The Royal Society for Public Health (RSPH) is an independent charity, dedicated to protecting and promoting the public's health and wellbeing. We are the world's longest-established public health body with more than 6,500 members drawn from the public health community both in the UK and internationally.

Our response to this consultation is based on the expertise of our policy team and three roundtable discussions which the RSPH hosted with the Health Foundation which engaged a total of 43 stakeholders drawn from:

- The Voluntary and Community Sector – senior figures representing 17 organisations in the health sector
- Local Health Systems – 16 senior figures from regional and local health systems including STP and ICS leads, Directors of Public Health, regional directors for Public Health England, and health leads for Combined Authorities.
- Central Government – 12 representatives from the Department for Health and Social Care, Public Health England, NHS England the Department for Digital, Culture, Media and Sport, the Department for Environment, Food and Rural Affairs, and the Food Standards Agency (including 5 Directors and 3 Deputy Directors).

• On a scale of 1 to 5, where 1 is very happy and 5 is very unhappy, what do you think of the concept of a health index as a way to measure health?

1

• On a scale of 1 to 5, where 1 is very happy and 5 is very unhappy, what do you think of the Health Index as presented in this consultation, as a way to measure health?

2

• To what extent do you feel the Health Index as we have presented it fulfils the aims we presented? (completely, to some extent or not at all)

To some extent

• On a scale of 1 to 5, where 1 is very likely and 5 is very unlikely, how likely are you to use the Health Index as it is currently proposed for your own analysis?

1

• Which elements of the Health Index's proposed structure would you want us to improve for you to be more likely to use it?

We would like to see greater consistency in how the structure of the Health Index is presented so that it is more explicit where certain conditions serve as risk factors for other conditions, as currently physiological conditions which also function as risk factors are split across the Healthy People and Healthy Lives domains, while mental health conditions are only sited in Healthy People.

The proposed structure of the Health Index into three domains, each composed of various subdomains, is an effective way of communicating the various wider drivers upon health outcomes which exist at every level of society. However, it is important for users to be aware that many indicators are not isolated variables or outputs but interact in complex ways with others across the domains. This complexity was raised by several participants in our

roundtables with leaders from Whitehall and VCSOs and we would recommend both user testing and then guidance from ONS to prevent misunderstandings.

In particular, users should be cautioned against reading the two higher domains as the sole drivers of health and the Healthy People domain's indicators as purely outcomes, when some of the measures in both Healthy People and Healthy Lives domains can be both at the time.

There are also some slight adjustments to where certain indicators are sited, based on the suggestions of participants to our roundtables about where certain indicators are measured:

- As high rates of unemployment are largely structural features of local economies, and individuals have little control over the job opportunities available to them in this context, we recommend unemployment is placed in Healthy Places rather than Healthy Lives.
- Measures of the prevalence of anxiety as a clinical condition should sit in the Mental Health sub-domain; whereas self-reported feelings of anxiousness may remain in the Wellbeing domain – but the two should be clearly distinguished, as the difference between clinical and 'normal' levels of anxiety should be appreciated by both policy-makers and members of the public.

• Which elements of the Health Index's data and content would you want us to improve for you to be more likely to use it?

We would like to see the Health Index present, as well as an overview of the nation's health, an indicator of the extent of the inequalities in outcomes and exposure to risk factors behind the headline figure, and to show whether those inequalities are increasing or decreasing over time. In addition to differences between regions, we would like to see the inequalities within regions (i.e. between boroughs) and between a range of demographic segmentations, in particular across ethnic groups.

We recognise that data may not be available across all indicators for the full range of geographical and demographic breakdowns, but we believe the best approach would be for the ONS to publish what data is available, while being transparent about the gaps therein, in order to drive better data collection.

In addition to breaking down the data by age and sex, there was great support across our roundtables for breaking it down by ethnicity as a way to inform action to reduce health inequalities, including in modifiable risks.

It is also important, we believe, to capture inequalities within places as far as the data allows. Therefore, we concur with the many participants across our roundtable discussions who observed that having the Health Index data at LSOA level would be far more useful for understanding and addressing the needs of particular communities than data at UTLA level.

Several participants at our roundtable for VCSO leaders noted they would ideally like the Index presented with ward-level data so they could best target their interventions, on the grounds that there can be great socio-economic and demographic differences between neighbourhoods. However, we believe that the most fundamental aim of the Health Index should be to influence national government to invest widely in the nation's health outcomes and, to achieve this goal, it is imperative that the data behind the Health Index is verified and the methodology is robust. It is our understanding that trying to get the data down to this low level would compromise the validity of the tool, which we consider paramount.

There are further communities, not defined by place, which also are subject to health inequalities and who experience worse health outcomes. We therefore, along with the organisations present at the roundtables who represented some such population groups, would be interested in seeing multiple versions of the Health Index which could capture some of these inequalities for, for example, people experiencing homelessness; unpaid carers; the LGBTQ+ communities; and different socioeconomic groups by including a breakdown by social grade. We recognise this may only be possible at a high geographical level and not for all indicators. However, we believe that showing the gaps in the data would help organisations make the case for improved data collection, which will underpin further efforts to understand and address health inequalities and health needs.

• Which elements of the Health Index's methodology would you want us to improve for you to be more likely to use it?

We would like to see robust sensitivity analysis undertaken for the Health Index so that users can be confident that it offers a reliable gauge of changes in the population's health. If the headline figure remains roughly the same year on year, the Index will be of little informative value and so it is unlikely to be widely used.

Confidence in the robustness and validity of the Health Index is of uttermost importance for it to gain purchase across local and central Government, and local health systems. Concerns were raised, particularly in our roundtable discussion with senior figures from Whitehall, about the methodology behind the Index, for instance, the assumptions which underlay the factor analysis, whether any causative relationships between the indicators had been factored into that analysis, the validity of their weighting, and whether the data was all of equally high quality.

Given these concerns, it is important that the methodology behind the Health Index and any limitations to its data are presented transparently. It is also important that the Index has a high degree of sensitivity so that it responds quickly to underlying changes in the population's health. This is important for the headline figure of the Health Index to be viewed as meaningful and to be used to support decision-making.

We recommend the ONS provide worked examples to demonstrate the sensitivity and use of the Health Index. Without helping users to become fluent in the meaning of the Index's results, there is the risk – as one senior figure in the civil service observed – of it being too abstract to be widely used.

Having heard this disquiet about the validity of the methodology and data behind the Index from high-level stakeholders, we would recommend the ONS, as the Index develops, prioritises data quality above adding in measures which, while representing a relevant driver of health or a notable health outcome, would compromise its robustness.

• Is there anything else we could change about the Health Index which could improve your likelihood of using it?

We would like to see guidance on how to use the Health Index for a range of purposes, informed by user journey testing, so that users approach the tool with the appropriate expectations of what conclusions can or cannot be drawn from it, and are supported in further investigating its constituent datasets and incorporating its insights with their own.

Transparency around the data behind the Health Index is important for both building trust in its methodology, ensuring valid conclusions are drawn from it, and for the purposes of further investigation. Therefore, for using it for RSPH's research purposes; for a policy-making context, as we heard from senior figures from Whitehall in our roundtable discussion; and for the campaigning and operational work of VCSOs, it would be useful for the Index to contain direct links to the original datasets and for the metadata to be included. This will allow it to be easily evaluated, analysed and combined with other datasets.

Relatedly, the Health Index could be more useful for people in combined authorities if it were possible to see the data at national, regional (including Combined Authority footprint), UTLA, and LSOA levels.

As with all new tools, the success of the Health Index will depend on how confident people become in using it. Therefore, we recommend the ONS invest resources into providing guidance on how the Health Index can be used for different audiences, after commissioning user journey testing into how various users will engage differently with the tool.

For instance, at the roundtable with leaders from local systems, we heard that participants would appreciate the Health Index including: guidance on how its data could be combined with localised datasets; and suggested actions on how certain measures could be improved – in order to help with in engaging elected members.

Providing worked examples of how the Index can be used would also help a wide audience become familiar with the tool, and help to ensure it is used appropriately. Therefore, we recommend the ONS invests in different ways of providing these – including in on-site videos, written guidance, and training for stakeholders.

• What additional health data do you think the Health Index should include?

We would like to see the inclusion of further drivers of health, particularly around the areas of social connectedness, the labour market, and housing in the Health Index. For the Index to be a useful tool for public health, we would also like to see measures relating to health protection feature alongside those relating to healthy improvement.

The themes of social connectedness and the labour market came up repeatedly across the roundtable discussions we held with VCSOs, local systems and Whitehall. There is an abundance of evidence showing that the strength of one's community and social relationships has an impact on both mental and physical health. For instance, greater social support has been linked to a lower risk for cancer recurrence, higher survival rates among heart attack survivors, lower blood pressure, better immune responses, and better psychological wellbeing.[1] On the other hand, social isolation has been associated with an increased risk of multiple diseases and mortality.[2] Therefore, we strongly recommend data from the Understanding Society survey is reviewed for inclusion in the Healthy Places domain. Participants at our roundtables recommended, for instance, measures which capture feelings of safety, belonging, fear of crime, loneliness, and digital connectivity.

[1] Cohen, S. (2004). Social relationships and health. American Psychologist, 59(8), 676-684; Stansfeld, S. A. (2006). Social support and social cohesion. Social Determinants of Health, 2, 148-71; Uchino, B. N., Cacioppo, J. T., & Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. Psychological Bulletin 119(3), 488-531.

[2] Stansfeld, S. A. (2006). Social support and social cohesion. Social Determinants of Health, 2, 148-71.

We also concur with the VCSO leaders at our roundtable who noted that it is not just unemployment which can have an impact on health outcomes; the quality and security of employment and the level of remuneration one receives is also highly relevant to health.[3] Therefore, indicators which capture, for instance, job satisfaction, disposable income, employment by standard occupational classification, underemployment, were all suggested by our roundtable participants to explore this driver of health in the Healthy Lives domain.

Another well-established strong influence on health comes from the quality and safety of housing and the security of tenure. While overcrowding has been linked to physical illness and psychological distress[4], we believe further indicators are required to fully capture the relationship between housing and health. For instance, substandard housing conditions such as water leaks, poor ventilation, dirty carpets, low temperatures, and pest infestation have been associated with poor health outcomes, in particular asthma.[5] Therefore, we recommend reviewing with a view to incorporating the proportion of homes which do not meet the Decent Homes Standard into the Healthy Places domain, and other measures from the English Housing Survey into the Index.

Instability in housing also has impacts on mental health, access to health services and is related to other risk factors like drug use.[6] We heard from representatives from housing and homelessness organisations that capturing insecure housing tenure as well as numbers living in temporary accommodation would align more with the definition of homelessness used by that sector, making it more useful for their research.

There is also opportunity for the Healthy Places domain to capture more barriers to accessing services than the purely physical one of distance. For instance, measures of illiteracy or English language proficiency would be able to reflect some of these barriers,[7] and could help regional and local health systems understand how their health campaigns and communications need to be targeted.

One of the strengths of the Health Index, we heard from a food policy expert, was that it included indicators for whole foods rather than specific nutrients (like fat, sugar and salt). This strength could be built upon by including a measure for consumption of red and processed meats – one of the risk factors for certain cancers, cardiovascular disease and type 2 diabetes. The ability to access healthy food is also an important enabler to eating well, and therefore, one senior civil servant recommended the ONS look to develop a measure for food deserts which could then be included in the Healthy Places domain.

---

[3] Burgard, S. A., & Lin, K. Y. (2013). Bad jobs, bad health? How work and working conditions contribute to health disparities. American Behavioral Scientist, 57(8), 1105-1127.

[4] Solari, C. D., & Mare, R. D. (2012). Housing crowding effects on children's wellbeing. Social science research, 41(2), 464–476.

[5] Zock, J. P., Jarvis, D., Luczynska, C., Sunyer, J., Burney, P., & European Community Respiratory Health Survey. (2002). Housing characteristics, reported mold exposure, and asthma in the European Community Respiratory Health Survey. Journal of Allergy and Clinical Immunology, 110(2), 285-292; Saeki, K., Obayashi, K., & Kurumatani, N. (2015). Short-term effects of instruction in home heating on indoor temperature and blood pressure in elderly people: a randomized controlled trial. Journal of hypertension, 33(11), 2338–2343.

[6] Hernández, D., & Swope, C. B. (2019). Housing as a platform for health and equity: evidence and future directions. American journal of public health, 109(10), 1363-1366; Kushel MB, Gupta R, Gee L, et al. "Housing Instability and Food Insecurity as Barriers to Health Care among Low-Income Americans." J Gen Intern Med, 21(1): 71-7, 2006; Haveman R, Wolfe B and Spaulding J. "Childhood Events and Circumstances Influencing High School Completion." Demography, 28(1): 133-57, 1991.

[7] Doctors of the World UK (2015) Access to Healthcare in the UK. [Online] Available at: https://mdmeuroblog.files.wordpress.com/2016/02/leaflet_access-to-healthcare_mdmuk_bd_pages.pdf

The safety of food, and not just its nutritional value, is also important to population health. Accordingly, we recommend the ONS review measures relating to the number of incidents of foodborne related illness and food hygiene rating data with a view to including them in the Healthy Lives and Healthy Places domains respectively. This would allow health protection teams and the Food Standards Agency identify any inequalities around exposure to unsafe food.

• Is there any health data proposed for inclusion which you think the Health Index should not include?

We do not believe, nor did we hear from any of our roundtable participants, that the Health Index in the beta version includes any superfluous measures or functionality.

• How would you want others to use the Health Index?

We would like to see the Health Index used to spark conversations about the wider drivers of health in such a way as to inspire a Health in All Policies approach at every level of the health and care system, and to encourage investment in the nation's health looks not just at treatment but also 'upstream' at prevention and improvement.

For the Health Index to have maximum impact, we would most want to see it engage decision-makers in the Cabinet Office and, even more so, in the Treasury, to facilitate cross-departmental working and, crucially, enable suitable levels of investment in public health, in its broadest definition. This, in turn, would have an agenda-setting function for every level of Government, which would drive concerted and co-ordinated action up and down the health and care system and, more importantly, beyond the boundaries of "health".

For the Health Index to gain traction across Government departments and become an embedded part of the systems and processes behind policy-making, we recommend that there is ministerial ownership of the Health Index. As one of the original intentions for the Index was for it to sit alongside GDP, it is important that there is an equivalent to the Chancellor of Exchequer's ownership of that measure. We believe the Health Index would be most impactful if it sat in the Treasury or Cabinet Office, as these would best enable the Health Index to be incorporated in a wide range of policy-areas. These two suggestions were also the most popular amongst participants at our roundtable for VCSO leaders.

We also believe that, in order to "focus public debate and policy attention" around health, there should be a legislative requirement for a minister to lay an annual report before Parliament on the Health Index for that year. That would ensure both accountability and Parliamentary scrutiny for any changes in the overall figure, but would also give a political event around which the media, the voluntary sector and the public can discuss the Index and their experiences of health and the drivers of health.

The Government is also more likely to prioritise improving the Health Index if it is a language in which a broad cross-section of its stakeholders and electorate are fluent, including a range of governmental agencies and public bodies, members of other political parties, VCSOs, think tanks, journalists and academics. Accordingly, we would like to see these individuals and organisations make use of the Health Index in their influencing, research and operational work, wherever appropriate.

Similarly, the more the Health Index gains currency on a UK-wide and international stage, the more credence it will be given by policy-makers at the highest level of Whitehall. Therefore, we would encourage the ONS to work in partnership with their colleagues across

the devolved nations to build Health Indexes which can be directly compared with that built for England. This would both make it more useful for Government Departments and VCSOs who work across the UK, and it is more likely to be adopted at the highest level of Government if it also employed by the First Ministers of Scotland, Wales and Northern Ireland. Similarly, just as GDP is a measure adopted internationally, we would encourage the ONS to support other countries to build their own Health Index as the Index for England will acquire greater significance – in terms of both meaning and impact – if it can be compared to that of other nations.

At other levels of the health and care system, we would like to see the Health Index used as a tool to engage a wide range of stakeholders – including those outside the public health community – in discussions around the wider determinants of health. The engaging and interactive visualisation of the Index is a particular strength in this regard, as it effectively communicates how a variety of factors, touching on multiple policy areas, have a bearing upon health outcomes.

The ability to use the Health Index in this way was highlighted by: representatives from Whitehall who were looking to facilitate a cross-departmental approach to policy areas like mental health and healthy, sustainable diets; leaders of VCSOs, who would be campaigning for a similar cross-government approach to tackle issues like homelessness and mental health; think tanks in convening and developing debates; and local public health teams, seeking to engage their elected members in investment in projects and services that influence the health of their local population in the broadest sense.

We would also like to see the Health Index be integrated into the Integrated Care System reform agenda, and in particular, support partnership working across ICSs. The strength of the Health Index in this regard, leaders of recently designated ICSs told us, was that it offered a metric which was not healthcare-centric, as well as its clear and engaging presentation. We would therefore like to see the Health Index used by ICS leaders in a way that focuses their mission on achieving good health rather than solely managing illness.

However, we are keen to see the Health Index not used as a performance management tool for ICSs or local government. This was a concern noted at our roundtable discussion for leaders from local systems. As one participant noted, responsibility for GDP sits with the Chancellor of the Exchequer; it does not filter down to Local Enterprise Partnerships. There was concern among attendees, which we share, that the ability to break down the data by region, responsibility for differences between areas might be apportioned to local government or even its citizens, with the role of national government in regional inequality not being sufficiently noted.

It was noted by one participant at the roundtable for VCSO leaders, for instance, that there are Government policies which have a clear bearing on health outcomes that could not be captured by the Health Index. Examples in this regard might relate to funding to local authority's public health budgets, social and affordable housing, and welfare benefits. There are also macro forces, like those relating to the economy and the climate, which can be expected to have an influence upon health. Therefore, it should be made clear to users what conclusions can or cannot be drawn from the Health Index. They should in particular be made aware that the Health Index does not demonstrate causality; it does reflect the health impact of every policy, nor every impact upon health of a particular political, social, economic or environmental change. In sum, we would like to see others using the Health Index to guide debate about health, but not assuming that it can, by itself, resolve that debate.

In order for the Health Index to be widely, but appropriately, employed, we recommend the Government supports its adoption. This could include funding to local, regional and national systems to demonstrate how the Health Index can be used, which could then be used to

provide worked examples for other users to follow; or a programme of webinars to build familiarity with the tool. Peer-to-peer learning and best practice could also be used to demonstrate its usefulness.

• The Health Index as presented here would be an annual release. We can explore development of a simpler index allowing for more frequent updates, such as quarterly. This would likely involve trade-offs for the breakdowns possible and breadth of definition of health. Would this be of interest to you?

We believe that for the Health Index to best fulfil the aims with which it was designed, it is vital that the data behind it is robust and covers a broad range of indicators as this is what will allow as many actors as possible to situate their work in the context of health and wellbeing, and to extend public health-focused conversations to a broader range of stakeholders. Therefore, while we heard from several participants at our roundtables with local system and VCSO leaders that having the data updated as regularly as possible would make it most useful for their purposes, we believe that maintaining the breadth of the definition of health should be prioritised. We note, in this regard, that local health systems already have other datasets available to them which are more 'live', and there is no need for the Health Index to try to supplant these at the expense of its own distinctive mission.

Moreover, measures of health do not typically see such dramatic annual changes as to make data relating to the previous year irrelevant. For the sake of facilitating discussions about the wider determinants of health, the previous year's data should suffice, and it is far more important for this purpose that it is robust and verified.

• The Health Index as presented here can be disaggregated by geography down to upper tier local authority (UTLA) level. We can explore development of a simpler index allowing for more granular geographic breakdowns. This would likely involve trade-offs for frequency of release and breadth of definition of health. Would this be of interest to you?

We believe that capturing the extent of health inequalities in England is an important part of how the Health Index should fulfil its goal "to monitor equity and better understand the drivers of health for different groups" and ultimately "improve the health of the nation". We know that inequality itself is related to various health and social problems.[8] Therefore, it is important to avoid any 'averaging effects' as much as possible and to appreciate the extent of inequality within regions. With this in mind, we recommend the Health Index present data at least at LSOA level. This view was shared by most participants at our roundtable discussions. Those representing VCSOs said seeing the data at this level would enable them to better understand where they should target their services. RSPH's Programmes team would also use the Index in this way when making the case for particular pilot projects or interventions.

We appreciate that several participants at our roundtable discussions observed that the Health Index would be most useful if the data was presented at ward level. But we believe that for the Health Index to best fulfil the aims with which it was designed, it is vital that the data behind it is robust and covers a broad range of indicators. This is what will allow as many actors as possible to situate their work in the context of health and wellbeing, and to engage a broader range of stakeholders in public health-focused conversations. We note, in this regard, that local health systems already have other datasets available to them which

[8] Rowlingson, K. (2011) Does income inequality cause health and social problems? Joseph Rowntree Foundation. Available at: https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/inequality-income-social-problems-full.pdf

are more granular, and there is no need for the Health Index to try to supplant these at a cost to its own distinctive mission.

• Do you have any other comments?

We strongly support the development of the Health Index and believe it is being launched at a highly opportune moment to fulfil its aims. The Covid-19 pandemic has placed a strong emphasis on good health as central to the functioning of the economy and all aspects of society, and shone a light on health inequalities. As the Health Index draws attention to the multi-faceted nature of health, the wider drivers which bear upon health outcomes, and regional and local inequalities, this tool can help shape and further the growing realisation that health is everybody's business, and stimulate 'health-wealth conversations' across the system. A clear strength of the Health Index this regard is its interactive visualisation, which many participants in our roundtables felt could engage a wide range of stakeholders beyond the public health community.

Accordingly we would like to see the ONS invest in capitalising on this opportunity by encouraging the Health Index to be embedded in the work of central Government as a priority, followed by local systems, and accessible to VCSOs, the media and the public. We believe this can best be achieved through ministerial ownership of the Health Index. We, and many of our roundtable participants, think it would be best sited in either the Treasury or Cabinet Office, as having the Index incorporated across government departments, with sufficient funding attached to addressing the priority areas it highlights, would help inspire a Health in All Policies approach.

We also believe that, in order to "focus public debate and policy attention" around the population's health and wellbeing, there should be a legislative requirement for a minister to lay an annual report before Parliament on the Health Index for that year. That would ensure both accountability and Parliamentary scrutiny for any changes in the overall figure, but would also give a political event around which the media, campaigners and general public can discuss the Index and their experiences of health and the drivers of health.

The more that the Health Index gains currency in countries outside England, the greater the impact we believe it will have within Whitehall. Thus, we would encourage the ONS to work in partnership with their colleagues across the devolved nations to build Health Indexes which can be directly compared with that built for England. This would make it more useful for Government Departments and VCSOs who work across the UK. The Index is also more likely to be adopted at the highest level of Government if it also employed by the First Ministers of Scotland, Wales and Northern Ireland.

We are keen to see the Health Index used as widely as possible but in ways which are appropriate and constructive, rather than in ways which are damaging to local systems. At our roundtable discussions, there were concerns about whether the methodology behind the Index was robust enough for it to be used in resource allocation decisions, modelling which policy interventions would have the greatest impact on health outcomes, or evaluating the effect of particular policy interventions.

For example, there were concerns about treating very different indicators as comparable to each other; the validity of the weighting they had been assigned in terms of their impact on health outcomes; and the fact that the Index might treat data of differing quality equally. It was also observed that indicators within the Index will interact with each other in complex ways, making it more of a challenge to pinpoint the most appropriate intervention. Likewise, to use the Index to allocate resources and evaluate policies, would require a high level of trust in the validity of the Index's comparisons between areas and over time, as well as its

sensitivity to capture changes in the population's health as a result of particular interventions. Based on the beta version of the Index, participants did not believe it was currently robust enough to work in this way.

We believe the best way to address these concerns is through providing worked examples of how the Heath Index can legitimately be used and by providing a 'health warning' against conclusions which cannot be supported by the data. To provide these examples, we recommend the Government provide support to local, regional and national systems to demonstrate how the Health Index can be used in various contexts.

We would like to see the addition of more indicators to capture some significant drivers of health which are currently missing, chiefly around social connectedness, the labour market, and housing. We also believe that the Health Index should seek to capture inequalities behind the headline figure and increases or reductions in levels of inequality over time. We therefore recommend the Health Index includes breakdowns for ethnicity; goes down to LSOA level to capture inequality within regions; and that the ONS looks to build a Health Index for other populations which are not defined by place but are likely to experience worse health outcomes than the national or regional average.

We appreciate that the data may not yet exist across all indicators for these demographic breakdowns, but we recommend publishing it where possible (not limiting the breadth of the indicators, but bringing to light the data gaps) so that the Health Index can drive better data collection. Beginning to address these inequalities starts with understanding them; the ONS thus has an important role to play in showing how far we have yet to go on this front.

However, our preeminent concern is that the Health Index inspires the confidence of policy-makers who are in a position to make a substantive impact on the nation's health. Therefore, we urge the ONS to prioritise data quality and validity above calls for further indicators if including them would compromise the robustness of the tool. As one participant at our roundtable noted, there is a risk of producing a tool which tries to keep everyone happy and as a result does not meet any of its potential audience's needs well. Above all, the ONS should seek to satisfy the needs of decision-makers in central government so that the Index becomes embedded in their systems and processes, which will in turn set the agenda for regional and local governments.

We would ideally like to see the Health Index inspire a Health in All Policies approach, or a Health and Wellbeing budget on the New Zealand model. If the Index could lend weight to these co-ordinated, cross-government ways of working, and encourage proper investment to be accorded to addressing public health in its broadest sense, then it would achieve its ultimate aim of having a nationwide, positive impact on the population's health.