vast majority will support policies that can be shown to positively impact those interests. Assemblies, by enabling community members to take part in this deliberation, support improved deliberation, understanding of policy and democratic processes among the whole population.[86]

A Citizens' Assembly or Jury approach resolves issues of equity of access by academics as a larger number of experts can be involved in the process of presenting evidence to an assembly. It radically transfers decision-making to citizens and prevents the development of fiefdoms and pursuit of personal policy interests among academics and policymakers. It builds up community wealth by: a) developing skills among community members; b) remunerating assembly or jury members at a fair level; and c) ensuring that there is opportunity for individuals across the region to make a case for investment in their own area, where there is a smaller-unit geographic focus.

There is, clearly, a risk in transferring decision-making power since perverse decisions are possible. However, the need for RPF and indeed Levelling Up[15] highlights the failure of decisions reached through less democratic processes. The transfer of decision-making power to citizens is trusted within the criminal justice system as a means of reducing bias and unjust use of power. An Assembly/Jury approach, particularly when members are chosen in a random, rotating and representative manner,[87] addresses the risks of clientelism and bias in funding awards, supporting greater equity and objectivity in assessment and increasing opportunity for applicants who have not previously engaged with the relevant Combined Authority or related organisations. A screening process of applications to serve on assemblies to ensure that basic requirements are met avoids the distribution of public funds to applicants incapable of receiving them legitimately and fulfilling roles effectively. However, the screening of applications should be restricted to a relatively small number of criteria, such as criminal conviction, residence and citizenship. This prevents domination of assemblies by small groups with outlying preferences.

## 5.10 Principle 10: Value expertise, but hold it accountable

There is a recognised tendency among academics toward risk aversion and preference to support research projects and endorse evidential claims that are the least controversial. This is because review processes necessarily identify areas of disagreement and disagreement is deployed as evidence of error, even when that disagreement is simply reasonable disagreement.[88,89] For example, one study[90] examined data on all applications to the Australian Research Council's Discovery Programme and found that the greater the degree of interdisciplinarity in the proposal, the lower the probability of its being funded. Studies have also shown very substantial levels of disagreement in scores provided by different reviewers, at between 24% and 35%.[89] In hyper-competitive funding contexts, a failure to secure top scores from all reviewers often means that funding will not be awarded.

The consequence is that the majority of funding for policy development research is directed toward work that is least likely to be capable of addressing significant challenges, such as health inequalities, for which all existing measures have had little impact and because of which an RPF is required. The tendency toward risk aversion among experts must be recognised both by policymakers and the public and any recommendation by experts measured against the need of communities for impactful interventions. Given the democratic characteristic of devolution, and given that other interventions have failed, the RPF cannot be allowed to fall into the trap of removing commitment both to the radical and the truly preventive in the use of resources.

The application of these principles aids, rather than hinders, pragmatism in decision-making, insofar as each of the principles are underpinned by a strong evidence base on their impact on policymaking. It also leads to institutional processes that aid prevention by virtue of their formulation. Figure 4 sets out a possible RDF decision-making structure for a NECA context as an exemplar. This illustrates the ways in which having clear principles leads to processes that are concerned directly with improving outcomes. It is important to highlight the extent to which the approach presented here achieves the very outcome with which Rawls is apparently concerned, but which is *de facto* precluded by his commitment to the difference principle.

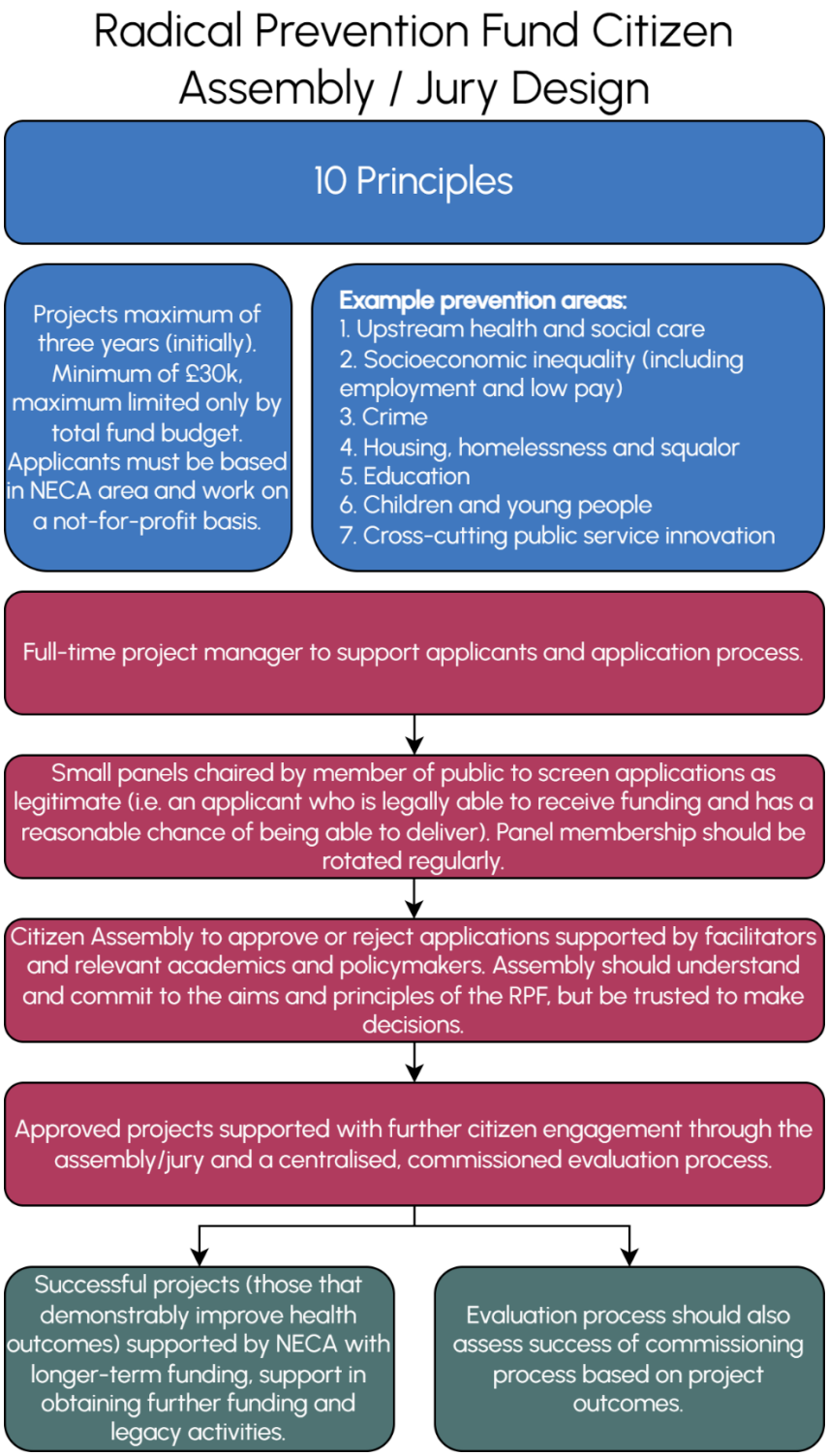

Figure 4: Radical Prevention Fund panel design

These principles provide a starting point for the development of an RPF that secures the stated objectives and the needs of communities.

# 6. Conclusion: Prevention Funds must be truly radical

This report traces the way in which adoption of the wrong principles has led to bad outcomes over the past four and a half decades. For too long, principle has been disconnected from outcome. Here, we set out a 'consequentialist' commitment to principle, arguing that adopting certain evidence-based principles leads to processes that improve outcomes. A Radical Prevention Fund (RPF) is an illustrative example of policymaking that benefits directly from understanding of the material basis of harmful social outcomes and the need for philosophically informed development of principle. The report establishes principles and high-level considerations and design features to underpin Combined Authority RPFs, with the North East Combined Authority (NECA) as an exemplar.

There are clear indications of a very significant social and economic return on investment from an RPF that addresses community priorities and inter-regional inequalities. The NECA area covers a large proportion of the North East which experiences some of the worst health inequalities and levels of poverty in the UK. There is good reason, too, for Combined Authorities like NECA to administer such funds, given their broad geographic and policy remit, and leading role in public service innovation. A design that focuses on radical, innovative and scalable interventions while transferring decision-making to citizens has the power to be impactful both in terms of the interventions funded and the process itself. Indeed, any design that aligns with the 10 Principles outlined in the article is likely to have a transformative effect on health inequalities in regions like the North East. It is essential that an RPF be viewed not solely as a funding mechanism, but also as part of an approach that builds on examples like the Preston Model, creating community wealth and establishing the North East, and other regions facing similar issues, as a true trailblazer, reflecting the devolution deal implemented in 2024.

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