Report of Task Group 9

SOCIAL INCLUSION AND SOCIAL MOBILITY

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INTRODUCTION

We live in a society that is highly unequal in terms of power, of wealth and of income. It is a society in which many are not included in the full life of the society. There is no doubt that there are also wide health inequalities. That these are linked cannot be doubted.

The remit of Task Group 9 was to examine social inclusion and social mobility. It was decided that the main focus should be on social exclusion and inequality more generally. The Task Group proceeded by drawing up a series of questions and commissioning experts in different fields to prepare working papers.
This report is based on the eight working papers prepared by experts in particular fields. Their contribution is gratefully acknowledged but they are not responsible for this report. Nor do all the members of the Task Group necessarily endorse all its conclusions or recommendations.

This synthesis report concentrates on social exclusion with little explicit mention of social mobility. In most discussions of social mobility the concern is with everyone having chances to move up a ladder which is fixed in terms of the number of rungs and the gaps between them. We are here concerned with social and economic inequalities that contribute to health inequalities – with the number of rungs and the gaps. We are also concerned at a more basic level, relevant to the lives of the many in society, that social mobility depends on the obstacles or exclusionary processes that prevent many getting even basic education and employment. These are the concerns with social mobility that are considered here.

This report begins, in Chapter 1, with a short discussion of the concept of social exclusion and its relation to health. Two different approaches to understanding social exclusion are identified: as a label describing a state of extreme disadvantage experienced by particular groups or as a description of powerful exclusionary processes that create obstacles to social mobility and the creation of an inclusive society, thereby contributing to health inequalities. Chapters 2 to 4 then describe how these exclusionary processes operate in and through structures of economic inequality, the labour market and public services. In Chapter 2 the Government's approaches to what it labels 'social exclusion', and to poverty and inequality more generally, are reviewed. The nature of the labour market is fundamental to creating an inclusive society and in Chapter 3 we focus on the exclusionary processes associated with unemployment and how their impact on health. Wider relationships between employment conditions (e.g. low pay, precarious employment) and health inequalities are the focus of another task group's report. Service provision can also help to create an inclusive society, or work against that goal. Ways in which services (both public and private) can

include or exclude by design and/or implementation are discussed in Chapter 4. Chapter 5 to 9 then summarise findings from rapid research reviews commissioned by the Task Group. These focused on the exclusionary processes relating to five circumstances: disability, mental health problems, homelessness,, ethnic minority, and asylum seeking or refugee status. These circumstances illustrate the multi-dimensional nature of exclusionary processes and the complex and multiple disadvantage these processes can give rise to. In Chapter 10 the importance of empowerment is considered. Finally, conclusions are drawn in Chapter 11

Chapter 1
SOCIAL EXCLUSION[1]

Social Exclusion (SE) is concerned with inequality. Perhaps inevitably, it is a term with many interpretations.   The roots of social exclusion lie in inequalities of power and wealth. In contrast to static and descriptive terms such as 'poverty', SE places the emphasis on dynamic processes that prevent many from being fully included in society.   Typically social exclusion is a label attaching to particular groups in society but, as Levitas points out, defining social exclusion in this way is:

> 'intrinsically problematic… Attention is drawn away from the inequalities and differences among the included. Notably, the very rich are discursively absorbed into the included majority, their power and privilege slipping out of focus if not wholly out of sight. At the same time, the poverty and disadvantage of the so-called excluded is discursively placed outside society' (Levitas, 2005:7).

Similarly, Silver argues that:

> By ghettoizing risk categories under a new label and publicizing the more spectacular forms of poverty requiring emergency aid, policies to combat exclusion may make it easier to re-target money on smaller social categories, like the homeless or the long-term unemployed. It may even undermine the universal social insurance schemes that traditionally protected the working- and middle-classes. In sum, therefore, just as the idea of exclusion has many meanings, it can serve a variety of political purposes'(Silver, 1994: 572).
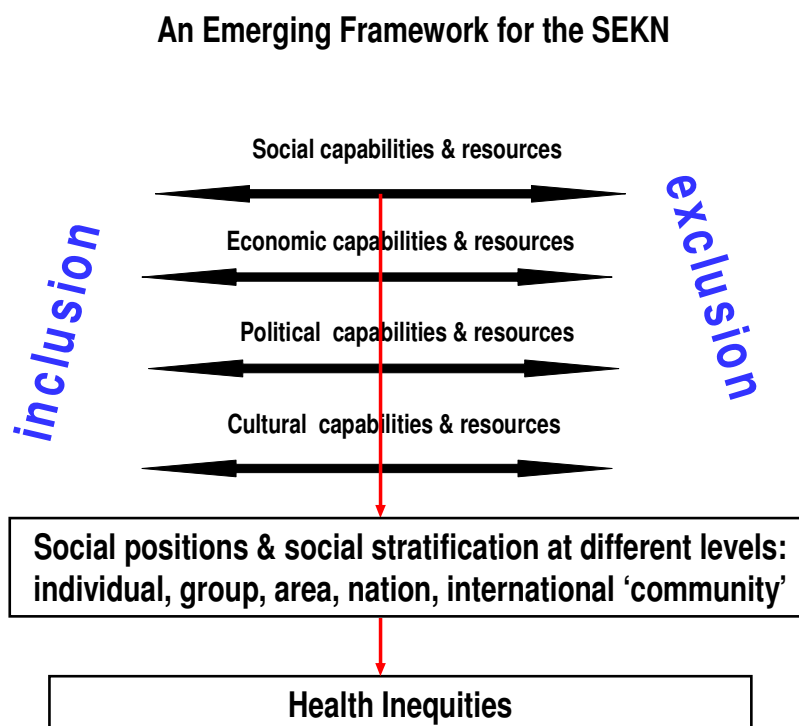
Despite the definitional difficulties there is widespread agreement that 'social exclusion' is:
   (a) *multidimensional*, encompassing social, political, cultural and economic dimensions, and operating at different social levels;
   (b) *dynamic*, impacting in different ways to differing degrees at different social levels over time; and
   (c) *relational*. On the one hand a relational perspective focuses on exclusion as the rupture of relationships between a group of people and the wider society. From this perspective social exclusion is typically understood as a '*state*' of multiple disadvantage experienced by particular population

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[1] This section draws heavily on Jane Mathieson, Jennie Popay, Etheline Enoch, Sarah Escorel, MarioHernandez, Heidi Johnston and Laetitia Rispel (2008), Social Exclusion: Meaning, measurement and experience and links to health inequalities:A review of literature, WHO Social Exclusion Knowledge Network Background Paper 1

groups existing outside the 'mainstream' of society unable to participate and without rights. Alternatively, a relational perspective highlights exclusionary processes embedded *in* unequal power relationships operating at many levels and producing a continuum within and between societies characterised by unequal conditions of inclusion and exclusion rather than a dichotomy of included and excluded people.

The Social Exclusion Knowledge Network working with the WHO Commission on the Social Determinants of Health set out a framework for understanding social exclusion which is shown diagrammatically below.

An Emerging Framework for the SEKN

As the SEKN stated:

> This framework challenges two common assumptions in the social exclusion literature: the idea that a particular group's ties to society can be totally ruptured resulting in a complete state of 'exclusion'; and a simplistic binary division between inclusion and exclusion. In contrast, in highlighting differential inclusion and/or exclusion it suggests that the focus for policy and action should be the conditions on which people are included in society – i.e. socio-economic inequalities - rather than the conditions experienced by particular multiply disadvantaged groups. Additionally, the framework allows for the possibility that a particular social group may be relatively excluded

along one or more dimensions but not on all dimensions. (SEKN, 2008:71)

The relationship between SE and health inequality is not a simple one. The SEKN has identified relatively little empirical research but argue that:

> 'The pathways linking exclusionary processes to health inequalities operate through the various axes of social stratification – class, gender, ethnicity/race, ability/disability, etc – and are both c*onstitutive* and *instrumental*. In constitutive terms, the right and freedom to participate in economic, social, political and cultural relationships has intrinsic value creating a sense of belonging to a social system and control over one's life that research has shown to be health promoting. Inequalities in opportunities to participate fully in social, political, cultural and economic relationships will therefore contribute to inequalities in health and wellbeing. In instrumental terms, inequalities in opportunities to participate in these relationships will result in inequalities in material circumstances which in turn contribute to inequalities in health.   For example, being excluded from the labour market or included on disadvantaged terms will lead to low income, which can in turn lead to poor nutrition, housing problems etc, which contribute to ill health. An exclusionary lens therefore produces a materialist explanation for health inequities. This gives primacy to the causal role of unequal relationships of power operating at different levels in society and producing unequal material living conditions and psycho-social circumstances'.

Some of the relationships between social exclusion and health inequalities are discussed in subsequent chapters but our primary focus is on describing the impacts of exclusionary processes on the social determinants of health including, for example, income, employment, education and housing and identifying action to address these.

Chapter 2
ECONOMIC INEQUALITY[1]

Policy on social exclusion since 1997
Social exclusion became a central government concept within months of
Labour's election victory in1997. Peter Mandelson announced the creation of the
Social Exclusion Unit (SEU), denouncing the "scourge and waste of social
exclusion" as "the greatest social crisis of our times" (Mandelson, 1997, pp 6 and
9). But what was meant by social exclusion? The term would never receive a
formal government definition, but it was clear from attempts to explain it that the
government's concern was with multiple deprivation. In 1999 Tony Blair
described it as "a short-hand label for what can happen when individuals or areas
suffer from a combination of linked problems such as unemployment, poor skills,
low incomes, poor housing, high crime environments, bad health and family
breakdown" (DSS, 1999, p23). This formula would stick, becoming the
explanation given on SEU publications thereafter (e.g. SEU, 2006).

The SEU was seen as important precisely because of the cross-cutting nature of
social exclusion: the aim of the unit was to coordinate policy across departments
to provide "joined-up government for joined-up problems". It had two main
purposes: to tackle the problem of area deprivation (discussed further below),
and to understand the complex problems of groups considered to be particularly
vulnerable. Between its first report on the poorest areas, *Bringing Britain
Together* (SEU, 1998) and 2006 the SEU drew up research reports and made
policy recommendations for a series of high-risk groups, including pupils
excluded from school, rough sleepers, teenage parents, 16- to 18-year olds not
in education, training or employment, young runaways, ex-prisoners, children in
care and young adults with complex needs. The rationale for the choice of
groups was never made explicit, but it has been pointed out that (a) responsibility
in each case is spread across government departments and agencies, increasing
the need for the SEU's co-ordinating role; (b) several of the groups are children
or young people, so the strategy may have been to reduce exclusion for those
who would have a lifetime to benefit; and (c) many of the groups are perceived to
impose costs on the rest of society (Burchardt, 2005).

The SEU, however, must be seen as just one small plank in the government's
overall strategy for reducing social exclusion and tackling poverty. National
Action Plans on social inclusion have been published every few years since 2001
as part of the European Union's Open Method of Coordination on social
inclusion, which is meant to engage member states in a mutual learning process

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[1] Based on Kitty Stewart, **Rapid Evidence Review on the UK strategy for tackling Social
Exclusion**

– although these have primarily been reports on the UK's broader strategies to tackle poverty and social exclusion. The 1999 publication *Opportunity for All* (OFA) pledged 'an integrated and radical policy response' to the combined problems listed under Blair's short-hand label (DSS, 1999, p23) and it is fair to say that extensive and sustained policy action followed across a wide range of areas. An independent assessment published a decade after OFA concluded that "a broad and ambitious social policy programme has attempted to tackle child and pensioner poverty, unemployment and worklessness, area and neighbourhood deprivation, inequalities in health and educational attainment and inequalities by ethnic background" (Stewart et al, 2009, p16). It is impossible to provide here anything approaching an adequate summary of the range of reforms pursued (see Hills et al, 2009 for more detail), but the strategy can be usefully broken down into four headings:

(1) Long term investment in children
 (2) Promoting employment and 'making work pay'
(3) Raising incomes for non-working households containing children or pensioners
(4) Area-based strategies

What did the government not do?

Overall, the government's strategy to tackle social exclusion can be seen as broad and ambitious, with action on a number of fronts. The belief in social exclusion as a multi-dimensional problem meant a multi-faceted response, with assaults from many angles at once. But not all angles were covered: some potential policy weapons were – deliberately – not included as part of the armoury. Before assessing the impact of the reforms laid out above it is worth considering the policies that were not introduced.

First, the generosity of the safety net for working-age adults was only increased where children were present in the household. Other adults were expected to find work, or live on benefits frozen in real terms and therefore falling further below the relative poverty line each year (Sefton et al, 2009). This can be seen as part of a long tradition of distinguishing between the deserving and undeserving poor. Second, the attitude towards overall income inequality, and specifically the incomes of the very rich, has been "intensely relaxed" (Peter Mandelson, 1998). The approach to social exclusion adopted by the SEU emphasised the exclusion of a few from the mainstream reinforcing a sense that what is happening in the mainstream is fine. The aim has been to close the gap between the bottom and the middle, as is reflected in the poverty measure of 60 percent of the median income level.

The impact of the strategy

Measured in terms of the share of children and pensioners living in relative income poverty, the story is one of modest success. For both groups poverty fell fairly rapidly up to 2004-05, but increased thereafter; over the full decade from 1996-97 to 2006-07 poverty is down several percentage points. In contrast, relative poverty among working-age people without children rose over the period as a whole. Overall, across the population as a whole, this translates to a slight fall over the ten years (Sefton et al, 2009).

Persistent poverty – defined as living below the relative poverty line for at least three years out of the preceding four – is down considerably, both for children (from 17% to 11% between 1994-97 and 2002-05) and overall (from 12% to 9%) (DWP, 2008, Table 7.1, BHC). However, the recent upturn in poverty is not yet reflected in these figures.

What falling poverty rates mean in reality is improved living standards, less financial anxiety and a greater opportunity to participate in community life for hundreds of thousands of households. Among lone parent households; the share unable to afford toys or sports gear for the children fell from 24% to 7%; and the share who said they worried about money almost always fell from 45% to 29% (Stewart, 2009, Table 3.2). These changes have extended to many households with children who remain below the poverty line; that is, it is not the case that the fall in poverty represents a shifting of people just across the 60% line, with no change for the rest of the distribution. Thus even among households with children where there were two adults, both out of work, the proportion without money for trips, outings or gifts for parties fell from 70% in 1999 to 40% in 2005 (Stewart, 2009).

Yet, aside from the large numbers who continue to live well below the poverty line, the recent upturn in poverty points to the fragility of the position of those who have made it out of poverty during the Labour years. Families both out of work and in low-paid jobs are heavily dependent on government's annual decision about whether to increase the level of tax credits relative to median earnings. Sefton et al (2009) argue that the smaller increases in 2005, 2006 and 2007 are likely to be among the key reasons that child poverty rose between 2004-05 and 2006-07. In the future the tax credit system could easily be dismantled or left to wither away in real terms. In this and many other ways,families remain dependent on government decision every year.

Employment
Overall unemployment fell to "exceptionally low" levels over Labour's first decade, and while sustained economic growth was clearly part of the explanation, the New Deal programmes are believed to have played a contributory role (McKnight, 2009). But in general most progress was made until 2001. After that, the long-term unemployment rate flattened out, while the rate for 18-24 year olds flattened and started to rise from 2005. By the first quarter of 2008 it was back to pre-New Deal levels (McKnight, 2009). The employment rate

of lone parents has increased steadily, from 46% in 1997 to 57% in 2007, albeit not rapidly enough to be on target to reach 70% employment by 2010, and there was also a slow but steady rise in employment and activity rates for disabled people (McKnight, 2009). It is striking that the groups for whom no programme of assistance was available, young people aged 16 and 17, saw unemployment rise steadily. One in four of the economically active in this age group were unemployed in 2007. Of course, the current recession presents a major threat to the progress that was made up to the end of 2007, with unemployment starting to rise sharply after the first quarter of 2008 (ONS statistics).

What sorts of jobs were created? Were they good quality jobs likely to lead on to higher paid work and a route out of poverty? Helped by the National Minimum Wage, we know that full-time hourly <u>wages</u> grew faster at the bottom than in the middle of the distribution between 1997 and 2002 (though wages at the top grew faster still), with real wages stagnating across the distribution from 2002 (McKnight, 2009). But while this brought to an end a twenty year trend of increasing earnings inequality, it did little to turn the tide. Earnings inequality remains considerably higher than in many other EU nations: 29% of women and 16% of men were low-paid (earning less than two-thirds of the male median) in 2006, compared to 10% and 5% in Finland, for example (Stewart, 2009a, Table 13.4). The rate of child poverty measured before taxes and transfers actually increased slightly between 1997 and 2006, despite the increases in parental employment (Stewart, 2009a).

Development of the strategy over time
Across many of the policy areas it is a common theme that more progress was made in Labour's first term-and-a-half than in the period since. Growth in education and health spending slowed after 2004-05, as did spending on child-related benefits and tax credits, while the New Deals for Young People and the Long Term/ 25 plus Unemployed lost momentum and area-based initiatives were wound down. The ambition of the government's early approach to tackling social exclusion was scaled back and other concerns – domestic and international – moved to centre stage.

The fate of the SEU is perhaps symbolic of a gradual shift in priorities (Stewart et al, 2009). In 2002, the SEU was moved out of the Cabinet Office to the new Office of the Deputy Prime Minister; in the Cabinet Office it had reported directly to Tony Blair and the move was a clear shift away from the centre of power. In 2006 the Unit was closed altogether and its work transferred to a smaller taskforce, back in the Cabinet Office but with a much narrower focus on a group that was described as the 'entrenched, excluded'. The government's adoption of the term 'high cost, high harm' to describe the families of concern caused considerable consternation and was soon dropped (see for example House of Commons Treasury Select Committee, 2007).

Stewart et al (2009) identify three main issues that affected progress in the second half of the Blair era. First, foreign affairs increasingly dominated government attention and resources as the build-up to the Iraq war began in 2003. Second, a gradually slowing economy placed an increasing constraint on public finances. Economic growth averaged around 3% per year between 1996-97 and 2001-02, and less than 1% between 2001-02 to 2006-07. Third, Blair devoted increasing attention to reforms aimed at expanding choice and competition in the public sector

The start of Gordon Brown's era as Prime Minister in June 2007 brought with it high hopes of a renewed emphasis on social justice, but while child poverty has remained a clear priority, with a new Child Poverty Unit having worked on legislation to enshrine the child poverty pledge into law, the wider agenda appears largely forgotten. Indeed, the abolition of the 10 percent income tax rate and the changes announced to inheritance tax were both regressive moves, although neither seems part of a consistent strategy.

One exception was precipitated by the financial crisis of Autumn 2008. Faced with a large and growing budget deficit, Brown's government made a break with commitments in the last three elections not to raise the top rate of Income Tax and announced that it would – if re-elected for a fourth term – introduce a new 45% top tax rate on incomes over £150,000, and reduce or phase out tax-free allowances for those earning more than £100,000. While the economic crisis may have made the reduction of social exclusion much more difficult in many ways, it had succeeded in achieving the previously unthinkable. The establishment of a National Equality Panel in late 2008 may also signal a new interest in inequality.

Conclusions
Many of the policies discussed here have clearly had some impact on reducing poverty and social exclusion: the lesson of the New Labour period is not that its initiatives were unsuccessful, or that nothing works. Rather, most things worked, if not as quickly as policy makers might have hoped.

One problem has been that in several areas, policies were wound down before they had a chance to demonstrate an impact; continued progress might have been achieved if momentum had been sustained. This is true for instance of area-initiatives and of the New Deals (although the recession clearly raises new difficulties for a strategy based on increasing employment). The latest evidence from the Sure Start Local Programmes is also positive, but Sure Start has now been diluted (though arguably also given a more secure future) in its conversion to Children's Centres. Increases in tax-credits and benefits slowed down, with inevitable consequences for child poverty, and there seems to have been a failure to understand that tax credits needed to continue growing over and above the growth in earnings if they were to continue to increase their impact. Had the Child Tax Credit been formally linked early on at least to average earnings it

would have made the situation of low-income families much more secure, both in recent years and for the future.

A second issue is that some policies were pursued but not sufficiently intensively. The "make work pay" approach was an important one, but most of the work was done through tax credits, leaving families dependent on government – and too often still below the poverty line. While investment in education may improve prospects for workers of the future, more could have been done to increase market wages, through a more ambitious National Minimum Wage, a stronger focus on helping people progress once in work, and a more hardline approach to low pay in the public sector.

But there are also lessons in terms of the completeness of the approach. Working age people with no children did badly under this government if they did not find paid employment; those losing their jobs in the current recession may be shocked to discover how badly. This raises pragmatic questions about the reality of achieving some of the goals the government did set itself: can children be offered an equal starting point while single pregnant women under 25 live on £50.95 a week in 2009/10? Can benefits/tax credits continue to be increased in real terms for children but not for adults – at what point will the discrepancy become politically unacceptable? But it also raises more fundamental questions about the nature of an inclusive society: is the explicit impoverishment of all those who cannot find a job – unless they have a child in the house – really compatible with the eradication of social exclusion?

Finally, there is the question of overall income inequality. The 90/10 ratio has remained fairly stable during the New Labour era and incomes have grown slightly faster for most of those in the bottom half of the distribution than for those in the top half. But because of the very rapid growth at the top (particularly for the top 2%) and slower growth in the bottom decile, the Gini Coefficient has risen. Does this matter for a strategy aimed at reducing social exclusion? Even with a restricted focus on the bottom end, the overall distribution is important. It is very difficult – probably impossible – to raise sufficient resources to lift the bottom towards the middle if the top is left untouched. In part the success of the child poverty strategy in the first two Labour terms was achieved through horizontal redistribution, from households without to households with children, and as noted there are limits to how far this can go. A greater degree of vertical redistribution would seem essential to further progress. This is also true because a relative poverty target would be much easier to meet against the background of a more progressive taxation system. Countries with lower rates of child poverty are achieving much greater levels of redistribution – not targeted through means-tested benefits to low-income families (which the UK now compares rather well on) but in general through the tax system, effectively lowering the goal posts by reducing post-tax median income (Stewart, 2009a, Figure 13.6).

But a wider question, if the aim is the reduction of health inequalities, is whether the focus on social exclusion is misplaced, leading as it does to concern with the gap between the bottom and the middle. If health inequalities are related to overall income inequality, as Wilkinson and Pickett (2009) argue, we need to assess the full picture. And this would mean considering not just taxation policy but also incomes and other remuneration at the top.

Chapter 3
UNEMPLOYMENT[1]

The overall association between employment status and health in Britain is substantial. Inequalities in health across employment status have been consistently indicated across many studies. Concerning the causal relationship, there have been two paths. In some studies, the causal relationship runs from employment to health (social causation), whereas others follow a causal direction from health to employment status (health selection). A large number of studies have shown that unemployment has a strong negative effect on health [Fone, 2007; Thomas, 2005; Virtanen, 2005; Kasl, 2000; Bartley, 1999], whilst other studies have indicated that poor health could increase the risk of leaving the labour market, and decrease the probability of returning to the labour market [Schuring, 2007; Disney, 2006; Cai, 2006; Cardano, 2004; Elstad, 2003; Flippen, 2000; Mheen, 1999].

There are many studies which found that unemployed individuals reported a higher risk of morbidity than employed individuals. These relate to: limiting long-term illness [Bartley, 2004], mental illness [Thomas, 2005], and cardio vascular disease [Gallo, 2006; Gallo, 2004]. The experience of unemployment has also been consistently associated with an increase in overall mortality [Voss, 2004], in particular suicide [Voss, 2004]. Unemployed people of working age have shown much higher hospital admission rates [Krauf, 2000], increased use of medication [Jin, 1997], and much worse prognosis and recovery rate [Leslie, 2007; Thomas, 2005; Bartley, 2004]. The table below shows that a cumulative duration of unemployment highly increases the risk of subsequent illness.

Estimated odds (95% CI) of limiting long-standing illness in 1991 with regard to history of unemployment over two censuses in 1971 and 1981 among men who were aged 15-40 in 1971 (Sources; Bartley, 2002)

No. of times unemployed	Adjusted for age	Adjusted for social class
0	1	1
1	1.88(1.70-2.10)	1.68(1.51-1.87)
2	3.04 (2.18-4.24)	2.50(1.79-3.50)

Using data from the Office for National Statistics Longitudinal Study (ONS-LS), Bartley and Plewis [2002] examined the importance of the accumulation of unemployment over the life course. This table shows that men who were unemployed at both 1971 and 1981 censuses have a three times higher risk of limiting long-standing illness than those who were employed at both censuses.

Several other issues were raised to clarify the complex association between unemployment and health. One of them concerns the duration of unemployment. Both short-term and long-term effects of unemployment influence health

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[1] Based on Myung Ki: A short review of the relationship between health and economic status

outcomes but in different ways. The immediate effect of unemployment has been of interest to some researchers, and a negative impact of redundancy on health outcome has been frequently reported [Sullivan, 2006; Ruhm, 2000; Gibbons, 1991]. In contrast, other studies emphasized the steady negative effect, proportional to the duration of unemployment, which progressively damage health [Maier, 2006; Hämäläinen, 2005; Voss, 2004]. The association between the duration of unemployment and health may vary, depending on the health measure used. While some measures such as general stress, depression, and suicide probably reflect more immediate impact due to job loss, other measures such as major depressive episodes and overall mortality seems to reflect constant impact in the long term.

Some evidence has started to be accumulated, indicating that 'transitions to and from employment status rather than a specific 'status' are associated with the risk of mental health and mortality [Thomas, 2005; Kivimäki, 2003]. Some studies have compared the risk of negative health outcome in relation to unemployment levels of household, neighbourhood, and society context. One study reports that the employment characteristics in the household contexts account for differences in health [Giatti, 2008]. It seems consistent that high neighbourhood unemployment rates increase adverse health outcomes [Lenthe, 2005; Osler, 2003]. However, the results are inconsistent, when comparing periods with high and low unemployment. [Martikainen, 2007; Åhs, 2006].

Three explanations for how unemployment affects levels of morbidity and mortality are put forward;
1. Poverty related to unemployment; financial problems as a consequence of unemployment, bringing lower living standards [Bartley, 1999, p86] and this may reduce social integration and the loss of self-esteem [Maier, 2006]. In this way, financial strain links unemployment to poor health status.
2. Stress due to unemployment; unemployment triggers an increase in general distress, anxiety, and depression [Voss, 2004]. It seems likely that job insecurity works as a chronic stressor [Ferrie, 2005].
3 Changes in health-related behaviours; unemployment alters health behaviour such as an increase in smoking and alcohol consumption, and a decrease in physical exercise, all of which are major risk factors for numerous illness [Ruglies, 2008; Maier, 2006]. There is growing experimental evidence that the increase of serum cortisol level and the reduced blood NK cell activity is associated with unemployment and job insecurity [Boscolo, 2008; Cohen, 2007; Maier, 2006].

The issue of health selection
Many studies which were set in the context of health selection consistently found that transitions into and out of employment were related to health status [Schuring, 2007; Cardano, 2004; Elstad, 2003; Mheen, 1999; Dwyer, 1999]. Although the negative effects of poor health on employment status are consistent, the impacts of health varied in response to other factors. The

reduction of labour participation due to health was reinforced when the effect of lower payment was incorporated into the effect of poor health [Disney, 2006; Cappellari, 2003]. Receiving disability benefit potentially accentuated a route to early retirement related to poor health [Little, 2007; Haardt, 2006; Faggio, 2003; Flippen, 2000]. In the table below it is suggested that all transitions between employment statuses are generally associated with poor health.

The estimated odds ratio for poor health to good health with regard to each transition (reference category: stable mobility) from multilevel multinomial analysis (Source: Ki, 2009)

Transitions		Men		Women	
		Poor health (%)	OR (95% CI)*	Poor health (%)	OR (95% CI)
Employment	Employment	21.1	1.00	24.4	1,00
	Unemployment	27.6	1.34(1.08, 1.67)	33.1	1.47(1.16, 1.87)
	Inactivity	43.6	2.68(2.18, 3.28)	35.8	1.65(1.43, 1.90)
Unemployment	Employment	27.0	0.86(0.66, 1.13)	31.0	0.50(0.35, 0.72)
	Unemployment	31.9	1,00	47.9	1.00
	Inactivity	55.5	2.62(1.93, 3.58)	53.8	1.23(0.88, 1.72)
Inactivity	Employment	44.6	0.42(0.31, 0.67)	32.6	0.64(0.54, 0.76)
	Unemployment	62.3	0.89(0.62, 1.27)	58.2	1.56(1.11, 2.20)
	Inactivity	66.6	1.00	49.2	1.00

* OR; Odds ratios, CI; 95% Confidence interval
Note: Transitions between t-1 and t year are modelled against previous health status using multilevel multinomial analysis adjusting for age and education, and it is fitted separately for each origin category (reference category: stable transition). British Household Panel Survey (BHPS), between 1991 and 2003 is used for the analysis.

This table suggests that the effects of health on the transition and reverse transition from employment to both unemployment and inactivity are continuously significant. Health is more closely connected with the transitions out of/into inactivity than unemployment. Health affects the pattern of transitions between men and women differently. When people withdraw from the labour force, men with poor health tend to turn toward inactivity; in contrast, women with poor health tend to end up in both destinations of unemployment and inactivity to about the same degree. Subsequently, poor health lowers the probability of re-employment from unemployment for women, but this is not the case for men.

In explaining health inequalities between employment statuses, both health selection and social causation are important, although social causation has been regarded as the dominant explanation [Kasl, 2000, p120; Banech, 2007a, p89; Acheson, 1998, p46].

Support for the importance of social causation needs to be emphasized in connection with the emergence of the flexible labour market. It has been observed that different subtypes of employment (e.g., temporary work) affect health differently. The selection of people with health problem explains some of the association between unemployment and higher level of morbidity and

mortality. The rise in numbers of economically inactive people suffering from a health problem may be attributed to this association. Unemployment is not the only aspect of the labour market contributing to health inequalities. The growth in economic inactivity and insecure employment (discussed in the working paper) are both important. Yet the role of unemployment as a key social determinant of health inequality is evident – and, as unemployment rises, of growing importance.

Chapter 4
INCLUSIVE SERVICE[1]

The services people receive are a major determinant of their standard of living. A key aspect of social exclusion, which profoundly affects daily life and, consequently, health, is *service exclusion*: a lack of access to services that enable people to live safe, healthy and satisfying lives. As Age Concern (2008) stated:

> '… *social exclusion means being unable to access the things in life that most people take for granted'*.

However, as with approaches to social exclusion and inclusion in general, service inclusion is a continuum relating to the *availability*, *accessibility, useability* and *quality* of services.

At its simplest, service exclusion means that services are not *available* to people who need them. This can be influenced by factors such as geography, pressures on suppliers and resource constraints For example, the consequences of living in 'food deserts' without easy access to healthy food are widely noted with people living in deprived urban areas, rural areas and areas with high concentrations of minority ethnic populations most affected[2] .

Even where services are available, however, they are not always *accessible*. People's access to services can be constrained by the way services are designed and delivered; the payment methods suppliers offer; or because people do not feel able to use them. In 2007 45% of dentists would not accept new NHS patients (CPPIH 2007) and an estimated 2.4 million people go without dental care.

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[1] This chapter is based on Claire Whyley, <u>Social Exclusion through the provision of services</u>, March 2009

[2] See for example, Policy Link *Healthy Food, Healthy Communities: improving access and opportunities through food retailing* Policy Link 2005; Larson N, Story M and Nelson M *Neighbourhood Environments: Disparities in Access to Healthy Foods in the US* American Journal of Preventative Medicine Vol 36, Issue 1, Pp 74-81, January 2009; Bolen E and Hecht K *New Access to Healthy Food in low-income communities* Californian Food Policy Advocates, 2003; Saltmarsh N, Smith J and Davison A *Improving Access to Healthy Food in the Rural Bedfordshire Heartlands* Bedfordshire Heartlands Rural Food Access, 2006;
Guy, C and David G *Measuring physical access to 'healthy foods' in areas of social deprivation: a case study of Cardiff* International Journal of Consumer Studies, Vol 28, No. 3 pp. 222-234, June 2004

Even when services are accessible, they may lack *useability* because of flaws in design or delivery, or because they are left behind by technological advances effectively excluding people from using them. Many people find it difficult, expensive and time-consuming to conduct their business by telephone, rather than face-to-face. These difficulties are compounded for those without a telephone, with speech or hearing impairments or short-term memory problems that make it difficult to cope with menus, passwords and pin numbers (Whyley 2008, O'Reilly 2008, Wells 2008). In one study, young mothers living in deprived areas reported frequently being unable to use local buses because they were not designed to accommodate children's prams and pushchairs (NCC 2008). Older people and those with sight problems, limited manual dexterity or physical impairments that limit movement can find it difficult to use ICT and other electronic equipment, and to access web-based services (Whyley 2008, George and Lennard 2008 (*Consumer Disadvantage)*, George and Lennard 2007).

The quality of service can also exclude people from the benefits services can provide. This may be because services are not sufficiently user-focussed, or because providers' perceptions of service-users affect their delivery. Or people may end up with services that don't meet their needs or have insufficient support to use them effectively. For example, people living in deprived areas were reluctant to visit their GP because they were intimidated by receptionists who questioned their need for an appointment (NCC 2008b). Doctors have also been found to perceive patients more negatively on the grounds of race and socio-economic status, affecting the quality of communication between them (Shouten and Meeuwesen 2006) and the diagnoses and treatments they receive (Van Ryn and Burke 2000).

Recommendations on reducing exclusion from services

There are a small number of 'primary drivers' of exclusion from services, which have a catastrophic impact on access to other services. These include restrictions on people's access to digital technologies and transport, low income, homelessness, unemployment and poor educational attainment. There may be others. It seems that these primary drivers are experienced in clusters, and each one of them, by default, reduces or removes access to other services. A focus on how to unpick the complex web of exclusionary processes that result from these primary drivers is urgently needed.

Groups, left behind by the Government's focus on families and pensioners, are at particular risk to being excluded from services, despite evidence that they may be particularly vulnerable. In particular, the working poor; people living alone; those who cannot find an affordable home; people who do not achieve a minimum standard of education; and those who are time-poor as well as cash-poor (O'Reilly 2008; Kenway and Palmer 2006; NCC 2008c; Burchardt 2008).

Further research should focus on how to ensure these groups have access to high quality relevant services.

The evidence suggests that actions to improve service inclusion fall into four broad categories:

• Securing availability - legislation plays a key role in ensuring the availability of 'lifeline' services deemed essential for health and well-being, but cannot address issues of accessibility, useability and quality. Regulation also has an important role in service inclusion.
• Increasing availability - innovation in the delivery of services has increased their reach to people who were previously excluded. Research has shown that facilitating the development of new supermarkets, grocery stores and farmers markets in deprived areas can increase healthy eating among people on low-incomes (Policy Link 2005; Harding A 2009).
• Promoting access – by increasing the affordability of services is crucial to service inclusion.
• Improving useability and quality - cross-sectoral partnerships, and greater involvement of service-users, can increase the extent to which people can use services effectively and benefit from them.

In addition there is a need for a more sophisticated approach to understanding service exclusion and its impact so that new approaches to developing fully inclusive services can be developed.

Chapter 5

THE IMPACT OF DISABILITIES[1]

Disability is a multi-dimensional concept and experience, arising from the interaction of health conditions and the environment (World Health Organisation, 2001).

While estimates of the prevalence of disability vary as a function of the methods used, there is no doubt that a significant proportion of people in England live with disability. The estimated prevalence of disability rises with age from 8% of English children who have significant Special Educational Needs associated with intellectual, developmental, communication, sensory or physical impairments,[2] through 15%-20% of working age adults (Bajekal, Harries, Breman, & Woodfield, 2004) to over 60% of people aged 85+ (Breeze & Lang, 2008).

Risk of disability is unequally distributed (Breeze & Lang, 2008; Emerson & Hatton, 2007c; Guralnik, 2006; McMunn, Nazroo, & Breeze, 2009; Newacheck & Halfon, 1998). Among children and adolescents there are clear social gradients in the distribution of most (but not all) intellectual, sensory and physical impairments. Among working age adults there is strong evidence of socio-economic gradients in the onset of functional impairments, and that the overall prevalence of disability is associated with lifetime socio-economic circumstances. Among older people, there are strong associations between wealth, the onset of physical impairments and the rate of decline in physical ability over time.

These gradients are likely to result from a combination of factors that vary in their significance across the lifecourse. In young children, exposure to socio-economic disadvantage prenatally and in early childhood will increase the incidence of health conditions and associated disability (Irwin, Siddiqi, & Hertzman, 2007). In later childhood, social gradients may also reflect the impact of child disability on family social mobility (Tibble, 2005). In adulthood, downward social mobility resulting from the exclusion of disabled people from the labour market is likely to play an important role in exacerbating existing social gradients. However, the *onset* of disability in mid and later life continues to show strong social gradients (Breeze & Lang, 2008; McMunn et al., 2009).

Disability, Social Exclusion and Social Mobility

In Chapter 1 social exclusion was conceptualised as encompassing capabilities and resources in multiple domains. There is extensive evidence to suggest that

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[1] Based on Emerson, , Intellectual and Physical Disability, Social Mobility, Social Inclusion & Health, Centre for Disability Research, Lancaster University

[2] Data extracted from DCSF 2008 Spring School Census.

disabled people are at significantly higher risk of exclusion in many of these areas.

- As children and adults, disabled people are more likely to experience income poverty and material hardship than their non-disabled peers (Beresford & Rhodes, 2008; Emerson & Hatton, 2007c; Emerson, Malam, Davies, & Spencer, 2005; Grewal, Joy, Lewis, Swales, & Woodfield, 2002; Office for Disability Issues, 2008; Williams, Copestake, Eversley, & Stafford, 2008).
- Disabled adults have significantly reduced employment opportunities (Berthoud, 2006; Burchardt, 2005; Emerson et al., 2005; Grewal et al., 2002; Rigg, 2005; Williams et al., 2008) and are at risk of exclusion from other socially valued modes of production, most notably parenting (IASSID Special Interest Research Group on Parents and Parenting with Intellectual Disabilities, 2008; Morris, 2003; Olsen & Tyers, 2004).
- Disabled people are less likely than their peers to vote or otherwise participate in the political and civic life of their communities (Emerson et al., 2005; Grewal et al., 2002; Williams et al., 2008).
- As children and as adults disabled people are more likely to have restricted social networks, have looser ties to their local community, to experience bullying and to be victims of crime (Department for Children Schools and Families, 2008; Emerson et al., 2005; Grewal et al., 2002; Shakepeare, 2006; Williams et al., 2008). The social disconnectedness of some disabled people is exacerbated by the use of segregated and, at times, geographically remote educational and residential services (Audit Commission, 2007; Emerson & Robertson, 2008; UNESCO, 1994).

While there is relatively little *direct* evidence on the association between disability and social mobility, there is abundant evidence that disabled people are disadvantaged with regard to key factors that promote social mobility. These include early childhood experiences, education, employment and labour market experiences, social and cultural capital, health and well-being.

Disability and Health

There is extensive evidence that people with disabilities experience significantly poorer health outcomes than their non-disabled peers (Disability Rights Commission, 2006; Emerson & Hatton, 2007a; Michael, 2008; Parkes et al., 2008). It is important to note, however, that these negative outcomes extend to aspects of health (e.g., mental health) that are unrelated to the specific health conditions associated with the person's disability (Emerson & Hatton, 2007a; Ouellette-Kuntz, 2005; Parkes et al., 2008). They also extend to the family carers of disabled children and adults (Hirst, 2004; Princess Royal Trust for Carers, 2004; Young, Grundy, & Jitlal, 2006).

As noted in previous sections children and adults with disability are at increased risk of exposure to social conditions associated with poorer health outcomes

(Graham, 2007; Irwin et al., 2007; World Health Organisation, 2008) As such, disabled people make up a disproportionate proportion of the population who may be considered to be 'at risk' of exposure to the social determinants of poor health.

Few studies have attempted to estimate the extent to which the poorer health outcomes experienced by disabled people may be attributable to their increased risk of exposure to these social determinants of health. The results of this nascent literature suggest that increased risk of exposure to socio-economic disadvantage may account for 20-50% of the risk of poorer mental and physical health among children with intellectual disabilities (Emerson & Hatton, 2007a, 2007b) and most or all of the risk of poorer mental health and low rates of well-being among mothers of children with intellectual disabilities or developmental delay (Emerson, Hatton, Blacher, Llewellyn, & Graham, 2006; Olsson & Hwang, 2008).

Other studies also point to the importance of social conditions for understanding the association between disability and health. For example, reduced psychological well-being among young disabled people is only evident under conditions of either social exclusion or economic adversity (Emerson, Honey, Madden, & Llewellyn, 2009). Similarly, in later life higher income appears to significantly buffer the psychological impact of becoming disabled (Smith, Langa, Kabeto, & Ubel, 2005).

Thus, poorer socio-economic circumstances appear to both increase the risk of health conditions associated with disability *and* exacerbate their impact on other aspects of health and well-being.

It is also likely that the poorer health outcomes experienced by disabled people are related to their experience of discrimination (disablism). The impact of disability discrimination on health is likely to be both direct and indirect.

- Direct effects of discrimination on health result from the existence of systemic discrimination in the operation of health care systems, the direct consequence of which is to impede disabled people's access to appropriate health and social care (Disability Rights Commission, 2006; Equality and Human Rights Commission, 2009; Michael, 2008; Office of the Deputy Prime Minister, 2005).
- Indirect effects of discrimination on health arise through two interconnected pathways. First, discriminatory systems and practices contribute to the social exclusion of disabled people (see above). As a result, disabled people are more likely than their peers to be exposed to living conditions associated with poor health outcomes. Second, the direct and indirect experience of disablism and disability discrimination may be expected to have a negative impact on the person's mental and physical health. While no direct evidence is available to support this contention,

equivalent processes (the experience of racism and racial discrimination) have been identified as central to understanding ethnic inequalities in health (see Chapter 7).

All of these effects are likely to be exacerbated among disabled children and adults who are also at risk of discrimination and social exclusion as a result of their ethnic identity, gender, sexual orientation or age.

Policy Recommendations

There exists in England a plethora of policies and guidance to reduce health inequalities and social exclusion and improve social mobility. These policies pay scant (if any) regard to the specific situations faced by disabled people, the apparent assumption being that the benefits of interventions targeted at deprived areas or families will accrue equally across all social groups. There is considerable evidence, however, that behaviour change interventions (whether 'upstream' or 'downstream') are likely to be more effective if they are tailored to the specific social and cultural contexts experienced by 'high risk' groups (National Institute for Health and Clinical Excellence, 2007). Without such attention to the specific contexts faced by disabled people, there is a real risk that they may fail to benefit from existing 'generic' policies (Disability Rights Commission, 2007; House of Commons Health Committee, 2009).

The NHS and its constituent parts are under a legal duty to pay due regard to eliminating discrimination and promoting equality of opportunity for disabled people. In coming to its recommendations, the *Commission* itself should model good practice by: (1) evaluating the likely impact of recommendations on the experience of disabled people (and other 'high risk' groups); and (2) considering what specific modifications or adjustments that may need to be made to ensure that disabled people experience equal benefits from any proposed initiatives.

There is also a need to: (1) monitor the progress toward reducing health inequalities at local, regional and national levels in such a manner that data can be disaggregated by disability status and sub-categories of disability; and (2) introduce changes to policy and practice in ways that enable their thorough evaluation, thereby maximising the potential for health gain and for policy learning (House of Commons Health Committee, 2009). All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.

In order to address the health circumstances of disabled people there is a need:

1) To promote disability relevant practice and information within health systems and to contribute to the collection and dissemination of information on the health of disabled people. The establishment of a Public Health Observatory (PHO) on Disability could make a significant contribution toward this aim;

2) To establish a national framework of guaranteed outcomes, based upon human rights principles, for health and social care (Equality and Human Rights Commission, 2009);

3) To bring GPs directly within the scope of the Disability Equality Duty and review the Quality and Outcomes Framework to ensure that it reflects and orients general practice to better meet the health needs of people with disabilities and their families;

4) To require the NHS to monitor key outcomes and the delivery of major health initiatives (e.g. screening) by disability and sub-groups of disability against population level indicators of need in order to be able to demonstrate compliance with the Disability Discrimination Act.

In order to address the experience of disability and thereby plausibly to affect health inequity there is a need:

1) For the Department of Health to fund a programme of work examining the nature and impact of disablism on health and, in conjunction with the Equalities and Human Rights Commission, to implement a sustained campaign of social marketing aimed at reducing disablist attitudes among the general public;

2) To improve the lives, services and outcomes for disabled children and their families by, for example, up rating the Disability Living Allowance, funding the development and evaluation of a national demonstration programme that delivers intensive early intervention for pre-school children at risk of significant disabilities and reviewing the situation of children providing unpaid care for disabled relatives.

3) Address the barriers to rewarding employment for disabled young people and adults by, for example, promoting and monitoring the entitlement to work experience for disabled children at school, reviewing the current interface between employment related support programmes and the benefits systems and the adequacy of employment support programmes for people with more severe or longer-term disabilities (Rangarajan, Wittenburg, Honeycutt, & Brucker, 2008).

4) Improve access to and quality in housing and supported accommodation for disabled children, adults and their families by, for example, undertaking a review of the housing needs of families with disabled children and undertaking a fundamental review of the rules and regulations that relate to residential care homes and their interface with charging policies and the benefits system.

Chapter 6

THE EXPERIENCE OF MENTAL ILLNESS[1]

Somewhere between 25% and 50% of the general population will experience a mental health problem at some point their lives (Anonymous 2000; Kessler et al 2005a; Kessler et al 2005b; Singleton et al 2001. The most common problems are depression and anxiety and the least common are the psychoses, i.e., disorders characterised by hallucinations, delusions, thought disturbance (lifetime prevalence around 3%) (Perala et al 2007). It is estimated that the costs of mental illness in the UK are over £70 billion per year, much of this arising from lost productivity, informal care, and premature death (SCMH 2003). This accounting, however, does not begin to take account of the impact of mental illness on individuals' and families' quality of life, an impact frequently compounded by widespread negative and discriminatory responses from others.

Those with a history of mental illness are one of the most socially excluded groups in society (Sayce 1998; SEU 2004; Morgan et al 2007). On all usual indicators, mental illness is associated with high levels of exclusion and downward (or lack of opportunities for upward) social mobility. This links directly to health inequalities: rates of mental illness are highest in the most disadvantaged and marginalised groups in society (Meltzer et al 1995; Meltzer et al 2002). There is considerable evidence demonstrating this across each of the domains of social exclusion utilised in the Poverty and Social Exclusion Survey (Pantazis 2006) – the labour market (employment); impoverishment (income); public services; and social relationships.

1) Research consistently shows that employment rates for those with a long-standing diagnosis of schizophrenia or other psychosis are only around 5 to 20% (Marwaha and Johnson 2004; Thornicroft et al 1998; Gaite et al 2002; Bailey et al 1998; Chandler et al 1997; ONS 1995; Thornicroft et al 2004; Perkins 2002). At the time of initial diagnosis, employment rates are around 40%, (Morgan et al 2008; Craig et al 2004; Barnes et al 2000) still very low compared with the general adult population (around 75%). Data from the Labour Force Survey indicate that approximately 20 to 25% of those with a

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[1] Based on **Craig Morgan and Chantelle Whelan Obstacles to social inclusion and social mobility of those experiencing mental illness**

long-term mental health problem in England were employed each year between 1998 and 2003. This compares with 60 to 65% for other disabled groups and around 75% for the whole adult population (SEU 2004; ONS 2003). The evidence is not only for serious mental illness. A number of studies have shown that rates of depression and other common mental disorders are elevated in the unemployed (Wilson and Walker 1993; Dooley, Catalano and Wilson 1994; Montgomery et al 1999). As discussed in Chapter 3, unemployment affects health and health affects unemployment. The OPCS Psychiatric Morbidity Survey, for example, found that those who were unemployed were the most likely to experience high levels of all mental health problems (Meltzer 1995).

2) Levels of poverty (however defined) are high in those with a mental illness (e.g. Boardman et al 1997; Lewis et al 1998; Croudace et al 2000; Payne 2006; Weich and Lewis 1998a; Weich and Lewis 1998b; Whitley et al 1998). This is in part a function of exclusion from the labour market, with significant numbers of those with a mental illness being dependent on long-term welfare benefits. This is compounded by high levels of debt (Meltzer et al 2002; Payne 2006; Beddington et al 2008) and low-take up rates of available welfare benefits. For example, a study conducted in south London found that over 60% of individuals attending a community mental health centre were not receiving their full benefit entitlements (Slade, McCrone and Thornicroft 1995). Further, when employed, there is a greater likelihood that those with a history of mental illness will be in low skilled, low paid, and insecure jobs (Meltzer 1995; Payne 2006; Thornicroft 2006).

3) There is evidence that access to services is more restricted for those with a mental illness than for the general population (SEU 2004; Payne 2006; Thornicroft 2006; NSIP 2009). This is again in part a function of the impact of exclusion from the labour market and poverty on the capacity of individuals with a mental illness to meet the costs of, for example, transport, leisure and decent housing (Evans, Wells and Moch 2003; Payne 2006). There is additional evidence that those with a mental illness are more likely to be refused insurance and access to financial services (Payne 2006; Thornicroft 2006; Read and Baker 1996). Perhaps more troubling still, there is strong evidence that those with a mental illness do not receive appropriate services for physical health problems (Thornicroft 2006). For example, research suggests those with a history of mental illness receive poorer quality care for diabetes and heart attack (Desai et al 2002; Druss et al 2001; Druss 2000). This has to be considered alongside evidence that those with a mental illness are more at risk of a range of physical health problems, including cardiovascular disease, diabetes, and HIV/Aids, (Rethink 2005) and have higher rates of mortality (Harris 2001).

4) As with the above domains, there is clear evidence that those with a history of mental illness, on a number of indicators, experience both more social

isolation and less community participation. For example, there is considerable evidence that social networks are much more restricted for those with long-standing mental health problems, both in terms of number and quality of relationships (e.g. Morgan et al 2008; Harris 2001; Howard, Leese and Thornicroft 2000; Evert et al 2003; Borge et al 1999; Brugha et al 2005). This is reflected in lower rates of marriage and higher rates of divorce and separation (e.g. Wade 2004). In a study in five European countries, only 17% of those with a diagnosis of schizophrenia were married (Thornicroft et al 2004). Furthermore, there is evidence that mental illness is associated with reduced participation in wider community and civic activities, such as voting in elections and membership of political parties (Payne 2006; Kirkbride, Morgan and Fearon 2006).

Following from this, it is no surprise that those with a mental disorder are more likely to live in socially deprived urban areas, characterised by poor housing, high levels of crime, and low levels of social capital (Kirkbride 2006; Allardyce et al 2005; Allardyce and Boydell 2006; Krabbendam and van Os 2005; McKenzie and Harpham 2006; De Silva et al 2005).

To present the evidence for each of these singly underplays the extent to which they overlap. These disadvantages are intricately linked and combine to compound and extend the suffering arising from mental disorder. For example, being unemployed often means reliance on welfare benefits, insufficient income to participate in social and leisure activities, and exclusion from a source of meaningful social relationships. This is the essence of what is meant by social exclusion. This, in turn, has a negative, ongoing impact on mental well being, creating for many a vicious downward cycle of disadvantage, emotional distress, marginalisation, and continued mental health problems (SEU 2004).

Disadvantaged groups A further important consideration is that mental illness can compound exclusion in already disadvantaged and marginalised groups. The strongest evidence here is in relation to ethnicity. For example, there is extensive evidence that rates of psychosis are around five times higher in black ethnic groups in the UK, compared with the white British population (Fearon et al 2006; Fearon and Morgan 2006; Morgan and Hutchinson 2009). There is now evidence that levels of exclusion (indexed by employment, housing, and social networks) are particularly high in patients from these groups, even at first presentation to mental health services (Morgan et al 2008).

Obstacles to inclusion and mobility It is possible to be more specific in identifying significant obstacles to social inclusion and mobility for those with a mental illness.

Material disadvantages, as noted above, impact directly on opportunities for social engagement and inclusion. This stems, at least partly, from unemployment. A number of barriers to employment have been identified in

other reviews (SEU 2004; Thornicroft 2006; Leff and Warner 2006) and at least three merit specific emphasis:

> 1) disincentives to employment in the welfare benefits system (particularly complex application processes and rules concerning 'permitted work' and earnings disregards for those seeking to return to work following a period of incapacity) (Leff and Warner 2006);
> 2) low expectations of mental health service staff, who may often underestimate the capacity of service users to sustain employment (which occurs within a general mental health service context in which meeting the social needs of service users are not seen as core tasks) (Rinaldi 2000);
> 3) employer discrimination – there is strong evidence that many employers are unwilling to employ people with a history of mental illness (DWP 2001; Manning and White 1995; Brand and Clairborn 1976; Britt 2000; Scheid 1999). This latter obstacle to employment is illustrative of perhaps the most important barrier to social inclusion encountered by those with a mental illness – widespread stigma, based on ignorance and prejudice, leading to discrimination in many areas, including: employment (as above), education, housing, leisure, health and other public services. This has been extensively documented in recent reviews (Thornicroft 2006).

In short, material poverty and stigma and discrimination are *the* major barriers to social inclusion and mobility for those with a mental illness.

Policy conclusions
In 2004, the Social Exclusion and Mental Health report of the Social Exclusion Unit (SEU 2004) identified a twenty-seven point action plan. This has since been the focus of a series of initiatives at all levels to promote social inclusion for those with a mental illness, conducted under the auspices of the National Social Inclusion Programme (NSIP). These initiatives serve as examples of what can be done, and are fully documented in *Vision and Progress: Social Inclusion and Mental Health* (NSIP 2009). While specific successes of NSIP can be listed, perhaps the major achievement is in demonstrating how coordinated actions across government departments, at national and local levels, and with the full participation of service users, can begin to challenge the exclusionary processes impacting on many with mental health problems. There is a clear need for a long-term coordinated programme through which actions can be commissioned, implemented, and evaluated, leading to an accumulation of evidence of what works and of good practice.

Employment policies can promote both recovery and social inclusion by providing routine, purpose, income, social interaction, and self-confidence (e.g., Drake, Becker and Beisanz 1996; Warner, Huxley and Berg 1999; McFarlane et al 2000; Mueser et al 2004; Angell and Test 2002). There is substantial evidence that those with long-term mental health problems can return to paid work with appropriate support (Leff and Warner 2006). A recent European wide trial of Individual Placement and Support (IPS) a vocational rehabilitation model in which

individuals are supported in finding and sustaining open employment reported positive results. During an 18-month follow-up period, over 50% of those with a severe mental illness who received IPS worked at least one day compared with only 28% of those who did not (Burns et al 2007). This adds to the already significant body of evidence that vocational rehabilitation services, particularly IPS, can significantly increase rates of employment in those with a mental illness (e.g., Twamley, Jeste and Lehman 1991; Becker and Drake 2003; Dixon et al 2001; Bond 1998; Becker et al 2001).

There needs to be a fundamental transformation in the orientation of mental health services towards promoting recovery and social inclusion. Leff and Warner (2006) have shown how the introduction of recovery orientated approaches to a mental health service can contribute to the development of a culture of optimism and change (pp. 112-113). In this sense, employment stands as a very important example of how mental health services can promote inclusion. Similarly, the development of day services (or community resource services) (NSIP 2009), the provision of dedicated specialist welfare benefits advice (Frost-Gaskin et al 2003), and the promotion of participation in arts and cultural activities are further examples of how mental health services can promote inclusion (Secker et al 2007). More specifically still, it is likely that such actions will have maximal impact early in an individuals' illness, making their incorporation into early intervention services essential.

Stigma and discrimination against those with a mental illness can be reduced (Thornicroft 2006; Leff and Warner 2006; Thornicroft 2006). There is strong evidence that contact with individuals with a mental illness can dispel myths and decrease stigma, (Couture and Penn 2003) and that use of service user testimonies in targeted training programmes with select groups (e.g., children, the police) is effective (Pinfold et al 2003; Watson et al 2005). The evidence for the effectiveness of national media campaigns to raise awareness has been mixed (Thornicroft 2006). The most recent such campaigns (particularly where television advertisements were used) have produced more promising findings (Jorm, Christensen and Griffiths 2005).

A public health perspective is required towards mental illness that embraces the need to reduce social exclusion in the wider society as a basis for reducing inequalities in mental health. The causal link between social exclusion and mental illness, particularly in groups with existing high levels of social exclusion (e.g., Black and Minority Ethnic) (Morgan and Hutchinson 2009), must be acknowledged. Such a public health perspective links with, and adds impetus to, wider strategies to tackle social exclusion as a basis for reducing health inequalities.

Chapter 7
ETHNIC MINORITY GROUPS[1]

The relationship between ethnicity and social inequalities involves economics, geographical segregation, racism and discrimination, citizenship and claims to citizenship. Inequalities in economic position across ethnic groups are marked. For example, 90% of Bangladeshis are in the bottom third of household incomes, compared with 69% of Pakistanis, 48% of Caribbeans, 45% of Indians, and 41% of Chinese.

Differences in health across ethnic groups, in terms of both morbidity (the presence of illness and disease) and mortality, have been repeatedly documented in the UK (for example, Marmot *et al*. 1984, Harding and Maxwell 1997, Nazroo 2001, Erens *et al*. 2001, Sproston and Mindell 2006). They seem to be a consistent feature of the social distribution of health in developed countries. Analyses around the 1991 census showed marked variation in mortality rates by country of birth and gender (Harding and Maxwell 1997:

- Men born in the Caribbean had low mortality rates overall, and particularly low mortality rates for coronary heart disease, but high rates of mortality from stroke, as did women born in the Caribbean;
- This high mortality rate from stroke and low mortality rate from coronary heart disease was also found among those born in West/South Africa, who also had a high overall mortality rate;
- Men and women born in the Indian sub-continent and East Africa (presumed to be South Asian migrants) had high rates of death from coronary heart disease, with the highest rates found among those born in Bangladesh;
- Those born in the Indian sub-continent also had high mortality rates from stroke;
- Those born in Ireland had high mortality rates for most diseases;
- The whole, the non-white migrant groups had lower mortality rates from respiratory disease and lung cancer;
- There were very high death rates among non-white migrants for conditions relating to diabetes.

These findings, based as they are on country of birth, cannot be extrapolated un-problematically to ethnic categories. Experience of UK-born ethnic minority people, which differs from migrants, is ignored. And the findings rely on the quality of the death certification process.

Jointly, morbidity and mortality data have identified the following kinds of 'high-level' findings:

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[1] Based on James Nazroo, Rapid Review

Generally poorer health among non-white minorities, with Bangladeshis having the poorest health, followed by Pakistanis, Black Caribbeans, Indians and Chinese.
High rates of diabetes across all non-white groups.
High rates of heart disease among 'South Asian' people, but particularly among Bangladeshis and Pakistanis.
High rates of hypertension and stroke and Caribbean/African people.
Low rates of respiratory illnesses across all non-white groups.
High rates of psychotic illness and young Black Caribbean men.
High rates of sexually transmitted illnesses among Black Caribbean people.

Explanations for ethnic inequalities in health
Such analyses do no more than provide a description of inequalities in health. However tempting it is to read explanations into the categories used (it is easy to speculate on what it is in terms of being South Asian that might lead to a greater risk of heart disease, for example), it is important that hypotheses are robustly tested.

Not surprisingly, the pattern of explanations proposed for ethnic differences in health tend to follow the model developed in the Black Report, with some additional explanations included to cover issues considered particularly relevant to ethnicity. The list of explanations typically includes: genetic differences; migration effects (selection of healthy, or unhealthy, people into the migrant population, and the impact of migration and new context on people); culturally based differences in lifestyle; poorer access to good quality healthcare; and socioeconomic inequalities, including experiences of racism and discrimination. Each of these is explored briefly below.

Much medical research has concentrated on biological differences between ethnic groups, on the assumption that biological differences simply reflect genetic difference and that genetics provide the explanation for ethnic differences in health. Although such work has uncovered biological difference (for example in levels of blood glucose and blood pressure), it has failed to identify (or even test for) genetic underpinnings, and has also failed to adequately characterise ethnicity, using crude groups that reflect 'race' thinking, such as South Asian and Black, thereby failing to observe important hetereogeneity in clinical and biological outcomes within such racially defined groups (Indians, for example, have average rates of heart disease, while Pakistanis and Bangladeshis have high rates). Most important is that such work has generally ignored the possibility that biological differences could result from socially determined exposures, as well as genetic differences.

Work on migration effects in the UK has generally suggested that those who migrate are healthier than those who do not, that this effect wears off with time

since migration, and wears off across generations, despite upward social mobility for post-migration generations (Smith *et al.* 2009).

Work on ethnic differences in lifestyle and health behaviours shows mixed results. For some behaviours ethnic minority people generally fare well (diet, alcohol and smoking) and for others they fare less well (exercise), but there is also great variation in behaviours across groups, generations and genders. For example, the pattern of smoking varies dramatically across the three main South Asian groups and across men and women in these groups. Importantly, for smoking there is evidence suggesting that rates of smoking are falling much more slowly for ethnic minority people than white people, and that the protective 'cultural' effects might be diminishing across generations. Research on inequalities in early life has suggested that children in families with more traditional behaviours have improved outcomes in relation to birthweight and breast-feeding (Kelly *et al* 2006, 2009).

Work on healthcare suggests that ethnic minority people do not face barriers in access to GP services – all except Chinese people appear to be more likely to use such services. In contrast, ethnic minority people appear, if anything, to be less likely to use hospital services, and are much less likely to use dental services. Evidence on the reasons for these differences is very limited. Work on the quality of healthcare received is also very limited. Evidence on subjective experiences suggests that ethnic minority people are more dissatisfied with care received than white people. The area that has been studied most extensively is the management of cardiovascular disease in secondary care. Here there is some evidence that South Asian people receive less invasive treatment than white people. However, as yet unpublished evidence, using data from the Health Survey for England, suggests that outcomes (level of undetected disease and level of poorly managed disease) for three prevalent conditions managed in primary care (hypertension, raised cholesterol and diabetes) are as good for ethnic minority people as those for white people (Nazroo *et al.*, 2007). The implication is that barriers do not exist in relation to primary care, but might in relation to secondary care.

Given the socioeconomic inequalities faced by ethnic minority groups in the UK, it is not surprising that most analysts agree that these make a substantial contribution to ethnic inequalities in health. As noted above, the complexity and multi-dimensional nature of the economic inequalities faced by ethnic minority groups makes empirical examinations of the economic basis of ethnic inequalities in health difficult. However, there is now clear evidence that morbidity and mortality within all ethnic groups – regardless of the condition focussed on – is strongly patterned by socioeconomic position. For example, richer South Asian people have low rates of cardiovascular disease. Those few empirical studies that attempt to address the complexity of the economic inequalities faced by ethnic minority people (rather than using single crude indicators) demonstrate

that much, if not all, of ethnic inequalities in health are the product of economic inequalities.

An additional dimension of social inequality faced by ethnic minority groups is racism and discrimination. There is limited evidence on the impact of this on the health of ethnic minority people in the UK, but the available evidence does suggest that both physical and mental health are adversely affected by: experiences of racial harassment; fear of experiencing racial harassment; experiences of discrimination; and the belief that people generally discriminate against ethnic minority people. Included in these 'indicators' of racism and discrimination are general perceptions of a racist society (belief that minority groups are discriminated against, fear of racism), personal threat (fear of racism and experiences of harassment), and experiences of events that undermine status and identity (experiences of harassment and experiences of discrimination).

Also of relevance are the inequalities and benefits associated with residential location. There is clear evidence that the economically poorer areas that ethnic minority people on average live in negatively impact on health over and above individual socioeconomic markers (Karlsen *et al* 2002). But there is also evidence that the aggregation of ethnic minority people in areas with those of similar ethnicity is beneficial, particularly for mental health (Pickett and Wilkinson 2008), although perhaps not for physical health (Karlsen *et al*. 2002). This is likely to operate through a combination of increased security (lower exposure to racial harassment and discrimination) and increased social support (Becares *et al*. 2009). Indeed, there is strong evidence showing that ethnic minority people rate the areas where they live much more highly than would be implied by indices of deprivation (Karlsen *et al*. 2002, Bajekal *et al*. 2007), precisely because these are locations where a sense of inclusive community for people like them has developed (Grewal *et al*. 2007).

So, although a concern with the detailed aetiology of specific conditions in particular groups might lead to a focus on the proximal causes of biological change, work on distal socioeconomic causes shows clearly that the social and economic inequalities associated with ethnicity are the main drivers of ethnic differences in health. But also that access to minority cultures and communities may well ameliorate some of this impact.

Mental health services

Black Caribbean people are three to five times more likely to be admitted to a psychiatric hospital with a first diagnosis of psychosis than white people. Admission rates are particularly high among young men, especially British born young men – 18 times higher in one study (Harrison *et al* 1998). Caribbean patients have more complex and coercive pathways into care, are more likely to present to hospital services in crisis and to be assessed as dangerous by health

care workers (although reviews of case notes show that prior to admission they did not behave more dangerously), and are around four times more likely to have compulsory treatment. In contrast, there are low rates of psychosis among populations in the Caribbean; and surveys in the UK indicate that the prevalence of psychosis in the community is not particularly high in the Caribbean population, not higher for young Caribbean men, and not higher for second generation young Caribbean men Such surveys also indicate that Caribbean people have very low rates of treatment for depression, despite greater need.

Some have suggested that the high rates of admission reflect real differences in need and do not reflect institutional racism in psychiatric services (Singh and Burns 2006). Others have suggested that psychiatric services reflect institutional racism that reflects the situation of Black Caribbean people in other social systems (for example, the criminal justice system). A third possibility is that the high rates of admission reflect the social adversity faced by ethnic minority people in the UK.

This is an area of great concern that urgently requires more investigation.

Policy implications

It is clear that there has been little policy development in this area, very occasional and fragmented implementation of policy at a local level, and no real evaluation of the impact of targeted, or general, policies on ethnic inequalities in health or their drivers. A recent review by Netto and colleagues (Netto *et al* 2008), which focussed on a handful of ethnic groups and CVD and cancer, but which did cover literature from across Europe and the US, concluded that:

> There is an extreme shortage of health promotion interventions related to the main causes of mortality, CVD and cancer for the minority ethnic groups that are the concern of the review. This is a gap which should be urgently attended to. High quality qualitative and quantitative research is also needed to evaluate the intervention and inform future interventions, and ultimately provide better outcomes for service users. (Pg. 6)

The message, then, is clear, there is a shortage of useful evidence arising from the evaluation of policy. In relation to ethnic inequalities more broadly, however, there is not a policy 'vacuum', rather a series of policies around culture, community and segregation that are populist and disregard the evidence base. Examples are the neglect of the importance of deprivation in the Cantle inquiry into inner city disturbances in the North West of England (Cantle 2001, Kalra 2002), and more recent pronouncements on 'sleep-walking' to segregation (Finney and Simpson 2009).

There is a need to develop evidence-based policy options in the specific field of ethnic inequalities in health; this should lead to trials of policy options and the

rolling out of successful policy, paying careful consideration to the specificities of ethnic groups, places, and contemporary context. The evidential basis of existing policy around ethnicity, segregation, culture and citizenship should be carefully examined; in particular, policies that undermine the citizenship claims and the social status of ethnic minority groups and communities require a careful scrutiny of their evidential basis and likely negative impact on such individuals and the communities within which they live. These processes should be linked to an 'ethnic proofing' of policies focussed on social and health inequality more generally, with particular attention paid to possible implications for a widening, or narrowing, of ethnic inequalities; evaluation of policies focussed on social and health inequality should be designed and implemented in a way that allows for an explicit consideration of issues relating to ethnicity.

In addition to the role of public services in the delivery of services, they also have an important role in relation to employment practices. As employers and trainers of staff, public service employers have the opportunity to provide a significant leadership role, at both a national and local level. For example, in 2005 the NHS directly employed 1.3 million people. 1.1 million of these were non-medical staff and of these 12.8% were from ethnic minority groups (ranging from 19% of nursing/midwifery/health visiting staff to 7.2% of managers). Of the medical staff employed 43% had ethnic minority backgrounds. Indirectly the NHS also employs a large staff through subcontracts (such as for cleaning services), and through associated industries.

As the example of the NHS shows, public service employers are key players in both national and local labour markets. As such they are able to set standards regarding good, equitable employment practices, and ensuring subcontractors meet these standards. Such practices could cover employment rights, holidays, sick leave, study leave, maternity leave, job security, job flexibility, limits to unpaid overtime, and management practices that promote autonomy and control at work. They could also include financial benefits, ensuring a more equitable distribution of salaries across employment grades. The immediate and longer-term impact of this on the broader social determinants of health inequalities is likely to be significant - particularly so for ethnic minority groups, who are over-represented in their workforces.

But overall, the implications of the evidence base for policy development are that ethnic inequalities in health require, in the short-term, employment policies, welfare, tax and benefit changes targeted at reducing economic inequalities, with a particular focus on the adverse economic position of ethnic minority people, and in the long-term policies that promote equitable life chances (education) and that address racism and the marginalisation of people with different ethnic backgrounds.

Chapter 8

HOMELESSNESS[1]

Incidence of homelessness

There is a fundamental, rights-based, distinction in homelessness between those who have a priority right to housing assistance from the local authority because they are deemed to be in immediate or imminent need[2], and those who do not. People outside local authority protection - single homeless people and childless couples - have no legal right to protection. These include: people sleeping rough; those in shelters and hostels provided, in the main, by the Voluntary and Community Sector (VCS); and people who precariously avoid absolute homelessness through the goodwill of friends and relatives, or by living in disused buildings.

In the last quarter of 2008, 67,480 households were living in temporary accommodation in England;[3] 65 per cent of homeless families in temporary accommodation were women in lone-parent households (Pleace et al., 2008). 69 per cent of the 12,070 total acceptances were households with children or including a pregnant woman; 8 per cent were young people (either 16 or 17 year olds, or care leavers aged 18 to 20); 1 per cent were homeless due to emergency; and 21 per cent due to mental illness, physical disability, domestic violence, old age or other special reason. In 38 per cent of cases, the reason for homelessness was because parents, friends or relatives (mostly parents), were no longer able or willing to accommodate them. A further 19 per cent of homelessness was due to the breakdown of a relationship, with over two-thirds of the cases involving violence. A further 11 per cent was due to the ending of an assured shorthold tenancy; and 4 per cent resulted from mortgage arrears.

Statistics for other groups of homeless people are less precise. Crisis estimates that around 43,000 people are in hostels, night shelters or refuges at any given

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[1] Based on Mary Carter, Homelessness and Health Rapid Review
[2] Under the 1985 and 1996 Housing Acts and Homelessness Order 2002 these are people without any housing and none that they have a legal right to occupy. The priority categories are: households with dependent children or where someone is pregnant; people who are vulnerable as a result of old age, mental illness, or physical disability, or some other special reason; people who are homeless as a result of disaster such as fire or flood; 16 and 17 year olds (except 'relevant children' for whom the social services authority has responsibility); care leavers aged 18-21 who are former 'relevant children'; people vulnerable as a result of violence or threats of violence; and people who are vulnerable as a result of spending time in the armed forces, prison or from a care background. In all cases applicants must show that they have not brought homelessness on themselves (are not 'intentionally' homeless). Those threatened with homelessness can remain 'homeless at home' until alternative accommodation is found.
[3] Statutory Homelessness: 3rd Quarter 2008, England: www.communities.gov.uk/housing/homelessness. The majority - 88 per cent - of temporary accommodation is self-contained (in local authority, registered social landlord, or private sector stock); 12 per cent is in B&B, hostels and women's refuges, with shared facilities.

time[1]. These range from night shelters to supported accommodation. The National Rough Sleeping Estimate for 2008 stated there were about 500 people sleeping rough in England on any single night (CLG, 2008). In London, around 87 per cent of rough sleepers contacted by outreach teams are male (CLG, 2008) and there are significantly more hostel bed spaces for men than women (Briheim-Crookall et al, 2008). Recent evidence based on a street count also suggests that up to 20 per cent of rough sleepers in London are from the EU Accession states (CLG, 2008).

The duration of homelessness varies, and may involve repeat episodes over someone's life. In the latest statutory figures, of the 13,850 households who moved on from the protection of the local authority, 56 per cent had been supported for less than six months and 19 per cent had been so for two years or more. There are significant regional variations, with London standing out as the area with much longer duration: 48 per cent were helped for longer than two years, a sharp increase on 2005 The South East and South West show similar trends and have current stays longer than two years of 18 per cent and 14 per cent respectively (CLG, 2009). Trends in duration and repeat episodes of sleeping rough have declined although there is continuing pressure, particularly in London, to find move-on accommodation so that people can leave hostels and live independently (CLG, 2008).

There is also some specific evidence of the relationship between prison and homelessness. A national study for the Ministry of Justice found that 15 per cent of men, 19 per cent of women and 10 per cent of young people were not in permanent accommodation before entering custody, about half of these had been sleeping rough (Stewart, 2008). The Social Exclusion Unit looked at the social characteristics of prisoners in comparison with the general population and found that 32 per cent of the prison population had been homeless compared to 0.9 per cent of the general population. It has calculated that stable accommodation can reduce re-offending by over 20 per cent (Social Exclusion Unit, 2002).

Link of homelessness to economic inequality and/or poverty

As might be expected for groups of people who are facing housing difficulties, homeless people across all distinctions are strongly benefit-dependent. The most recent – and most comprehensive – data on statutory homeless households in temporary accommodation carried out over 2005/06 found that 29 per cent of adults in families were in paid work (base 3015 respondents), compared to 70 per cent of adults in families in the general population (Pleace et al. 2008). Among families who had been in temporary accommodation for over a year, the proportion of adults working was 22 per cent. With a further 18 per cent in education and training.

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[1] www.crisis.org.uk/policywatch/pages/hidden_homeless.html

Income Support was being paid to 53 per cent of families, compared to 13 per cent in the general population. 24 per cent of families were paying back Social Fund loans (either Crisis or Budgeting), and a further 30 per cent had taken out other forms of loan, including from banks, credit/store cards and loans collected at their home. A third were behind with the repayment of at least one of their loans (Pleace et al. 2008).

The picture for other categories of homeless people is even more bleak; estimates provided by VCS housing and support providers suggest that only between 5 per cent and 10 per cent of the hostel homeless population are working (St Mungo's, 2003; Singh, 2005). Long-term unemployment (36 months and above) is particularly entrenched for homeless people with disability, mental health issues, alcohol issues and drug issues (CESI, 2006a). Long term rough sleeping and the maintenance of employment are inherently incompatible; and there is no information on the number of people who maintain work whilst very temporarily sleeping rough.

Whilst greater emphasis has more recently been placed on employment support for homeless people – across all categories – it generally reflects the low skills/education base that people are starting from. Many hostels facilitate or provide access to vocational courses and provide into-work training (Briheim-Crookall et al, 2008). It is shown to require greater time and support than anticipated. Employment is most often found in low-skilled, low pay jobs (Dean, 2003; Cribbens, 2005; CESI, 2006, 2006a).

Health circumstances of homeless people

There are no overall statistical profiles of health circumstances covering the diversity of homeless people.

There is most information about the single homelessness. Mental health issues are a key feature and encompass a range of conditions from depression and stress, related to immediate homelessness-related pressures, to serious and enduring mental illness that pre-dates as well as possibly being intensified by, current situations. Schizophrenia, personality disorders and self-harming all feature within studies of hostel dwellers and people sleeping rough. (Social Exclusion Unit, 2004; Croft-White and Parry-Crooke, 2004; FEANTSA, 2006; CESI, 2006a; St Mungo's, 2007; Rees, 2009). Most of these sources also describe how they are often, but not for all people, linked to issues of drug and alcohol use in complex and multiple exclusion issues[1]. London outreach work suggests that of people sleeping rough, 41 per cent have problems relating to drugs, 49 per cent with alcohol and 35 per cent with mental health, with around a quarter having a combination of these problems (CLG, 2008).

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[1] These most deeply excluded adults have been prioritised under Public Service Agreement 16, tackling Adults facing Chronic Exclusion within the Social Exclusion Task Force

People sleeping rough and those in hostels who have slept rough for long periods, also have very poor physical health – higher rates of TB and hepatitis than the general population, poor condition of feet and teeth, respiratory problems, skin diseases, injuries following violence, infections, digestive and dietary problems and rheumatism or arthritis (FEANTSA, 2006a). Mortality rates, particularly for those with mental ill health, are up to nearly five times higher than for the equivalent age group in the general population (Rees, 2009).

Over 80% of projects in a survey of needs and provision of services for homeless single people and childless couples in England, stated that they could access GPs, legal advice, talking therapies and alcohol and drug services (both structured treatments and harm minimisation). Although these were available in-house in some projects, they were much more commonly accessed by referring to external agencies (Briheim-Crookall et al, 2008). However, there is considerable qualitative evidence that access to health care is problematic due to:

- *A lack of knowledge* of local services available which can cause inappropriate use of emergency health services, including Accident & Emergency departments and ambulance calls (including repeated call-outs to the same person) (Bunce, 2000; Bilton, 2008).
- *Administrative barriers* when accessing GP services and getting medical notes transferred (Wincup et al, 2003) and getting health assessments completed, particularly where more than one agency is required to provide services (Park, 2002; Croft-White and Parry-Crooke, 2004).
- *Lack of availability*, particularly in accessing detox facilities or finding doctors to prescribe methadone. Homeless people may also be deemed 'not sufficiently motivated' or otherwise unlikely to succeed, particularly where they have previously been through a detox programme. Specialist services generally operate at full capacity and beyond. (Croft-White and Parry-Crooke, 2004).
- *Lack of understanding* on the part of health professionals as to the needs of people with multiple and complex issues and on their engagement with individuals (Croft-White and Parry-Crooke, 2004) which can lead to exclusions from services such as A&E for challenging behaviour, or inappropriate hospital discharge to unsuitable accommodation conditions (Waters, 2000).
- *Stigma and prejudice* experienced or perceived, particularly within mainstream settings (Croft-White and Parry-Crooke, 2004; Wincup et al, 2003; PSI Working group, 2004).

By comparison with single homeless people, priority homeless households present with fewer extreme health issues and recent work suggests that mental stress is alleviated when they are temporarily housed and moving beyond the stresses (especially of relationship breakdown and violence) that precipitated their homelessness (Pleace et al, 2008). Previous research, which may be less

relevant following the shift away from the use of B&B to house families, highlights the particular detrimental effects on children such as behavioural problems (mood swings, over-activity, disturbed sleep), impaired development of motor and speech skills, and being more prone to accidental injury (Pleace and Quilgars, 2003; Reacroft, 2005). Pleace et al did, however interview children and found that they were affected by dislocation from friends and playgroups etc. (2008). Other work has found high rates of contact with social services and an increased incidence of children being placed on the child protection register (Quilgars, 2001) that may be reinforced by later findings that social services teams often focus on child protection because there are less resources for wider family support; and that homeless families have become wary of approaching social services for fear that their children might be taken into care (Randall and Brown, 2003).

Recommendations

In order to address the health circumstances of homeless people there is a need:

1. To develop statistically rigorous longitudinal data on the health and support needs of all categories of homeless people
2. To undertake a structural review of health service delivery to all homeless people – including mechanisms and access - with a view to measuring long-term outcomes, exploring alternative models, improving access and, facilitating smoother cross-over with mainstream services where appropriate.
3. In the interim, to extend training on homelessness awareness to mainstream services used by homeless people.
4. To review the 'fit' between hostel residents and the level of health support attached to their accommodation, to ensure that help is provided where it is most needed.

In order to address homelessness and thereby plausibly to affect health inequity there is a need:

1. To increase, as a matter of urgency, the supply of decent housing to reduce the increasing length of stay in temporary accommodation being experienced by higher numbers of priority households in the pressure areas of London, the South East, South West and East of England.
2. To extend access (through rent deposit schemes, floating support, etc.) to decent private properties so that people with lower support needs can move-on from hostels more quickly.
3. To undertake longitudinal analysis to better understand the structural and social - rather than immediate - causes of homelessness, which can then be used to develop alternative housing models and tailor service delivery.

4.   To strengthen the effective participation of homeless people to be able to contribute to policy-making structures at micro, local, regional and national levels.

Chapter 9
ASYLUM SEEKERS AND REFUGEES[1]

Asylum seeking

Asylum – the protection given by a country to someone who is fleeing persecution – is granted under the 1951 United Nations Convention Relating to the Status of Refugees. Where applicants can prove their case and fulfil tightly enforced criteria, they are, since 2005, given leave to enter/remain as a refugee, or under humanitarian protection, for five years, and then are usually known as a 'refugee' (although the word has no status in law)[2]. At the end of five years, they can apply to become a British citizen.

Whilst an application is being processed, asylum seekers are either placed in detention or dispersed to housing around the UK (to reduce pressures on London and the South East) on a no-choice basis[3] where they receive financial support at 70 per cent of the level of Income Support. They are not allowed to work and access free English language training[4]. When an asylum application is granted, the refugee has 28 days to transfer to mainstream welfare structures and access permanent accommodation and either find work or claim unemployment and housing benefits as part of the process of integration. Those whose claims are rejected have 'no recourse to public funds' but can claim hardship support in the form of temporary housing and vouchers (worth £35 a week) and free access to English language training, where it is not deemed to be safe or reasonable to return to their country of origin, and where they agree to be voluntarily returned at a later date. Those who choose not to return voluntarily have 21 days' grace before support is stopped.

In 2007 there were 23,430 new applications for asylum in the UK, of which 6,540 were granted one of the forms of leave to remain. An estimated 16,800 people, including dependants, were refused in 2007; and, Asylum removals and voluntary departures, excluding dependants, fell 22% in 2007 to 12,705. Including dependants, there were 13,705 asylum seekers removed and departing voluntarily, (Home Office, 2008). The number of new applications in 2007 was

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[1] Based on Mary Carter, Asylum seeker/refugee Rapid Review

[2] See ICAR website
[3] Accommodation contracts for asylum seekers' housing is awarded under five-year contracts directly between the Home Office and housing providers in the eleven UK regions, the majority of which are with private sector companies.
[4] Permission to work was rescinded in 2002. If an application has not been decided within 12 months, the asylum seeker can then apply for permission. Free ESOL was removed in 2007 but is available for applicants who have waited more than six months for a decision.

around 4 per cent of the total number of immigration applications for the year (Taylor, 2009).

There are no comprehensive figures for the total number of applications for asylum that are refused and estimates range from 300,000 to 500,000 (Taylor, 2009).

Asylum seekers/refugees, economic inequality and poverty

As the above outline shows, there is a clear relationship between asylum seeking status and economic inequality/poverty, at least until the point when an application receives a positive decision. This relationship has been exacerbated by the nature of the areas selected for dispersal. Due to a very tight timetable for implementation, were chosen primarily on the basis of a supply of available and affordable housing, thus creating a strong correlation between dispersal areas and recognised area of deprivation (Hynes, 2006).

What is known about the employment status of asylum seekers/refugees suggests that labour market participation is low – the Department for Work and Pensions puts the unemployment level at 36 per cent, around six times the national average (DWP, 2003). Wages and conditions for those who do find work are poor; literacy. Formal education and skills are mixed and include both the highly skilled and very poorly skilled. Jobs found are not always commensurate with skills and qualification (there is underemployment); and there are significant barriers and obstacles to finding work (Carter, 2008). Refused asylum seekers are not entitled to work, benefits or housing unless they agree to return to their country of origin, and are given just 21 days before their assistance is cut off rendering them completely destitute (Holman, 2008). There is increasing focus and concern, about the situation of people who receive no support. Recent research in Leeds with 56 destitute asylum seekers found that the average amount of money they were able to accumulate in a week was £7.65 (Taylor, 2009). People survived on handouts and goodwill, entering into moneyless transactions exchanging work for goods, or finding cash-in-hand work where they could. This is often at much lower rates: one example given was a man paid £5 for three hours work; in another, women had resorted to selling their bodies, but for only £3-5 as opposed to the £20 other prostitutes were charging (Taylor, 2009).

Health circumstances of asylum seekers and refugees
The physical status of asylum seekers on arrival is not perceived to be a major problem, but may deteriorate after arrival (Burnett and Fassil, 2002). However, refugees and asylum seekers are known to have high rates of mental health problems such as depression and post-traumatic stress disorder, especially those that have survived war and torture (Ryan et al, 2008). These are difficult issues to unpick, however, as measurement tools are limited, there are cultural barriers to discussing or relating experiences, and problem associated with the

medicalisation of grief and loss. Additionally, impact of the migration process on loss of social status, isolation and uncertainty about what the future holds are significant (Tribe, 2005; Turner et al, 2003; Rees, 2009). There may be signs of psychological distress but that does not necessarily signify mental illness (Burnett and Peel, 2001).

Certain issues, such as the clinical treatment of torture and war wounds, will be unfamiliar to most health care professionals and may be further complicated by somatisation, where physical symptoms sometimes on the parts of the body that had been tortured may be presented with no apparent cause but are a manifestation of psychological distress, (Burnett and Fassil, 2002; Olsen, 2006). Refugees and asylum seekers are in high- risk categories for TB, HIV and other communicable and tropical diseases, depending on where they are from and the countries they might have travelled through. For TB, in particular, overcrowded living conditions or closer proximity to carriers would promote transmission for those not previously affected (Burnett and Fassil, 2002). There is also evidence of low take-up of vaccination and screening programmes (Blackwell et al 2002; Médecins du Monde, 2009)

Women may be especially vulnerable having faced gender specific persecution such as rape, sexual violence, forced sterilisation, genital mutilation, trafficking and domestic violence; as well as the psychological trauma they are likely to experience (Refugee Council, 2009). Gender also influences the delivery of health care – in many societies, for example, women are reluctant to consult male doctors[1].

Asylum seekers access to treatment has become a fundamental issue in the UK. There are well-documented problems associated with: being able to register with a GP, language and culturally sensitive delivery – access to interpreters and translation, inappropriate use of children to interpret, cultural differences in perception and treatment of health problems (Burnett and Fassil, 2002; Burnett and Peel, 2001). A project in East London which has helped almost 900 people – primarily migrants - to gain access to GPs since it was set up in 2007, reports that it takes more time, more support and more cajoling to find a practice willing to register their clients (Médecins du Monde UK, 2009).

An increasing body of evidence shows that the physical and mental health of destitute refused asylum seekers deteriorates rapidly. Without an address, many are refused primary care registration and they have been subject to government regulation – now partly rescinded – to charge them for 'secondary care (i.e. specialised care usually carried out in a hospital) on the basis that it would prevent 'health tourism'[2]. Additional health problems such as malnutrition,

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[1] See HARP health for asylum seekers and refugees portal.
[2] Measures were put in place in 2005. In April 2008 a judicial review decided that it had been unlawful in not stating that some refused asylum seekers may be 'ordinarily resident' and therefore entitled to care. (Refugee Council, 2009).

anaemia, stomach problems and clinical depression have been reported and the Red Cross have estimated that 26,000 refused asylum seekers are now living off Red Cross food parcels (Centre for Social Justice, 2008; Taylor, 2009). The burden of support for those who are refused asylum is falling on other asylum seekers, refugee communities, faith groups, religious institutions and voluntary organisations to help provide basics of food and, sometimes, a place to sleep (Refugee Action, 2006).

The special case of children
In 2007, around 7,700 children sought asylum in the UK, some with their family, others as Unaccompanied Asylum Seeking Children (UASC) (Refugees and Migrant Justice, 2009). UASC are particularly vulnerable as they are unlikely to have a trusted adult to help them through the asylum process, but will still need to prove their case. It is estimated that around 2,000 children are detained with their families each year for the purpose of immigration control (Crawley and Lester, 2005). The detention of children has a triple impact: exacerbating or causing mental health problems, including depression and changes in behaviour; physical health consequences affecting eating and sleep patterns; and impacts on education due to disruption from mainstream schooling and changes to the ability or willingness of children to learn (Crawley and Lester, 2005; Hodes, 2008). The Chief Inspector of Prisons has argued that immigration removal centres can 'never' be a suitable place for a child, and has reported cases of disabled children being detained and some children spending large amounts of time 'incarcerated' (HM Inspector of Prisons, 2008).

Explaining the health circumstances of asylum seekers/refugees

The context within which the health disadvantage of asylum seekers/refugees is discussed is intensely political. Asylum rights are highly contentious within a national policy that seeks to reduce the number of asylum claims and 'manage' migration (of which asylum forms a very small part). There is, therefore, a deliberate policy intention of strengthening borders and limiting welfare entitlement (Bloch and Schuster, 2002; Morris, 2002). This can be expected to have a direct impact on the health of the people involved. Welfare support and rights for asylum seekers and refugees are located within a framework of tiered entitlement (Dwyer and Brown, 2005) with a patchwork of delivery that is differentiated by socio-legal status and 'conditionality' (Dwyer, 2008).

There are a number of health issues that are particular to refugees and asylum seekers (aside from those more generally relating to poverty and economic inequality), many of which stem from their experience of flight and exile. A Department of Health guide separates that experience into three sections:
- *Pre-flight experience* – this may include oppression, persecution, harassment, conflict, witnessing combat, imprisonment, violence, torture, rape, fear, famine, death of family and friends;

- *Flight* - this may involve escape, paying traffickers to cross borders, hazardous conditions, the fear of being discovered and imprisoned, uncertainty, physical and sexual abuse, deprivation, separation and loss of family members;
- *Exile* – this may include anxiety about the outcome of asylum claim, fear of deportation, detention, poverty, homelessness, cultural shock, language barrier, racism, isolation, unemployment, boredom, homesickness, separation and loss of family, friends, community status, occupation, income and home, and guilt and anxiety about those left behind. Feelings of insecurity, powerlessness and inability to settle (Department of Health, 2003)

Most striking in the account of economic and health inequality outlined above is the impact of the asylum process once people have arrived in the UK. This is evidenced most sharply in the detention of children and the creation of destitution, which is in effect the deliberate creation of social exclusion by the government (see Burchardt, 2005) has described as reaching the threshold of inhuman and degrading treatment under Article 3 of the European Convention on Human Rights (Joint Committee on Human Rights 2007, 3:120).

Policy recommendations

To address the health care disadvantage of refugees and asylum seekers there is a need to:
1. Roll out the Refugee Healthcare Professionals Programme across the NHS, particularly in areas with high numbers of asylum seekers, refused asylum seekers and refugees.
2. Improve access to primary care for all asylum seekers and refugees, in conjunction with additional measures to clarify entitlements, and improve access to specialist services.
3. Extend awareness and training of refugee and asylum seekers' health issues across the NHS, especially with regard to the effects of torture and experiences of violence.

To address the negative social and economic impacts of asylum seeking and refugee status there is a need to:
1. Overhaul policy and approaches towards refused asylum seekers to prevent destitution and alleviate its impacts.
2. Remove work restrictions on asylum seekers whilst their claim is being processed and reinstate free access to English language courses.
3. Include the skills of existing refugees within managed migration skills shortage assessments.
4. Review the treatment of children within the asylum process, in particular towards ending the use of detention for all children;

introducing a model of independent guardians to support unaccompanied children; and reviewing age assessment procedure and practice.

Chapter 10
EMPOWERMENT[1]

The health consequences of powerlessness
There is an extensive and diverse body of research on the social, economic and health consequences of the differential control people – individually and collectively – have over the forces shaping their lives.   Much of the research focuses on individual control and there has been a major focus on 'testing' the 'demand, control, support' (DCS) model of workplace health put forward by Karasek and colleagues. This posits that health is negatively associated with higher demands and positively associated with higher control and social support at work. In general research reports a strong association between health experience and control over and/or participation in decision making at work and suggests that control is a more powerful predictor of health than job demands. However, typically this body of work does not consider the relationship between employment-related factors and factors operating in other domains of life. Marmot's influential Whitehall study and subsequent work bridges this divide by exposing the gradient in health and illness associated with inequalities in both material rewards and social status and control that characterise the English civil service and looking beyond the work of paid employment.

Although less extensive there is also research that suggests that control over resources and decision making at the collective/community level can also have powerful postiive impacts on health. Canadian research for example has reported a six fold difference in youth suicide amongst native american people depending on the degree of community control of key resources including land, health and education services. There is also a considerable body of research reporting that the degree of control individuals and groups have over decisions that affect their lives also impacts on intermediate determinants of health inequalities including the effectiveness of interventions aiming to improve conditions of daily life for low income people and the quality, uptake and effectiveness of services (see for example, Narayan, 2002).

In theory there are a number of possible interlinked pathways between activities aimed at increasing individual and/or collective empowerment and health outcomes. Four possible pathways are highlighted below and in the diagram.

Pathway 1: Improved *Information flows:* Identifying population needs more accurately and obtaining better quality information from communities on factors

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[1] Based on Jennie Popay, **Empowerment and engagement: mechanisms to promote inclusion and address health inequalities: A rapid review of evidence and recommendations for action**

operating as barriers to service uptake may contribute to the design of more appropriate and accessible services/interventions. In theory this can lead to health improvements and reduce health inequalities through an increased uptake of more effective services and/or more effective interventions.

Pathway 2: Governance and guardianship: Promoting and supporting community engagement in or control of a service and/or interventions may increase the appropriateness and accessibility of services/interventions, increase uptake and effectiveness and hence have positive health outcomes.
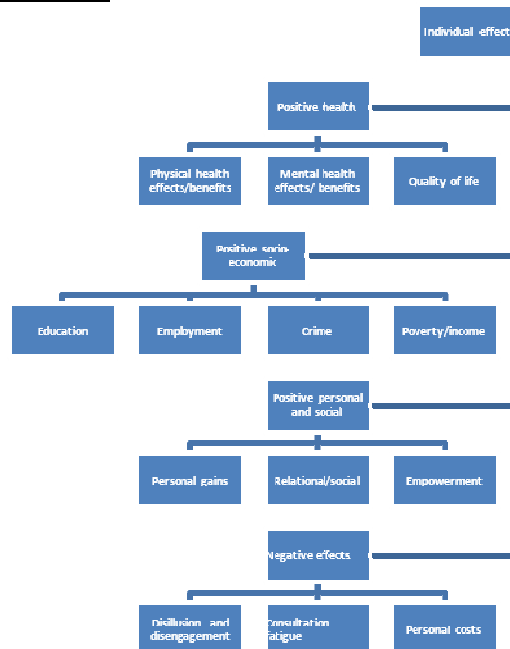
Pathway 3: Social capital development: Enhanced community empowerment may contribute to the development of relationships of trust, reciprocity and exchange within communities, strengthening social capital, which has been shown to be linked to improved health.

Pathway 4: Control and empowerment: Community empowerment may result in communities acting to change their social, material and political environments.

Empowerment, health and wellbeing
The range of *individual* benefits and dis-benefits that have been reported in research on health initiatives that have aimed to empower individuals and groups are summarised in the diagram below.

The experience of community engagement

- Individual effects
  - Positive health
    - Physical health effects/benefits
    - Mental health effects/ benefits
    - Quality of life
  - Positive socio-economic
    - Education
    - Employment
    - Crime
    - Poverty/income
  - Positive personal and social
    - Personal gains
    - Relational/social
    - Empowerment
  - Negative effects
    - Disillusion and disengagement
    - Consultation fatigue
    - Personal costs

In general the evidence suggests that empowerment and engagement initiatives can produce positive outcomes for the individuals directly involved including:

increased self efficacy, increased confidence and self esteem, personal empowerment , improved social networks; a greater sense of community and security and improved access to education leading to increased skills and paid employment. A greater sense of community is itself a strong predictor of participation in social action.   Research also reports significant health benefits for individuals actively involved in community empowerment/engagement initiatives including improvements in physical and mental health, health related behaviour and quality of life. Importantly, however, there is also evidence that done badly initaitves aimed at empowering individuals and groups/communities can also damage people's health.

Empowerment in UK policy and practice

Tthe pursuit of empowerment in the population at large and amongst disadvantaged communities is explicit in the policies of some government departments in England. Empowerment is now seen to be central to local government reform, urban regeneration, policing, education, housing and devolution. It is typically argued to be the mechanism whereby needs are to be identified and appropriate and therefore effective and sustainable solutions will be developed and implemented (refs). In contrast, engagement and involvement, (rather than empowerment), is the dominant language of the Department of Health and the NHS and are central planks of the English strategy to combat health inequalities.

Engagement and involvement are more eclectic arenas of activity. They do not rest on a readily identifiable body of knowledge and they lack the defining value base underpinning the concept of empowerment. They may explicitly encompass the aim of empowerment or their objectives may be more modest than this (Rogers & Robinson, 2004).

Notwithstanding these important distinctions, the specific methods and techniques used in the pursuit of empowerment and engagement/involvement are equally diverse and there is much overlap between them. Wallerstein (2006 op.cit.) for example, has identified common characteristics of strategies aiming to promote or sustain empowerment including: group dialogue; collective action; advocacy and leadership training; organisational development; and activities aimed at giving more power to community members, such as tenant management organisations, many of which are to be found in engagement strategies in England. Specific methods aimed at promoting community engagement and/or empowerment include: public meetings, consultation surveys, citizens panels and juries, rapid appraisal techniques, neighbourhood committees, community forums, participatory evaluation and research and community champions. The latter are people from a local community (of place or interest) chosen to provide leadership in support of action to improve health.

A key element of the health inequalities strategy in England is the role of voluntary and community organisations in the provision of services that aim to engage with the most disadvantaged groups and/or to increase opportunities for people to make healthy lifestyle choices. Specific initiatives include funding for community food initiatives in disadvantaged communities, the Safer and Stronger Communities Fund to support improvement in parks and public spaces and a Physical Activity Promotion Fund and regional physical activity coordinators. The strategy has also sought to develop new forms of community leadership including 12 'Communities for health' pilot sites which aim to promote action across organisations on a locally chosen health priority; a network of health trainers drawn from communities and from public, private and voluntary sector organisations to help share good practice.

In general, however, whilst local empowerment and engagement initiatives seem to give people better access to information about decision making and policy development and influence on how some funds, for example, the Neighbourhood Renewal Fund, are spent, outside of the housing field there is little evidence that the communities involved have a significant impact on major policy decision making (Popay et al 2007).

Barriers and enablers to community engagement processes

Barriers to effective empowerment and/or engagement practice have been consistently reported in research evaluating a wide range of different types of initiatives with different groups in different contexts and countries. Eight broad categories of barriers have been identied.
Lack of community capacity: Activities aimed at consciousness-raising amongst disadvantaged/poor people have been demonstrated to be an important element of successful empowerment but there is also evidence that, at least in the UK, people are well informed about the structural determinants of their disadvantage. Never the less people may resist attempts to 'empower' them partly because of their frustration over the lack of effectiveness of such initiatives in the past. Failed attempts at empowerment and engagement therefore can cast long shadows forward negatively impinging on future initiatives and partly explaining what can be perceived to be disinterest or apathy amongst some groups. **The practices of empowerment and engagement may be** inadequate including inappropriate timing and style of meetings, failure to accommodate cultural diversity and a lack of attention to accessibility issues. A related barrier is the **mis-use of positional power by professionals** who can control the types of issues to be addressed and exclude some communities from the process. There are also major cultural **and attitudinal constraints on effective empowerment and** engagement amongst professionals and local politicians including stereotyping of particular groups (e.g. disabled people) and the dominance of deficit images of disadvantaged communities. Differential access to c**ommunicative resources and knowledge** also create barriers. Research suggests that networking and shared learning across community groups can

reduce these barriers. The ***personal transaction costs*** for the individuals involved are rarely reimbursed including for example, demands on time and travel costs. Research also points to the pivotal role of central government in shaping the prospects for, and outcomes of attempts to empower and engage communities at a local. Key themes to emerge from the research include:

• Discordance between government rhetoric and the reality of implementation when central government demand for 'quick wins' undermins attempts at empowerment/engagement;

• The limited skills and competencies of local and national policy leads in relation to community empowerment/engagement.

• The in-flexibility on rules and regulations.

• Tensions policies objectives e.g. Sure Start's focus on partnerships with parents being undermined by the focus on organisational efficiency in relation to children centres.

Arguably, local stakeholders have some responsibility to attempt to influence the behaviour of central government and their own organisations. It would appear, for example, that senior HAZ figures neglected to take the community engagement agenda back into their own organisations and up to national sponsors, focussing instead on developing local community capacity to. Without this development the values, policies, processes and approaches that have undermined community empowerment and engagement initiatives in the past will remain in the future. There is also a need for greater understanding at local and national level of the complexity and sophistication required for effective community empowerment and participative planning for health improvement. As evaluators have argued "logical planning does not seem to be part of the natural culture of practice in the partner agencies that have committed themselves to improving the population health".

Recommendations

1. Across government there are different definitions of and approaches to empowerment/engagement and it is almost certainly the case that in the same areas local people are being 'engaged' by the NHS and empowered in different ways and for different purposes by mutliple policy actors. This is an area crying out for a more coherent approach across government departments and at local level;

2. The evidence suggests that the practice of empowerment (rather than engagement and involvement) with its explicit value base associated with recognising *lay experiential expertise* and changing power relationships will – if done well and this is key – deliver health benefits at individual and community (interest and place) level. From a health inequalities perspective there is a need for initiatives that explicitly aim to empower people individually and collectively

3.   Many health interventions adopt engagement or empowerment strategies as a mechanism for delivering action that has been designed by other people (typically professionals). As a result, the desired outcomes (e.g. a change in lifestyle or greater social capital) and perhaps to a lesser degree specific action to achieve these are not chosen by the people who are the target of the intervention and may not be a priority for them. This approach has less chance of being empowering than initiatives in which empowerment is the primary goal.

4.   Too often in England local policy initatives have begun with a strong commitment to authentic community empowerment only for this 'psychological contract' with local people to be broken by an insistence on 'quick win's from central government. Future policies must recognise the empowerment requires a long term commitment and must be given priority over short term policy objectives.

5.   There have been a number of reviews of evidence on the effectiveness of engagement/involvement/empowerment initativies commissioned by different government departments with slightly different specificaitons. A review of reviews is needed and a more coherent approach to this research agenda within government.

6.   Few evaluative studies of engagement/empowerment initiatives identified for the recent review of evidence on community engagement and empowerment undertaken for NICE included health outcomes (however defined) – this is an important agenda for future research

7.   There is some evidence that community development expertise is associated with better outcomes for empowerment/engagement interventions particularly in the housing field e.g. tenant management initiatives. Consideration should be given to public funding of community development approaches to health inequality reduction. However, it is important the the groups who are the targets of interventions are able to 'control' the remit and work of any community development workers, not the public sector professionals, and there is also scope for increasing the community development skills and competencies of local activists rather than committing the majority of funding to professionals whatever field they are in.

8.   In the short term the NICE guidance on community engagement for health improvement should be implemented across the health system and monitoring of performance on community empowerment should be incorporated into mainstream governance systems. In the longer term common standards for community empowerment should be developed and implemented across the public sector.

CONCLUSIONS

This report began by discussing social exclusion and inequality in general terms. It has highlighted the powerful exclusionary processes that are contributing to health inequalities in England and considered the experience of particular groups and policy areas to illuminate the nature and impact of these processes. The pivotal role of authentic empowerment of individuals and communities – giving them real power over decisions that shape their lives – has been emphasised in the final chapter. Specific recommendations have been made at the end of each chapter and these are not repeated here. Rather we highlight here four over-arching conclusions from our work.

The first general conclusion is that the 'macro' matters for the 'micro'. The overall degree of inequality in Britain affects the circumstances of those who are most vulnerable. Economic inequality is the principal driver of social exclusion, underpinning and compounding exclusionary processes operating along other dimensions - social, cultural and political. Together these processes drive health inequality: evidence suggests that health inequalities cannot be substantially reduced without reducing economic inequality..

A second conclusion, relating to the 'macro' level, is that unemployment damages health. Employment problems are exceptionally severe for some groups, either contributing to ill health or resulting from it. Inevitably if unemployment generally rises, as it is doing, then the most vulnerable – among whom those with health problems stand out – will suffer most, and health inequality will increase. Economic strategies to maintain full employment are fundamental to reducing health inequality.

Third, the 'micro' matters. Some groups are more severally affected by exclusionary processes than others – notably, people who are disabled, those experiencing chronic illness (including mental illness), people from minority ethnic groups, those who are homeless or seeking refuge – and the impact of these proceses exacerbates health inequalities. To take three examples from many in the preceding chapters:
- Reducing the stigma and discrimination towards those suffering mental illnesses can improve their employment, their income and their health.
- Preparing those leaving the armed forces and prison much better for life on release can reduce their homelessness and their health problems.

It is not enough to say that with less inequality and unemployment all health inequalities would disappear. There are many special circumstances that lead to special problems that are not effectively addressed in our society – a society that caters largely for the contented, conformist majority. The need to identify those

'micro' problems, as this report has sought to do, and build in diversified provisions that address them in a non-excluding way is the third over-arching conclusion of this report.

The fourth over-arching conclusion from the report is that empowering people – giving them real control over the decisions that affect their lives – is key to delivering a more just society and greater health equity. But this will require central and local government recognising and making the profound changes in organisational and professional culture and practices that authentic empowerment requires.
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We cannot live in a society in which health is equal for all. We can live in an inclusive society that limits inequality, in which all who need it have the opportunity to be employed, and in which the diversity of human conditions is catered for, and even celebrated. In such a society, health inequalities will be as low as is humanly possible.

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