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## Chapter 4

# Policy objectives and recommendations

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### 4.1 Introduction

The recommendations set out in this chapter are informed by evidence of what works to reduce inequalities in the social determinants of health. The analyses produced by the nine task groups set up by the Review and the subsequent consultation, research and analysis undertaken during the Review allowed an assessment of the best available evidence.

The criteria for making the recommendations also include ‘deliverability’ and build on the lessons from current and previous health inequalities strategies, discussed in Chapter 3.

The recommendations

- are based on the best evidence of effectiveness, as outlined in this chapter.
- build, in many cases, on existing programmes or interventions, but require a scaling up of size and intensity to effectively reduce inequalities across the social gradient. This reduces the need to reinvent the wheel, which has afflicted many previous policy initiatives.
- build on policies in the areas described and in other areas. There is intended to be complementarity or synergy between the recommended policies to reduce health inequalities. For example, high quality parenting programmes can achieve multiple impacts on inequalities in children’s early years, education and health outcomes and parental health and well-being.
- can mainly be delivered by enhancing existing models of delivery, as outlined in Chapter 5. Recommendations requiring significant reorganisation of the structure and architecture of delivery systems were avoided unless there was a compelling case for it, for instance, with the tax and benefit systems. There was a widely voiced concern to avoid advocating disruptive system changes.
- would mainly be effective by having a proportionate effect across the social gradient, although in some cases only the most disadvantaged would be directly affected, for instance the minimum income for healthy living.
- are illustrated by examples of costs and benefits, although it has been impossible to cost all the proposals we make or to provide quantification of the full range of long-term benefits. The analysis of the costs of health inequalities in Chapter 2 shows that they can be measured in both human

terms and in economic terms. The scale of these costs, and therefore of doing nothing, provides clear evidence that investments in social determinants of health, as outlined in this chapter, are cost effective. Moreover, our estimate of the costs of doing nothing gives extra support to the interventions and policies we recommend. Many interventions will require significant long-term investment before the savings are realised but given the strong social justice and moral case for intervening and some evidence of cost efficacy, we argue that the initial outlay is justifiable.

- are presented in terms of three delivery periods: 2011–15, 2016–20 and beyond 2020. Some of the recommendations are for redirecting existing money, for instance rebalancing pupil spend towards the early years. Others, particularly in the later periods, require new money.
- are for the whole of government and across organisations at local and national level, and therefore require cross-agency working, set out in Annex 2.

The case studies included in this chapter illustrate some of the key themes in the recommendations. Like many interventions, most have not applied a long-term evaluation. Many lack this evaluation because they are short-term projects while others are in the process of being evaluated. While this report advocates systematic effective evaluations, the case studies provide examples of innovative interventions and good practice.

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# Policy Objective A

## Give every child the best start in life

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### Priority objectives

- 1 Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- 2 Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
- 3 Build the resilience and well-being of young children across the social gradient.

### A.1 Introduction

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status (see summary of data in Chapter 2). To have an impact on health inequalities we need to address the social gradient in children’s access to positive early experiences. Later interventions, although important, are considerably less effective if they have not had good early foundations.<sup>255</sup>

The importance of the early years, from pre-birth to the age of 5, to later life outcomes is widely acknowledged and consequently has received considerable policy attention. Since 1997 the Government has made the reduction of child poverty a top priority and there has been significant investment in the expansion of early years education and care, extension of parental leave, increased family support through the development of Sure Start Children’s Centres and fiscal measures designed to support families with children. This activity represents a revolution in early years provision and parenting support and, although it takes time to measure the outcomes of early years interventions, evidence is now emerging that these policies are making an impact.<sup>256</sup>

However, much more needs to be done. To deliver long-term reductions of inequalities we need continuing political commitment to these policies and increased investment in the early years. In short, we need a second revolution in the early years.

## A.2 Recommendations

### A.2.1 Increased investment in early years

**Recommendation:** Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

There has been, and continues to be, significant policy attention and public investment in the early years and in family support. The evidence on the importance of the early years has informed recent and current policy initiatives. The Government's *Every Child Matters: Change for Children* programme is described as aiming 'to ensure that support for parents becomes routine, particularly at key points in a child or young person's life. The government, in partnership with local areas, intends to ensure parents and families have access to the support that they need, when they need it, so that all children can benefit from confident, positive and resilient parenting, from birth right through to the teenage years.'<sup>257</sup>

The commitment to the early years has been enacted through a wide range of policy initiatives, including Sure Start and the Healthy Child Programme and is being developed through current proposals in the Families and Relationship Green Paper (January 2010). However, it is vital that this is sustained over the long term with even greater priority given to ensuring expenditure early in the developmental life cycle, on children below the age of 5, and that more is invested in interventions for which there is good evidence of effectiveness.

Evidence shows that social spending on children

early in the life cycle is likely to be more effective in enhancing children's long-term outcomes than later investment and that the 'social profitability' of investment is likely to differ significantly across the child's life course. The timing of investment is critical according to the outcomes one is seeking to influence. For example, Cunha and Heckman<sup>258</sup> show that cognitive ability (IQ) stabilises between 8 and 10 years of age, while behaviour remains modifiable into late childhood. A model of adult skill formation developed by Heckman<sup>259</sup> concludes that investment in children should be most intensive during early childhood and should taper off as children age. Rather than treating childhood as undifferentiated, Cunha and Heckman's model recognises the importance of different childhood stages and is based on the following evidence-based arguments:

- Skills gaps between individuals and social groups emerge early in life.
- Critical and sensitive periods exist during the child's life where skills are more easily acquired.
- Returns to investment are high for young disadvantaged children and lower for disadvantaged adolescents, although returns from specifically targeted interventions with young people can be high.
- Investment at different ages is complementary. If early investment is not followed up by later investment, its effect is lessened.

A 2009 report by the Organisation for Economic Cooperation and Development (OECD) compares levels of social spending at different stages of a child's life – 0 to 5 years, 6 to 11 years and 12 to 17 years.<sup>260</sup> The majority of countries, including the UK, spend proportionately more on children as they get older.

**Table 4.1** Variation in the distribution of expenditure on childhood education by age in selected European countries, 2003

|                    | Ratio middle to early childhood | Ratio late to middle childhood | Ratio late to early childhood |
|--------------------|---------------------------------|--------------------------------|-------------------------------|
| Austria            | 1.33                            | 1.09                           | 1.45                          |
| Belgium            | 1.35                            | 1.30                           | 1.76                          |
| Denmark            | 1.34                            | 1.02                           | 1.36                          |
| Finland            | 0.85                            | 1.27                           | 1.08                          |
| France             | 1.00                            | 1.31                           | 1.31                          |
| Germany            | 1.38                            | 1.15                           | 1.58                          |
| Italy              | 1.98                            | 1.04                           | 2.06                          |
| Ireland            | 1.87                            | 1.19                           | 2.24                          |
| Iceland            | 1.11                            | 0.83                           | 0.92                          |
| Hungary            | 0.90                            | 1.03                           | 0.92                          |
| Netherlands        | 2.02                            | 1.17                           | 2.36                          |
| Norway             | 1.31                            | 1.20                           | 1.57                          |
| Portugal           | 2.13                            | 1.10                           | 2.35                          |
| Spain              | 2.00                            | 0.92                           | 1.84                          |
| Sweden             | 1.23                            | 1.09                           | 1.34                          |
| United Kingdom     | 1.35                            | 1.09                           | 1.48                          |
| OECD average       | 2.06                            | 1.12                           | 2.30                          |
| Standard deviation | 1.65                            | 0.16                           | 1.93                          |

Source: Organisation for Economic Co-operation and Development (OECD)<sup>261</sup>

Table 4.1 summarises how spending per child is distributed across the three major stages of childhood in several European countries, using 2003 data. Out of 28 OECD countries, 26 spent more per child in late childhood than in the early years; and 23 spent more on middle childhood than on the early years. In 2003, Hungary was the only OECD country spending more per child on the early years than in later stages of childhood.

Identifying total expenditure in the early years in England is difficult because the data are held across a variety of central government departments as well as local government. It is therefore not possible to accurately assess the extent to which the ratio of spending on the under-fives in England has changed since 2003. However, looking solely at education expenditure, there has been a steady increase at all stages in England since 1997, but the proportion of spending by stages of childhood has remained virtually unchanged over the same period – see Figure 4.1. In 2001–2 education expenditure on the under-fives represented 13 per cent of the total spend on education (excluding post-16); in 2007–8 it was 12 per cent. If further and higher education are included, the proportion of spending on the education of under-fives has remained virtually static at 8 per cent.

A 2009 report from Action for Children and the New Economics Foundation estimated that the cost to the UK economy of continuing to address current levels of social problems such as crime, mental ill

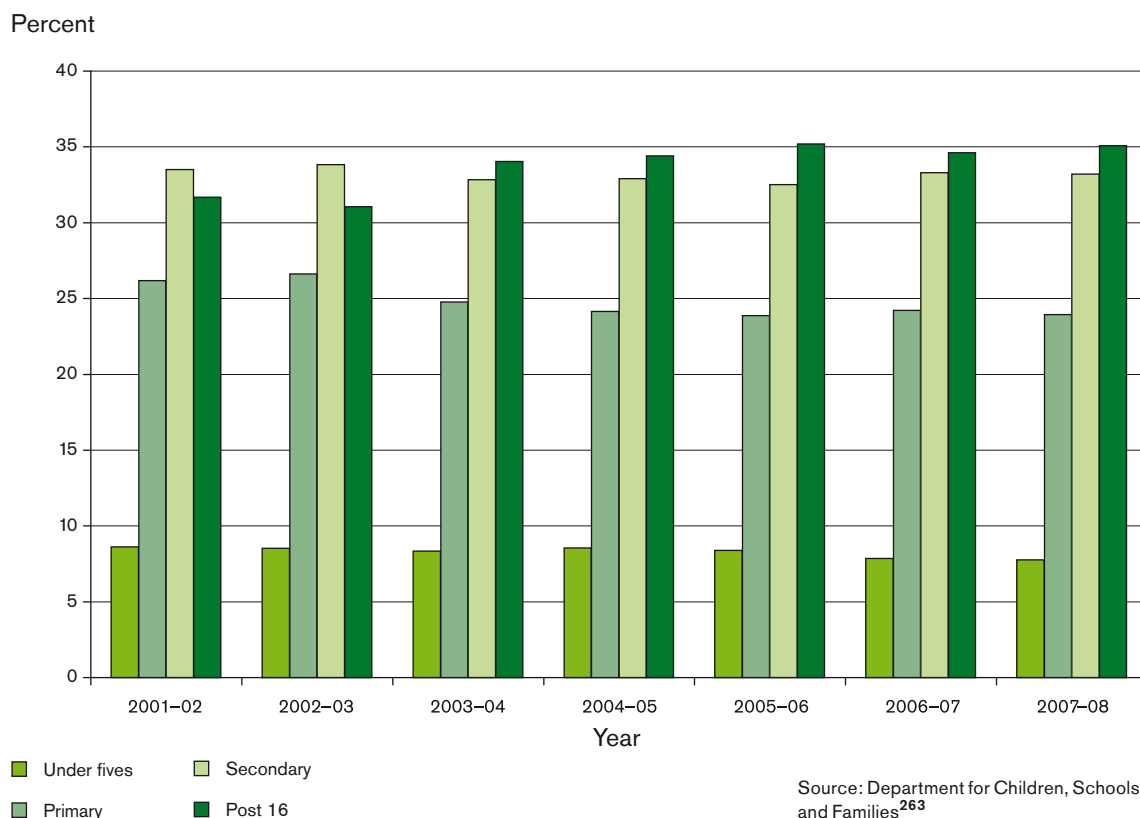
health, family breakdown, drug abuse and obesity will amount to almost £4 trillion over a 20-year period.<sup>262</sup> The report argues that investing in a combination of targeted interventions and universal childcare and paid parental leave could help address as much as £1.5 trillion worth of the cost of these social problems, leaving the UK in a similar position to nations such as Finland, Sweden and Denmark, which have the best social outcomes in the OECD.

Investing in the policy priorities we set out below will not only offer long-term savings in terms of health care: it will also deliver returns to education, employment and social cohesion. Implementing our recommendations will help ensure that all young children have the best possible start in life, will give support to parents and ensure good quality early childcare and education are proportionately targeted to reduce the social gradient in early years outcomes.

### Summary

- Investment in early years is vital to reducing health inequalities and needs to be sustained, otherwise its effect is lessened
- Returns on investment in early childhood are higher than in adolescence
- Currently, spending is higher in later childhood years and needs to be rebalanced towards the early years
- Gaps between individuals and social groups emerge early in the life course.

**Figure 4.1 Education expenditure by age group, 2001–8**



### A.2.2 Supporting families to develop children's skills

**Recommendations:** Support families to achieve progressive improvements in early years development, including:

- 1 Giving priority to pre and postnatal interventions, such as intensive home-visiting programmes, that reduce adverse outcomes of pregnancy and infancy
- 2 Providing paid parental leave in the first year of life with a minimum income for healthy living
- 3 Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
- 4 Developing programmes for the transition to school.

#### *Pre and postnatal interventions*

Support to families needs to start prenatally to improve the health and well-being of mothers. There are strong associations between the health of mothers and the health of babies and equally strong associations between the health of mothers and their socioeconomic circumstances. This means that early intervention before birth is as critical as giving ongoing support during their child's early years. As a 2005 report on maternal health from the World Health Organisation states: 'Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life.'<sup>264</sup>

Central to this is ensuring that women have an adequate level of income and other material support during pregnancy to enable them to maintain a good level of health and nutrition. This requirement needs to be taken into account when considering minimum income levels for healthy living (see Policy Objective D).

All families need some information and support during pregnancy and postnatally but some require additional support. Proportionate universal programmes are therefore very important. One example is the Healthy Child Programme, a universal, preventive programme tailored to the needs of each family with support provided to planners and practitioners (through the PREview project) to identify the factors in pregnancy and around birth that are associated with health and well-being outcomes for a child at five years.<sup>265</sup> This type of universal pre and postnatal support is important in several respects. It has no stigma attached and levels of take-up are extremely high. As such, it offers an ideal opportunity for informal family assessment, not just in terms of parents and their new baby, but to identify other needs of the family and the option of signposting to other services relating to older children.

Positive attachment between a young child and their primary care-giver, usually but not necessarily the mother, has been consistently shown to be important for healthy early development.<sup>266</sup> Early, secure attachments contribute to the growth of a broad range of competencies, including the self-

esteem, self-efficacy and positive social skills that are associated with better educational, social and labour market outcomes in later life. Isolation and depression are two important factors that impact negatively on maternal attachment capacity and which supportive interventions can alleviate.

There is strong evidence that early intervention through intensive home visiting programmes during and after pregnancy can be effective in improving the health, well-being and self-sufficiency of low-income, young first-time parents and their children. Trials in the United States have shown significant and consistent benefits from home visiting including: improvements in women's prenatal health; fewer injuries to children; greater involvement of fathers; increased employment and improvements in school readiness. These findings are supported by evidence from research in Britain.<sup>267</sup> Systematic reviews of home visiting programmes show good evidence of improved parenting skills, child development, reduced behavioural problems and improved maternal mental health and social functioning.<sup>268</sup>

Ensuring that parents have access to support during pregnancy is particularly important. NICE guidelines on intra-partum care<sup>269</sup> and the Standards for Maternity Care developed by the relevant Royal Colleges in the UK provide guidance for improvement in the safety and the experience of maternity care for both the infant and the mother.<sup>270</sup> These highlight the need for a strong midwifery workforce which provides the infrastructure to support women and their partners during pregnancy, birth and early parenthood, for delivery of services that avoid unnecessary intervention, and for ensuring that those women who do, or may, require intervention are signposted at an early stage to specialist care.

A welcome initiative is the development of Family Nurse Partnership pilot schemes. These were established in 10 pilot areas in March 2007 with a second wave of 20 sites funded from March 2008, as an intensive, preventive, home-visiting programme delivered by specially trained nurses and midwives with experience of working with families in the community. It is a structured programme offered to at-risk, first-time young parents from early pregnancy until the child is two years old, on the basis that pregnancy and birth are key points when most families are receptive to support and extra help and interventions can have significant impact at these times. Early evaluation findings are promising.<sup>271</sup>

The strong evidence for the effectiveness of pre and postnatal home visiting suggests that there is scope for this type of intervention to be developed further, particularly for disadvantaged parents. A key challenge is the recruitment of appropriately skilled and qualified staff in the context of critical shortages of some professionals, such as health visitors. To overcome this, consideration should be given to piloting models deriving from the Family Nurse Partnership to test ways of working with a wider range of families as well as exploring alternative models of intensive home visiting, where there is good evidence of effectiveness.

### *Parental leave during the first year*

Sensitive and responsive parent–child relationships are associated with stronger cognitive skills in young children and enhanced social competence and work skills later in school.<sup>272</sup> It is therefore important that we create the conditions to enable parents to develop this relationship during the child's critical first year. This involves making it practical and affordable, through providing paid parental leave for the whole of the first year, and, where required, providing parents with the understanding and skills needed to forge a positive relationship with their child.

Maternal employment in the first year, particularly if early and full-time, is associated with poorer cognitive development and more behaviour problems for some children. For 1–5 year olds there are no adverse effects of maternal employment on cognitive development, but there may be negative effects on behaviour if children are in poor quality child care for long hours.<sup>273</sup> Research has linked maternal employment to lower levels of breastfeeding, increased rates of obesity at three years and poorer indicators of diet and physical activity at five years.<sup>274</sup> These findings do not imply that mothers, or fathers, should not work, but they do indicate that changes in parental employment patterns are not inevitably benign and they highlight the need for policies to support parents to promote the health of their children and to enable them to remain at home with their child for the whole of the first year, if they so choose.

Paid parental leave is associated with better maternal and child health with studies finding an association with lower rates of maternal depression,<sup>275</sup> lower rates of infant mortality,<sup>276</sup> fewer low birth-weight babies, more breast-feeding and more use of preventive health care.<sup>277</sup> This highlights the importance of parents across the social gradient having access to paid parental leave during the whole of the first year as well as the availability of good quality childcare and flexible employment thereafter, including for those young children with parents not in work who are assessed as likely to benefit.<sup>278</sup> Despite important attempts to make childcare more affordable through the childcare element of the working families tax credits, many parents find it difficult to afford to remain at home with their child for the whole of the first year, even if they would prefer to do so.

### *Routine support to families throughout the pre-school years*

All parents need support at times, and most parents will need to turn to someone for information or advice at some point, particularly if they are first-time parents. Where parents are very young, have other difficulties in their lives or have little social support from their family or community, they are likely to need more support. This may relate directly to parenting, or may be in response to other needs – material, social or emotional – related for example, to income, housing or having access to mental health services that recognise their needs as parents.

Since April 2008, local authorities have had a duty to provide information, advice and assistance

to parents and prospective parents of children and young people up to age 20 (introduced in section 12 of the Childcare Act 2006). It is important to maintain this access to universal provision in recognition that all families need help sometimes. Early access to support can also prevent difficulties from escalating and act as a gateway to more intensive or specialist support for those who need it, for example, making a referral to specialist services for disabled children or signposting to advice on income and benefits.

Home visiting and outreach services offering family support for early child development should be provided to all families who have children under the age of three years and are assessed as in need of additional support. These services should be staffed by qualified and experienced key workers drawn from a range of professional backgrounds, for example health visitors, midwives and social workers, capable of offering case management and support for families with complex material, social and health needs. This key worker support should be available throughout the pre-school years to ensure that children access the best quality early years education and have support through the transition to school, as well as ensuring that parents receive consistent parenting support and signposting to other appropriate services, including evidence-based parenting programmes.

Early years key workers need the skills to provide advice and support to parents on child development, to identify where there are additional needs and facilitate access to specialist input, including child health, where required. Key workers may be drawn from the statutory sector, for example from the local authority, Children's Trust or Primary Care Trust, but key worker support could equally be commissioned from third sector organisations.

Sure Start Children's Centres are an obvious source of this outreach support and many are already providing it. These centres are intended to be service hubs where children under five and their families can receive integrated services and information.<sup>279</sup> Services vary but should include access to early education and childcare, parenting support, family health services and help for parents to obtain work. By the end of March 2010 there will be at least 3,500 Sure Start Children's Centres and it remains important for local authorities, Primary Care Trusts and Job Centres Plus to ensure that these services are provided consistently in all areas and meet the needs of families across the social gradient.

It remains important to ensure that Sure Start Children's Centres reach families who could benefit the most. Many parents seek out and make use of their local Children's Centre and a very small minority who have come to the attention of children's social care services because of safeguarding concerns may get referred to a Children's Centre. However, it has been observed that families not using Children's Centres can include those who are not coping well but whose difficulties have not come to the attention of statutory services.<sup>280</sup> Such families may not know about the potential benefits of Children's Centre services, or may actively avoid them. Reaching these families requires sensitive outreach and the provision

of non-stigmatising support that brings direct and tangible benefits to the families concerned as well as supporting child development – for example, enabling access to housing support and benefits/debt advice as well as parenting programmes. The DCSF is currently working with the Children’s Workforce Development Council (CWDC) on developing a training course for Children’s Centre practitioners engaged in outreach, to build on and develop the ways in which they undertake this sensitive and important work.

Parents are the most important ‘educators’ of their children for both cognitive and non-cognitive skills. Parental involvement in their child’s reading has been found to be the most important determinant of language and emergent literacy.<sup>281</sup> Parenting style also makes a difference. Recent analysis of data from the Millennium Cohort Study suggests that parents who combine high levels of parental warmth with high levels of supervision are more likely to have children at age five who are more confident, autonomous and empathic. On the other hand, a ‘disengaged’ parenting style is associated with poorer outcomes for children.<sup>282</sup>

There is a growing body of evidence that theoretically sound parenting programmes, which are underpinned by strong research evidence, can provide positive gains for parents and children.<sup>283</sup> Reviews have found that parent-training programmes can be successful in improving maternal psychosocial health,<sup>284</sup> in improving emotional and behavioural adjustment of young children under three,<sup>285</sup> and in contributing to safer home environments and reduced unintentional injuries in children.<sup>286</sup> However, quality and consistency of delivery are critical to the effectiveness of parenting support programmes. Trials of the Incredible Years programmes in the US and UK have demonstrated effectiveness in the treatment of conduct disorders

and for children known to be at risk of developing them. The programmes contain the key components recommended by NICE.<sup>287</sup> Investment in parenting support needs to be accompanied by measures to ensure that programmes are consistently delivered to the level of quality shown to have the best results.

Attention also needs to be given to ensuring that the most effective parenting programmes reach parents across the social gradient. Despite the substantial increase in the availability of parenting support in disadvantaged areas, there remains concern that it is still not reaching the most disadvantaged parents in those areas.<sup>288</sup> A recent report on follow up work to support implementation of the NICE/SCIE guidance on parenting programmes discusses effective approaches to maximise take-up of programmes.<sup>289</sup>

### Summary

- Early interventions during pregnancy and ongoing support in early years are critical to the long-term health of the child and other long-term outcomes.
- Universal and proportionately targeted interventions are necessary.
- Emerging evidence shows that Sure Start Children’s Centres have a positive impact on child outcomes.
- Families have the most influence on their children.
- Adequate levels of income and material and psychological support and advice for parents across the social gradient are critical.
- Intensive home visiting is effective in improving maternal and child health.
- Good parent–child relationships in the first year of life are associated with stronger cognitive skills in young children and enhanced competence and work skills in schools.

## What makes parenting programmes effective?

The National Academy of Parenting Practitioners (NAPP) lists eight parenting programmes for which there is currently a good evidence base.<sup>290</sup> These are:

- Incredible Years
- Parenting Positively
- Triple P
- Strengthening Families Strengthening Communities
- Family Links
- Mellow Parenting
- Strengthening Families Together (10–14)
- Families and Schools Together

NAPP identifies three key elements underpinning evidence-based parenting interventions: eligibility criteria, fidelity and the intensity with which it is delivered (sometimes referred to as ‘dose’).

### Eligibility criteria

These need to be used to ensure that the target group of parents are those whom the research shows are most likely to benefit from the selected programme.

### Fidelity

Most evidence-based programmes have a set of ‘active ingredients’ that are essential for ensuring they remain effective. Programmes need to be delivered with sufficient fidelity to ensure that these are not lost.

### Intensity

The amount of intervention received affects its impact. There is a need to ensure that parents sustain attendance and to increase the level of intensity for those with more complex needs.

### A.2.3 Quality early years education and childcare

**Recommendation:** Provide good quality early years education and childcare proportionately across the gradient. This provision should be:

- 1 Combined with outreach to increase the take-up by children from disadvantaged families
- 2 Provided on the basis of evaluated models and must meet quality standards.

Good early years provision is good for all children, but it has a disproportionately positive impact on the development of disadvantaged children.<sup>291</sup> Attending a high quality or more effective pre-school acts as an important protective factor even for children who go on to attend a less effective primary school.<sup>292</sup>

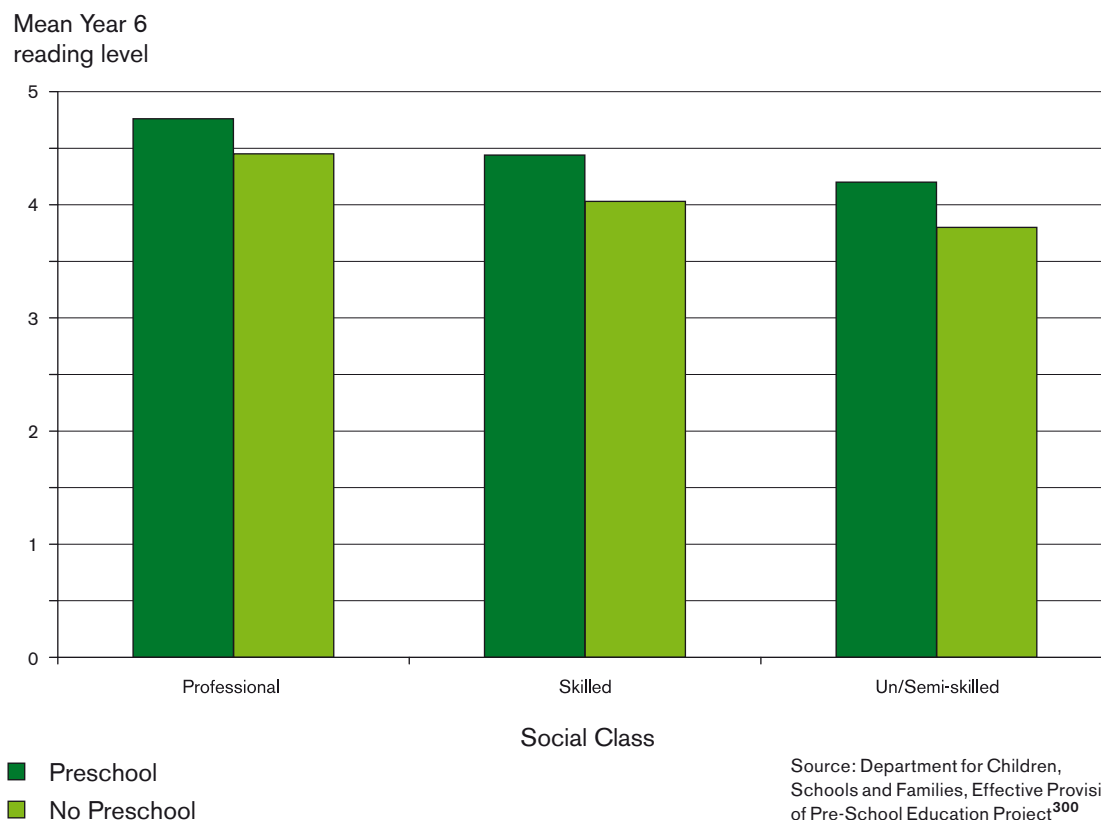
Good quality early childhood education and care can help to address inequalities in life chances. Research from the US found that high quality centre-based programmes of early education enhance vulnerable children's school-related achievement and behaviour. These effects are strongest for poor children and for children whose parents have little education. Programmes that are continued into elementary school and that offer high 'doses' of early intervention have the most sustained long-term effects.<sup>293</sup> A review of 27 systematic reviews to promote mental health and prevent mental health problems in children and young people found that

high-quality pre-school programmes were effective in improving self-esteem and behaviour.<sup>294</sup> The classic High/Scope Perry Preschool Study of a deprived US community consistently found better outcomes for those who had a pre-school programme. They were more likely to hold a job, commit fewer crimes, more likely to have graduated from high school and have higher earnings.<sup>295</sup>

A longitudinal study of 3,000 children (age 3–7 years) from differing social backgrounds across England also found that pre-school education enhanced all-round development.<sup>296</sup> High quality pre-school programmes lead to stronger and more enduring effects on outcomes, especially for disadvantaged children, boys, and children with special educational needs.<sup>297</sup> It was found that an early start and the duration of attendance impacts on effectiveness, as does having higher qualified staff – see Figure 4.2. The key components of quality in early years settings are highly trained managers and staff with good knowledge of the curriculum and how young children learn, combined with skill in adult–child interaction.<sup>298</sup>

In a Daycare Trust report on the costs of quality early years care, two dimensions of quality daycare are described: 'structural' and 'process' aspects.<sup>299</sup> 'Process' dimensions are the characteristics of the child's experience – for example interactions with others, learning experiences, variety in stimulation, responsiveness in environment. 'Structural' dimensions focus on aspects of the environment that are

**Figure 4.2** Reading at age 11 by social class and pre-school experience, findings from the Effective Provision of Pre-School Education Project (EPPE), 2008



fixed, such as staff and manager qualifications, staff pay, stability/retention of staff, adult–child ratios, group size, management structure, physical environment, and the interaction between these factors.

This evidence supports the argument that priority needs to be given to improving access to the best quality early education and care across the social gradient. There remain concerns that children in disadvantaged areas and/or from poorer families are less likely to access the best quality early years programmes when they are likely to derive most benefit from it. More needs to be done to remedy this situation through outreach work from Sure Start Children’s Centres and ensuring that places are allocated and retained according to the socioeconomic composition of the areas they serve.

As well as improving access to early childcare and education, there is a need to ensure that all early years programmes are delivered on the basis of the best available evidence of effectiveness.

When Sure Start was established, its introduction was based on robust evidence of the effectiveness of the Perry pre-school model evaluated over many years in the US. The first Sure Start Local Programmes (SSLPs) in England varied according to local need: all supported children and their families by offering a range of integrated services including early education, childcare, health and family support in specified geographical areas and they pioneered different ways of working with deprived communities. The National Evaluation of Sure Start (NESS)

was commissioned in early 2001 and evidence of what made a Sure Start Local Programme effective became available in 2005 and 2006. This evidence has influenced the subsequent development of Sure Start Children’s Centres and the concept of a ‘Full Core Offer’ which all Children’s Centres are now expected to deliver within two years of designation. The ongoing learning from research is vital to ensure that children and families benefit from support based on the best available evidence.

Ensuring the effective integration of prenatal and postnatal policy and service delivery is also critically important. Based on what we know about effective interventions at each developmental stage, from pre-birth to pre-school, policy needs to be aimed at promoting maternal health and a positive family environment both before birth and throughout the pre-school years. There is still concern that some families fall through the gap between pre and postnatal services, particularly when they are the responsibility of different agencies and professional groups.

Currently, there is an unhelpful separation between policy and practice for the prenatal period, including national policies, Local Area Agreement targets and the Lord Darzi clinical pathways groups for infant mortality and maternity care, and those aimed at improving outcomes for early years and child health. This artificial separation gets in the way of more joined-up thinking about improving childhood outcomes. A shared definition of early child

### Case Study Providing targeted and universal services to children and families

Linden Children’s Centre is located in the Sure Start Local Programme in Hackney Downs, North London. It has a catchment area of five wards with around 2,500 resident children under the age of five. The centre is open from 8am to 6pm, 48 weeks a year and offers 89 day care places and its services reach an average of 800 children under five. The Centre has grown from the combination of an existing Sure Start Local Programme and an early years nursery. The Linden Children’s Centre provides both universal and targeted childcare and education services with focus and extended services for vulnerable and low income families.

The universal services offered to the entire community encompass:

- Early education and childcare
- Family support, including visits to all children in the Centre’s area within two months of birth
- Links with schools, extended schools, and out-of-school activities
- Links with Children Information Service, Jobcentre and other training providers, including providing information about health services, childcare, early education, play, training,

housing and unemployment along with support for parents and carers who wish to consider training and employment.

Additional targeted services include:

- Early identification of children with special needs and disabilities, with inclusive service and support for families
- Additional visits based on need following a Common Assessment Framework
- Multi-disciplinary team that includes a Family Support Worker
- Accident prevention loan scheme, advice and information
- Increasing involvement of fathers
- Information and guidance on breast feeding, hygiene, nutrition and safety
- Smoking cessation interventions
- Speech and language therapy and other specialist support
- Early intervention parenting programme.

For more information see [www.learningtrust.co.uk/childrens\\_centres/linden.aspx](http://www.learningtrust.co.uk/childrens_centres/linden.aspx)

development needs to include the prenatal period and incorporate an understanding of the impact of intergenerational factors on child health and well-being, that is, the health of mothers and their own nutritional and other environmental experiences during childhood.

Despite these systemic challenges, there are many practical examples of more integrated approaches being developed – for example, Family Nurse Partnership (FNP) programmes working successfully with Children’s Centres in preparing for the transition from the end of a FNP programme into Children’s Centre support. Ensuring that practitioners such as Children’s Centre outreach workers and health visitors work together is of vital importance and, where necessary, local systems need to be adapted to facilitate this.

Providing adequately for families in their children’s early years needs to be seen to be the responsibility of a range of agencies alongside Health and Children’s Services. An integrated policy framework is needed for early child development to include policies relating to the prenatal period and infancy, leading to the planning and commissioning of maternity, infant and early years family support services as part of a wider multi-agency approach to commissioning children and family services.

A further key priority is the continuing development of the early years workforce. There has been significant investment in recent years in developing an integrated approach to the children’s workforce including the development of a core competencies framework. However, the childcare workforce, particularly in the early years, remains low paid and of low status. There are serious concerns about the number of staff available to provide essential early years support. For example, there has been a nearly 13 per cent drop in whole-time equivalent health visitors since 1998 while the number of live births has increased by 8.5 per cent in the same period.<sup>301</sup> There are similar concerns about the availability of qualified and experienced social workers and the number of highly skilled staff working in early years settings. If we are serious about giving priority to supporting families and children in the early years, much more needs to be done to increase numbers and raise the quality and status of the workforce.

This is particularly the case in early childhood education and care settings where quality is key to achieving the best outcomes. There is good evidence that increasing the pay and qualifications in early years settings to match those of equivalent roles in schools can reduce staff turnover and establish the foundations for ensuring that children receive the best early active learning experiences.

### Summary

- Good quality early childhood education has enduring effects on health and other outcomes
- These outcomes are particularly strong for those from disadvantaged backgrounds
- A good quality workforce makes a difference to health outcomes but the childcare workforce remains low paid and low status
- Pre and postnatal policy and services should be integrated.

### Time period: 2011–2015

- 1 Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.
- 2 Support families to achieve progressive improvements in early child development, including:
  - Giving priority to pre and post natal interventions including intensive home visiting
  - Providing paid parental leave in the first year of life with a minimum income for healthy living
  - Giving routine support to families through parenting programmes, children’s centres and key workers, to meet social need via outreach to families
  - Supporting children and families through the transition to school.
- 3 Provide good quality early years education and childcare proportionately across the social gradient. This provision should be:
  - Combined with outreach to increase the take-up by children from disadvantaged families
  - Provided on the basis of evaluated models and must meet quality standards.

### Time period: 2016–2020

- 1 Continue to incrementally increase expenditure on early years development progressively across the social gradient.
- 2 Support families and children to achieve progressive improvements in early years development, including:
  - Continuing to give priority to pre and postnatal support including intensive home visiting
  - Progressively increasing the coverage of paid parental leave in the first year
  - Supporting families through parenting programmes, children’s centres and key workers, to meet social need
  - Maintaining support through the transition to school.
- 3 Progressively increase the coverage of good quality early years education and childcare across the social gradient, including:
  - Progressively improving the quality of the early years workforce.

### Time period: 2020 and beyond

- 1 Maintain the higher level of early years expenditure and ensure it is distributed across the social gradient.
- 2 Support families and children to achieve progressive improvements in early years development.
- 3 Make paid parental leave in the first year available to all.
- 4 Make good quality early years education and childcare available to all.
- 5 Other dimensions of inequality intersect in important and complex ways with socio-economic position in shaping people’s health status.

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# Policy Objective B

## Enable all children, young people and adults to maximise their capabilities and have control over their lives

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| Priority objectives |                                                                                                                                                             |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1                   | Reduce the social gradient in skills and qualifications.                                                                                                    |
| 2                   | Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people. |
| 3                   | Improve the access and use of quality life-long learning across the social gradient.                                                                        |

### B.1 Introduction

To achieve equity from the start, investment in the early years is crucial. However, maintaining the reduction of inequalities across the gradient also requires a sustained commitment to children and young people through the years of education. Central to this is the acquisition of cognitive and non-cognitive skills, which are strongly associated with both educational achievement and a whole range of other outcomes including better employment, income and physical and mental health, as described in Chapter 2. Overall, success in education brings many advantages. If we are serious about reducing both social and health inequalities, we must maintain our focus on improving educational outcomes across the gradient.

Inequalities in educational outcomes are as persistent as those for health and are subject to a similar social gradient, shown in Chapter 2. Despite many decades of policies aimed at equalising educational opportunities, the attainment gap remains. As with health inequalities, reducing educational inequalities involves understanding the interaction between the social determinants of educational outcomes, including family background, neighbourhood and peers, as well as what goes on in schools. Indeed, evidence on the most important factors influencing educational attainment suggests that it is families rather than schools that have the most influence.

Therefore, schools alone cannot address educational inequalities but they clearly do play an important role in the lives of children and young people. This role extends beyond educational attainment: schools and families together are important for promoting the development of children – physically, socially and emotionally as well as cognitively. Education is not just about attainment: it should also enable children to develop their personalities, talents and abilities, to build resilience, self esteem and to live a full and satisfying life.

Learning does not just happen in schools and it does not stop when we leave school. To enable people to fulfil their potential, opportunities for lifelong learning and skills development need to be promoted, not only in formal educational settings, but also in the workplace and in communities.

## B.2 Recommendations

### B.2.1 Reduce the social gradient in educational outcomes

**Recommendation:** Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority.

There is strong evidence that educational achievement leads to a range of positive outcomes, including good health. Prerequisite to such achievement is the acquisition of both cognitive and non-cognitive skills, particularly in early childhood. It is therefore crucial that reducing inequalities in skills development and educational achievement across the gradient remains a top priority objective.

Although the most recent data available from the Department for Children, Schools and Families does show some improvement, as we showed in Chapter 2 serious inequalities persist, despite many years of policy initiatives and investment aimed at narrowing the achievement gap.

Much of the policy focus has been on schools, and clearly school improvement is important. However, many of the influences on educational outcomes are outside the control of schools. Only around 10–20 per cent of the variation in educational attainment between different pupils can be explained by differences between schools and even less variation in other outcomes, such as well-being, can be explained by schools.<sup>302</sup> Just as we cannot hope to reduce health inequalities just by changing the NHS, similarly we cannot radically impact on education inequalities just by intervening in schools.

Other policy initiatives have focused on specific disadvantaged groups, responding to the evidence that some groups of pupils have particularly poor educational outcomes. Such targeted interventions may be important for raising the attainment of some individuals or groups, but have not succeeded in reducing inequalities across the gradient. This leads us to propose that greater emphasis needs to be given to the wider social determinants of educational attainment and wider social inequalities. Family and community-based factors, including material inequalities, are key to both education and health.

#### Summary

The acquisition of cognitive and non-cognitive skills is strongly associated with educational achievement and a range of other outcomes including better employment, income and physical and mental health.

- The focus on improving educational outcomes across the gradient is crucial to addressing health inequalities.
- Educational inequalities persist.
- Addressing inequalities in education requires action outside of schools.
- Proportionately targeted interventions to meet the needs of disadvantaged groups are needed.

## B.2.2 Reduce the social gradient in life skills

**Recommendation:** Prioritise reducing social inequalities in life skills through:

- 1 Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
- 2 Consistent implementation of the full range of extended services in and around schools
- 3 Developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and well-being.

There is considerable evidence that inequalities in educational achievement emerge very early and that parents' transmission of skill across the generations is crucially important.<sup>303</sup> For example, the mother's education is a good predictor of a child's cognitive abilities at ages three and five.<sup>304</sup> A clear link has been made between parental basic cognitive skills and the skills of their children.<sup>305</sup> This evidence supports the argument for a continued emphasis on early education as a key policy priority, accompanied by family-based interventions to support parents to develop their child's learning, as well as a continued emphasis on the development of parents' own basic skills through lifelong learning.

The evidence strongly supports the economic efficiency of early years investment that is sustained through the primary school years. Later remediation is possible but it has been estimated to cost 40 per cent more to attain later what can be accomplished by early investment.<sup>306</sup> The impact of investment in the pre-school years is likely to evaporate unless it is sustained through school, particularly through the years of primary education. Children who fail to acquire basic skills in the primary years are likely to fall further behind, as success in later stages of education relies on literacy and numeracy as well as on non-cognitive life skills.

The strength of this evidence supports the argument that priority should be given to early cognitive and non-cognitive development, starting in the early years and continuing through childhood. It is crucial that effective early programmes are followed through with effective provision in the primary years: even the most effective early years interventions can be 'washed out' by poor quality primary education. Success in learning at school is rooted in the stimulation and encouragement a child receives at home, in the family and in the community. Where parents have not gained these skills themselves, disadvantage is passed from one generation to another. School-based interventions need to be linked to work with parents, the family and the community, with an emphasis on enabling parents to support their child's cognitive development and life skills.

Families assessed as in need of progressively intensive support in the early years should continue to be provided with help throughout the transition to school. This transition can be difficult for many

children, with those from disadvantaged backgrounds in particular often coping poorly with the move to a more formal approach to learning. Even the best primary schools struggle with an intake of children who lack 'school readiness', that is, those whose behaviour stops them from learning and/or who lack the necessary communication and social interaction skills, as described in Chapter 2.

Specific interventions such as Reading Recovery (see case study below) have an important role in providing additional support to children who have literacy difficulties. Given the clear links between literacy and other educational outcomes, it is important to maintain support for such well evaluated programmes. However, it is equally important to implement these specific programmes in the context of a holistic approach to children's education.

Strategies in the primary years need to keep involving the whole family.

Integral to this approach is the need to work across school-home boundaries and the provision of a range of extended services around schools to families and communities in their area. The Extended Schools initiative was launched in 2005, as a key vehicle for delivering the Government's objective of lifting children out of poverty and improving outcomes for them and their families.<sup>307</sup>

Subsequently, the terminology has changed to 'extended services' or 'extended services in and around schools', a change that places greater emphasis on the idea that schools, usually working together in clusters, should provide access to a range of services locally, whether delivered by the school and on school premises or not. All schools were required to make a 'core offer' of extended services by 2010, and many are already offering an array of such services. The 'core offer' includes access to a range of activities, childcare in primary schools, community access to school facilities, swift and easy referral to specialist services and parenting support.

An evaluation published in 2007 highlighted positive early findings from full-service extended schools. The evaluation reported that these schools were impacting positively on the attainment of pupils, particularly those facing difficulties, and were having a range of other impacts on outcomes for pupils, including engagement with learning and family stability. Full-service extended schools

typically experienced improved school performance, better relations with local communities and an enhanced standing in the area.<sup>308</sup> In the light of such evidence, it is important to continue to embed the development of extended services in and around schools in mainstream practice. There is an important opportunity for schools to play a bigger role in providing resources to families and communities and ensuring a whole-child approach is taken that pays attention to physical and mental health and the ongoing acquisition of non-cognitive skills.

This type of approach has implications for the workforce mix in schools, which will increasingly need more professional non-teaching staff with skills in, for example, enabling children's play and young people's self-directed leisure and in working across school-home boundaries to help parents to encourage and support their children's learning. It also has implications for the role of schools as commissioners of services to provide a broader range of support to families and children both in and out of school.

As guidance from Play England shows, play forms a vital part of a happy childhood, as well as being important for children's ongoing and future well-being.<sup>309</sup> Play may help to combat childhood obesity by increasing activity levels; aid children's mental and emotional responsiveness; improve their social skills; and promote their resilience. Play also helps children to develop learning and problem-solving skills, key to their ability to achieve in school and in later life.<sup>310</sup> As part of their extended services, schools have an important role in maximising the value of play and leisure activities for child development.

One of the tenets of education is that children learn more and better when they enjoy it. The final report of the Independent Review of the Primary Curriculum highlighted the importance of play and proposed extending and building on the active, play-based learning of the Early Years Foundation Stage across the transition to primary education, especially into Key Stage 1.<sup>311</sup> Opportunities for play are an important feature of after-school provision as part of the varied menu of activities and the childcare elements of the core offer of extended services, which all schools were required to provide by 2010.<sup>312</sup>

The considerable amount of time children and young people spend in school means that schools have the potential for fulfilling an important role in

### Case Study Reading Recovery

Evaluations of specific early literacy interventions such as Reading Recovery (implemented in England through the Every Child a Reader programme) have shown positive findings. Children participating in Reading Recovery are shown to make significantly better progress than children receiving alternative interventions.<sup>313</sup>

An economic analysis of the benefits of Every Child a Reader by KPMG estimated that the

scheme could offer a return of more than £17 in the next 31 years for every £1 spent now, based on the estimated costs of problems associated with poor literacy such as truancy and poor employment prospects.<sup>314</sup>

Maintaining support for programmes that are well evaluated is key to realising a reduction in health inequalities in educational outcomes.

promoting the health and well-being of children and young people and laying the foundations for healthier outcomes in adulthood through school-based health programmes.

Interventions to address health through schools fall into two main types: specific programmes delivered in educational settings, and targeted on particular health outcomes, and/or particular groups of learners for example, focusing on drug misuse, mental health, teenage pregnancy, or obesity. The second type can be broadly termed ‘environmental’ interventions, aimed at creating school environments that have characteristics held to produce better health outcomes. In practice, the distinction between environmental and programmatic approaches is often one of emphasis, with some combination of the two present in some instances.

There is some evidence that targeted health programmes in schools can have significant impacts on certain health outcomes. A review of the international evidence suggests that the evidence is strongest in relation to school-based programmes targeting mental health, healthy eating and physical activity.<sup>315</sup> This review of the effectiveness of targeted interventions aimed at promoting the mental well-being of children aged 4–11 suggested that anxiety prevention programmes based on Cognitive Behavioural Therapy can be effective. Brief interventions worked better for emotional problems than for conduct problems. Multi-component programmes showed positive effects in social problem solving and the development of positive peer relations. However, the review also concluded that having more than one condition at the same time made intervention delivery difficult and long-term outcome evidence was lacking.

Evidence from the US suggests that social and emotional learning (SEL) programmes improve students’ social-emotional skills, attitudes about self and others, connection to school and positive social behaviour. SEL was also found to improve students’ conduct problems and emotional distress. SEL programmes were found to be effective in both school and after-school settings, for racially and ethnically diverse students, and for students with and without behavioural and emotional problems.<sup>316</sup> In England, the mental health programme SEAL (‘social and emotional aspects of learning’), has been promoted by government, and there is some evidence of positive outcomes.<sup>317</sup> However, reviews of the evidence suggest that the effects of programmes are variable, plus there are problems with the robustness of the evidence base.<sup>318</sup> Most evaluations focus on relatively short-term impacts and it is less clear as to whether or not these are sustained in the long term.

Internationally, there is considerable interest in ‘health promoting schools’ initiatives that support schools in taking wide-ranging action so that they, for instance, develop a formal health curriculum, a health-promoting physical and socio-emotional climate, and health-oriented school-community interactions.<sup>319</sup> Such a combination is currently being attempted in England through the National Healthy Schools Programme, established in 1999, and where the strands include personal, social, health and economic (PSHE) education, healthy eating, physical activity and emotional health and well-being.<sup>320</sup> There are some similarities between initiatives of this kind and school improvement programmes that seek similarly wide-ranging developments in the characteristics of schools associated with better educational outcomes. Indeed, some of

### Case Study Meeting children's emotional needs at school

The Place2Be is a charity working inside schools to improve the emotional well-being of children, their families and the whole school community. The Place2Be provides counselling services to children in some of the UK’s most deprived neighbourhoods. It is currently working in 155 schools across the UK in 17 regional hubs, making services available to over 50,000 children.

Along with those experiencing everyday worries about friendships and football teams, counsellors regularly see children who lash out or self-harm; children who have witnessed stabbings or violent gang initiations; children living with parental drug or alcohol misuse. The Place2Be provides one-to-one and group counselling services to help children to make sense of their experiences, to cope and make better-informed decisions about their lives, enabling them to learn more effectively and to move through school with growing prospects rather than growing problems.

The organisation has an in-house research and evaluation team working closely with an advisory committee of external academics. All children taking part in one-to-one and group work are assessed at the beginning and end of the intervention using Goodman’s Strengths and Difficulties Questionnaire, an externally-validated tool for assessing children’s emotional and social difficulties. Results show that, for most children, there is a significant improvement between their entry and exit scores – with 71 per cent showing improved total difficulties scores after engaging with the service according to parent ratings, and 60 per cent showing improved scores according to teacher ratings.<sup>321</sup>

Providing this type of emotional support and helping to build resilience in children should be mainstreamed and offered in every school and is key to a successful extended school.

For more information see [www.theplace2be.org.uk](http://www.theplace2be.org.uk)

the characteristics of health-promoting schools are themselves similar to those that seem to make schools educationally effective.<sup>322</sup>

There is some evidence that health-promoting schools can have positive impacts. The nature of the school environment seems to have an impact on health outcomes for pupils and there is evidence that it is possible for schools to change in ways that can impact on health-related behaviours, knowledge and attitudes.<sup>323</sup> The evidence informing and emerging from the National Healthy Schools Programme in England suggests that well designed, broad-based whole-school approaches to promoting health can have a positive impact on health – as well as on education-related outcomes among children and young people.<sup>324</sup> However, neither the process of school change nor the impact of changed school practices on children is straightforward and it is not clear how far impacts in the school years translate into better adult health outcomes.<sup>325</sup>

### Summary

- A clear link exists between parental cognitive skills and the skills of children.
- When early years investment is sustained through the primary years it has most benefit.
- Children who fail to acquire basic skills in the primary years are likely to fall further behind and have more limited life chances.
- Success at school is rooted in the stimulation and encouragement a child receives at home and in the community. School-based interventions need to link with families and communities.
- Extended services based in schools have a positive impact on pupil attainment and on family stability.
- Play develops life and cognitive skills.

### B.2.3 Ongoing skills development through lifelong learning

**Recommendation:** Increase access to and use of quality lifelong learning opportunities across the social gradient by:

- 1 Providing easily accessible support and advice for 16–25 year olds on life skills, training and employment opportunities
- 2 Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
- 3 Increasing availability of non-vocational lifelong learning across the life course.

Lifelong learning has the potential to impact on health inequalities in two ways. Centrally, but indirectly, it is important for providing the skills and qualifications for employment and progression in work; and directly there is evidence that participation in adult learning in itself impacts on health behaviours and outcomes.

As discussed in Policy Objective C, employment status is closely linked to health, with those in higher status jobs being healthier; and there is a clear relationship between unemployment and poorer health.

Not having qualifications or having only low levels of skills are both associated with lower chances of being employed and being in lower paid work. Gaining skills and qualifications can have an impact on income, although the wage return varies according to both the type and level of qualification obtained. The evidence points to the importance of providing opportunities for people to acquire higher levels of skills and qualifications beyond compulsory education.

In recent decades, investment in post-compulsory learning has been heavily weighted towards the 18–25 age group, as shown in Figure 4.1. Young adults are clearly important recipients of this investment as new entrants to the labour market. However, a large proportion of this overall expenditure goes into higher education which disproportionately benefits middle class young people and those with higher academic attainment. There remain some serious gaps in the provision of vocational skills development for other groups of young people, in particular access to work-based learning routes. As noted in the next section, young people are still the group most likely to be unemployed and to be in low-skilled jobs.<sup>326</sup> Ensuring that young people receive individualised support to gain skills involves starting well before they leave school and maintaining the support through the transitional years from 16–25.

Participation in post-compulsory education has a range of potential benefits relevant to health outcomes. Participation in any form of learning may stimulate further personal development which may provide the opportunity to progress in the labour market, as well as other benefits. For example, acquiring NVQ2 has been shown to increase the likelihood of participating in further accredited learning.<sup>327</sup> There are also consistent findings that adult learning improves confidence<sup>328</sup> and self-efficacy,<sup>329</sup> which have been shown to be positively associated with health behaviours.<sup>330</sup> Adult education has been shown to increase social capital, which is in turn associated with better health.<sup>331</sup>

Analysis of cohorts of adult learners shows that participation in adult learning contributes to positive and substantial changes in health behaviours. For example, the estimated effect of taking one to two courses (of any type) between the ages of 33 and 42 is a 3.3 percentage point increase in the probability of giving up smoking.<sup>332</sup> However, the evidence also seems to suggest that the greatest benefits are gained by those who are already likely to be healthier. If people from lower socioeconomic groups gain fewer health benefits from education than those from higher socioeconomic groups then a general increase in learning activity could widen rather than narrow health inequalities. The conclusion here, then, is that if an aim of policy is to narrow health inequalities through adult learning, it needs to target its attention at those who could benefit most to have the most positive effect.

The Government's White Paper 'The Learning Revolution' outlines its latest plans to further increase the level of lifelong learning in England, but the total funds spent on lifelong learning are not expected to rise. The direction of learning and skills policy

remains focused on those in work, through policies like Train to Gain.

While such a work-based approach may still have beneficial effects on the health of those who newly engage in learning and may even narrow inequalities in health outcomes among the in-work segment of society, it may perversely increase the disparities between those in work and those out of work. Given that the latter include the most socially disadvantaged, non-work-based lifelong learning policies need to be available to the unemployed and economically inactive to have any effect on tackling health inequalities. A comprehensive policy is required that would encourage people not in work to participate in learning activities in greater numbers. This will need to include readily available information and

advice to point people in the direction of learning opportunities.

### Summary

- Participation in adult learning impacts positively on health behaviours and outcomes.
- Gaining skills and qualifications can have an associated impact on income.
- Support and advice over ongoing learning, training, housing, debt, physical and mental health and relationship concerns is particularly important for the 16–25 age group, who miss out on many other forms of help and support.
- Adult learning improves confidence and self-efficacy, increases social capital and leads to positive and substantial changes in health behaviours.

## B.3 Policy Recommendations

### Time period: 2011–2015

- 1 Prioritise reducing social inequalities in pupils' educational outcomes.
- 2 Prioritise reducing social inequalities in life skills by:
  - Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
  - Consistently implementing the full range of extended services in and around schools
  - Developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and well-being.
- 3 Increase access to lifelong learning opportunities across the gradient, by:
  - Providing support and advice for 16–25 year olds on life skills, training and employment opportunities, delivered through centres that are easily accessible to young people
  - Increasing opportunities for work-based learning for young people, including apprenticeships, and for those changing jobs/careers.

### Time period: 2016–2020

- 1 Ensure that the priority in improving educational outcomes is implementing effective interventions to reduce the social gradient.
- 2 All schools should take an extended role in supporting families and communities and take a 'whole-child' approach to education by:
  - Delivering a full range of extended services in and around schools
  - Having the school-based workforce work across school-home boundaries and address social and emotional development, physical and mental health and well-being.
- 3 Further extend access to lifelong learning opportunities across the gradient, by:
  - Maintaining and providing further resources of easily accessible support and advice of 16–25 year olds
  - Further extend work-based learning for young people and those changing jobs/careers
  - Increase availability of non-vocational life-long learning across the life course.

### Time period: Beyond 2020

- 1 Improvements in educational outcomes focused on reducing the social gradient.
- 2 Schools to provide a 'full service' approach in supporting families and communities and take a 'whole child' approach to education.
- 3 Increase the use of lifelong learning opportunities across the gradient, by intensive resourcing of:
  - Easily accessible support and advice for 16–25 year olds
  - Work-based learning for young people and those changing jobs/careers
  - Non-vocational life-long learning across the life course.

# Policy Objective C

## Create fair employment and good work for all

| Priority objectives |                                                                                               |
|---------------------|-----------------------------------------------------------------------------------------------|
| 1                   | Improve access to good jobs and reduce long-term unemployment across the social gradient.     |
| 2                   | Make it easier for people who are disadvantaged in the labour market to obtain and keep work. |
| 3                   | Improve quality of jobs across the social gradient.                                           |

### C.1 Introduction

As the evidence outlined in Chapter 2 shows, being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities. However, jobs need to be sustainable and offer a minimum level of quality to include not only a decent living wage but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from those adverse working conditions that can damage health.

The evidence suggests that policy to reduce the social gradient in employment and working conditions should be focused on two interrelated aims:

- First, to reduce the adversity of working conditions and employment.
- Second, to target interventions proportionately towards lower socioeconomic groups.<sup>333</sup>

The importance of employment and the quality of work is recognised by policy-makers and reducing unemployment in particular has been a primary aim of a range of policy initiatives over the past 15 years. At least some of these have met with some success and potentially improved health among the workforce. In particular, Public Service Agreement 16, on socially excluded adults, sets out the Government’s aim to increase the proportion of socially excluded adults in education, training and employment.

### C.2 Recommendations

#### C.2.1 Active labour market programmes

**Recommendation:** Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment.

Active labour market programmes (ALMPs) seek to integrate the unemployed into work rather than simply providing passive income support to people without work. ALMPs can be classified into several types. There is direct job creation, which is often offered to the long-term unemployed as either a means of preserving good working habits or a work-test for benefit receipt. A second approach is that of direct government subsidies to employers to maintain staffing (wage subsidies), or grants for entrepreneurial start-ups. Third, retraining and reintegration programmes may be offered to increase occupational and industrial mobility among the unemployed. Last, some ALMPs focus on improving the efficiency of the job-matching process, including mobility grants, re-interview programmes, and efforts targeted at groups at risk of long-term unemployment.

ALMPs have become a major feature of both domestic and international labour market policy and social development interventions. OECD countries in particular have extensive experience with ALMPs, often targeted at the long-term unemployed, workers in poor families, and particular groups with labour-market disadvantages. In England they form a core component in the delivery of welfare-to-work policy, the New Deal programmes and broader policies of urban regeneration. The long-term unemployed, young people and lone parents have been the focus of government attention, with emphasis on work as the best route to prosperity and increased social mobility for disadvantaged individuals and communities. Programmes such as the New Deal are used to increase employability and reduce the risk of being unemployed. Interventions include job search assistance and training, as well as wage and employment subsidies, aiming to enhance labour supply and improve the functioning of the labour market.

Particular attention has been given to lone parents through the New Deal for Lone Parents (NDLP), in response to concerns that these parents and their children are one of the most vulnerable social groups in the UK. There are concerns about the exceptionally low rates of employment among lone parents and

a growing consensus that this leads to poverty and social exclusion. The NDLP has since undergone successive reforms towards a more mandatory and tailored system.

So how effective have these initiatives been? The evidence suggests that they have had some success in getting people into jobs. Reductions in overall unemployment from 1997 onwards were clearly partly attributable to sustained economic growth, but the New Deal programmes are believed to have played a contributory role.<sup>334</sup> But in general, most progress was made in the period up to 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.<sup>335</sup> The employment rate of lone parents has increased steadily, from 46 per cent in 1997 to 57 per cent in 2007, albeit not rapidly enough to be on target to reach 70 per cent employment by 2010. There has also been a slow but steady rise in employment and activity rates for disabled people.

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 was 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 2009.<sup>336</sup>

There is also some evidence that ALMPs have contributed to increasing income among recipients, though they have been most effective when combined with other fiscal and benefits measures to ‘make work pay’. For example, since the NDLP and complementary measures have been in place, lone parents in the UK have increasingly moved into employment and relative poverty among lone parent families has substantially declined. The different qualitative and quantitative evaluations and studies carried out to date suggest that the implementation of active labour market programmes, New Deal for Lone Parents and New Deal Plus for Lone Parents, combined with measures to make work pay through the Work Family Tax Credits (WFTC), partly account for this positive trend.

Evaluations of ALMPs, and the government training programmes used to deliver them, have mostly examined labour market outcomes such as earnings, re-employment opportunities and the cost effectiveness of programmes. This is clearly important for health inequalities: if ALMPs can be shown to improve participants’ basic skills and education, thereby increasing their potential for entering the labour market and securing employment, the indirect health benefits could be very significant. However, there is less evidence, particularly from the UK, on how these policies and social interventions directly affect the quality of life, in particular the health and well-being, of those they intend to help. The evidence that is available suggests that participation in ALMPs, specifically government training programmes, can have a positive effect on the psychological health and subjective well-being of the participants compared with unemployed people not involved in an ALMP.

Making a substantive claim for the potential of ALMPs to reduce health inequalities more broadly is problematic given the individualised and context-specific nature of the evidence available. For example, the effects of ALMPs seem to vary according to a range of individual factors, including the initial attitude of participants to work, or ‘job readiness’, and the effectiveness of their allocated adviser. However, the evidence does suggest that health improvements can occur via participation in ALMPs, despite material circumstances remaining poor, via psychosocial mechanisms such as increased social contact, social support, and generating feelings of control and self-worth.

There is also good evidence that ALMPs can have significant benefits for people with mental health difficulties. Employment for people with a range of mental health conditions can promote both recovery and social inclusion by providing routine, purpose, income, social interaction and self-confidence<sup>337</sup> and there is evidence that those with long-term mental health problems can return to paid work with appropriate support.<sup>338</sup> A Europe-wide trial of Individual Placement and Support (IPS), a vocational rehabilitation model that provides individuals with support to find and sustain open employment, reported positive results. During an 18-month follow-up period, over 50 per cent of those with a severe mental illness who received IPS worked at least one day compared with only 28 per cent of those who did not.<sup>339</sup>

This adds to the body of evidence that vocational rehabilitation services, particularly IPS, can significantly increase rates of employment in those with a mental illness.<sup>340</sup> This evidence has been reflected in the New Horizons programme, launched in December 2009 as a cross-government programme of action to help improve everyone’s mental well-being, and the services that provide mental health care.<sup>341</sup> A national mental health and employment strategy was also launched in December 2009, designed to improve well-being at work for everyone, and to deliver significantly better employment results for people with mental health conditions.<sup>342</sup>

Overall, it can be concluded that active labour market programmes to assist disadvantaged groups to move into employment have been successful when measured by the relatively short-term indicators currently available. However, there is a need to further investigate the longer-term impacts of these programmes. Issues such as job retention, progress in the labour market, the net effect on income, and specific health outcomes have not been a priority in research and evaluations so far.

### Summary

- Unemployment and particularly long-term unemployment has significant impact on physical and mental health.
- Being in good work protects health.
- ALMPs should intervene early and work best when combined with other fiscal and benefits measures.
- ALMPs can lead to health improvements, particularly benefits for mental health. More research is needed to better understand their impact.

## C.2.2 The development of good quality work

**Recommendations:** Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of work across the social gradient by:

- Ensuring public and private sector employers adhere to equality guidance and legislation
- Implementing guidance on stress management and the effective promotion of well-being and physical and mental health at work.

Develop greater security and flexibility in employment by:

- Prioritising greater flexibility of retirement age
- Encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

As we have already noted, creating jobs is not sufficient to impact on health inequalities. Just as important is the creation of ‘good jobs’. There are 10 core components of work that protects good health and promotes health. Good work is:<sup>343</sup>

- Free of the core features of precariousness, such as lack of stability and high risk of job loss, lack of safety measures (exposure to toxic substances, elevated risks of accidents) and the absence of minimal standards of employment protection.
- Enables the working person to exert some control through participatory decision-making on matters such as the place and the timing of work and the tasks to be accomplished.
- Places appropriately high demands on the working person, both in terms of quantity and quality, without overtaxing their resources and

capabilities and without doing harm to their physical and mental health.

- Provides fair employment in terms of earnings reflecting productivity and in terms of employers’ commitment towards guaranteeing job security.
- Offers opportunities for skill training, learning and promotion prospects within a life course perspective, sustaining health and work ability and stimulating the growth of an individual’s capabilities.
- Prevents social isolation and any form of discrimination and violence.
- Enables workers to share relevant information within the organisation, to participate in organisational decision-making and collective bargaining and to guarantee procedural justice in case of conflicts.
- Aims at reconciling work and extra-work/family demands in ways that reduce the cumulative burden of multiple social roles.
- Attempts to reintegrate sick and disabled people into full employment wherever possible by mobilising available means.
- Contributes to workers’ well-being by meeting the basic psychological needs of experiencing self-efficacy, self-esteem, sense of belonging and meaningfulness.

A range of evidence on the most effective interventions to create better work is summarised below.

### C.2.3 Reducing physical and chemical hazards and injuries at work

Employers have a responsibility to comply with legal requirements and to provide qualified personnel to monitor and control conditions of work. Successful implementation requires the laws to be sufficiently robust, the enforcement agencies to be adequately

### Case Study Improving lifelong learning opportunities for low-paid workers

In Northern Ireland, the union UNISON has developed a partnership programme with Health and Social Care Trusts and the Open University. Staff from across disciplines in health and social care are eligible, including those working in direct care provision, administration, catering, cleaning, security and labs. The programme aims to support health and social care staff to improve their practice, develop knowledge and skills and to award them with a qualification that would support them to improve their skills and job possibilities.

The academic course engages learners who may never have considered university study an option for them. Approximately 70 per cent of those coming onto the programme left school with fewer than five O’Levels/GCSEs. UNISON developed a study skills course and an exam preparation day as part of the programme and negotiated release for staff to attend tutorials. Additional support

was put in place for learners with dyslexia and close contact between UNISON and the Open University during each course ensured that extra support could be provided for learners if needed. This has resulted in a much higher retention rate than the UK average.

Participants have used the course to enter preregistration nurse training, gain job promotions (for example, a kitchen stores worker [band 1] applied and succeeded in gaining a position as a rehab worker [band 3]) and pursue further study with the Open University towards a full degree.

The partnership has supported over 500 low-paid workers to access the level 4 Health & Social Care certificate, which awards 60 credits towards a degree.

For more information see [www.ulearnni.org](http://www.ulearnni.org)

resourced and the legal framework to be sufficiently clear to enable prosecutions to succeed – for example, the limited successful use of recent corporate manslaughter legislation in England. As an essential prerequisite, an unambiguous and comprehensive risk assessment has to be established. In the UK, the Health and Safety Executive (HSE) has developed the necessary tools and procedures and has responsibility for implementation.<sup>344</sup> A recent extension includes the assessment of a stressful psychosocial work environment (see below).

A further challenge concerns the prevention of injuries and accidents at work. The legal and organisational measures undertaken by occupational cooperatives in Germany over the last century have been particularly successful. For instance, over a period of 40 years, from 1960 to 2000, the number of work-related accidents was reduced from 140 per 1000 employees to 40 per 1000 employees. Major measures included improved monitoring and documentation of accidents, systematic implementation

of safety measures performed by a well-trained new professional group (safety experts), such as instruction-related or technological innovations, and comprehensive legal regulations protecting vulnerable groups. As several low status occupations were at increased risk, such as construction workers, wood and sawmill workers, farmers and agricultural workers, they had the largest health gain.

More recently, a nationwide campaign against falls at work was launched in Germany, where public personalities from sport and films served as role models to reinforce appropriate behaviour. This approach had previously been shown to be effective among less educated occupational groups. Among occupations involving frequent physical mobility (for example, using stairs frequently or involving heavy lifting or dragging), falls were reduced by 15 per cent during the two-year campaign.<sup>345</sup> Another trial with relevance to injury prevention, conducted in the US, concerned increased autonomy at work. Particularly relevant for manual workers, this study

### Case Study A great place to work

Artizian is a medium-size catering company with contracts held nationally. It employs 350 people and 30 per cent of its staff work part-time or are casual workers. It provides fresh-food catering in restaurants of blue-chip companies. Artizian has a strong belief in a shared company vision, integrating employees' views into its work strategy, and making all senior management known to all workers, keeping them visible and seen to work. The company's motto, which it seeks to share with all of its employees, is to 'eat, work and enjoy every day'.

In 2009 Artizian won the Health, Work and Well-being award at the National Business Awards. It was rewarded for improving the health and well-being of its workforce in a way that also benefits the organisation. Artizian has also received health and safety awards because of its low level of accidents. It offers yearly health and safety training for all staff, rather than the statutory requirement of training every three years. Artizian provides all new staff (at all levels) with two days' induction and in the catering industry where employers have to take over existing employees when winning a new contract, this means providing training to employees who may have had little, if any, previous training.

Artizian has highly visible policies on stress at work and seeks to ensure that staff are aware that their health will be a priority. For example, it provides return-to-work interviews for those returning from long-term illness. While the company cannot afford an occupational health therapist, it employs a consultant and a nutritionist to monitor sickness and provide advice to staff. Its sickness benefits are comparable (or lower) than similar companies' benefits. Artizian finds its staff do not use these

benefits, instead depending on other forms of support it offers. It has a low staff turnover at all levels, from management to kitchen porters.

Artizian attributes the main elements of its success in retaining staff and the low level of absence due to sickness to:

- Providing learning and development opportunities for staff at all levels, including alternatives to formal external training when budgets are tight.
- Committing to its values, even when times are difficult: it looks after redundancies and does not cut the training budget.
- Liaising with GPs (with the employee's permission) to provide support to the employee with their health and health care to get people back to work.
- Consulting with staff and going beyond formal statutory requirements, for example, running a regular 'gossip' session for staff, allowing staff to informally voice their concerns.
- Rewarding the 'employee of the month' with a day off.
- Recruiting staff who hold similar values to the company and training managers to understand the company's values and its benefits.

Artizian's methods demonstrate that there are inexpensive methods to meet their employees' psychosocial needs and provide a healthy workplace. Its efforts have led to being rewarded not only with the National Business Award, but also with low sickness levels and low staff turnover.

For more information see [www.artizian.co.uk](http://www.artizian.co.uk)

found that increased control over the pace of work had a protective effect on the risk of occupational injury.<sup>346</sup> Importantly, organisational commitment, mainly from managers, and self-managing work teams, where feasible, reinforced this effect.

A recent Europe-wide project on the impact of safety representatives on reducing occupational health hazards concluded that having trade union representation in the assessment and control process leads to better compliance with the rules, lower accident rates and fewer work-related health problems.<sup>347</sup>

### C.2.4 Shift work and other work-time factors

The current available evidence does not suggest that restructuring the work schedules of manual shift workers will achieve large reductions in social inequalities in health. However, it does indicate considerable room for improvements of work-time organisation in daytime work, as follows:

- Given the health-adverse effects of long working hours, overtime and excessive work, hours need to be controlled more systematically, particularly in jobs where legislation is often not strictly applied.
- The implementation of rest breaks is desirable, particularly in jobs with a fast pace, work pressure, multiple interruptions and monotony. Rest breaks have been found to reduce the risk of injury.<sup>348</sup>
- Individual work-time control, for example with regard to flexitime or time banking, was shown to reduce sickness absence, specifically among employed women, and to moderate adverse effects of psychosocial stress at work on sickness-related absence.<sup>349</sup>

### C.2.5 Improving the psychosocial work environment

Several recent systematic reviews have summarised current evidence on health effects following improvements of the psychosocial environment.<sup>350</sup> A majority of intervention studies have addressed behavioural changes, especially stress management programmes, while fewer have tested the effects of changes in the work environment. Several conclusions can be drawn from these reviews:

- Relatively consistent results were obtained on the positive effects on mental health and, where available, sickness absence from interventions that increased participants' job control and degree of autonomy at work.<sup>351</sup> There is less evidence for the positive effects of reducing demands or augmenting social support.<sup>352</sup>
- Interventions that worked well were characterised by a participatory approach involving employee representatives and management personnel, for example in the form of 'problem-solving committees' or 'health circles'.<sup>353</sup>
- Increasing task variety as part of the job and strengthening team working resulted in inconsistent and at best modest improvements in health. Similarly, introducing more autonomous production groups in factory-based mass production did not show the desired effects on health.<sup>354</sup>

- Work-related burnout and psychobiological stress reactions were significantly reduced by reward-enhancing measures based on organisational and personnel development, including leadership training.<sup>355</sup>

There is emerging evidence that the combined effects of making changes to the setting-focused work environment and employee-focused mechanisms for coping with adverse work are stronger and more sustainable than their separate effects.<sup>356</sup> Thus, tailoring organisational interventions to specific subgroups or contexts provides an effective approach to achieving intervention goals.

Several studies indicate that combining change to the work environment with healthy lifestyle interventions in employees increases the probability of them adopting health-promoting behaviour. This is the case not only in white-collar employees, but also in skilled blue-collar workers.<sup>357</sup> The latter results are relevant in view of the well-documented steep social gradients in health-adverse behaviours and of the potential for preventive gain by reducing them.

Health-promoting psychosocial work environments have been shown to improve return to work in the chronically ill and particularly in people with mental health problems, so preventive and rehabilitative efforts need to be strengthened.<sup>358</sup> In addition, there is a strong business case in terms of sickness absence reduction and productivity gain for introducing such measures, in particular the Individual Placement and Support Models.<sup>359</sup>

In conclusion, despite the paucity of intervention studies directed at the work environment and the methodological limitations of many of them, there are some promising first results that illustrate the potential health gain that could be achieved by improving the psychosocial quality of work environments. Lack of control and lack of reward at work have been shown to be critical determinants of a variety of stress-related disorders and to be more prevalent among lower occupational status groups. Focusing interventions around these dimensions and targeting less privileged groups within the workforce is a high priority. The evidence suggests that structural (mainly organisational and workplace-related) and personal (mainly behavioural) interventions may improve the health and well-being of exposed groups within the workforce.

Obviously, there are many obstacles to promoting and expanding good work. For instance, labour market constraints may prevent any rapid decrease in low-skill jobs and the current economic crisis may undermine efforts towards establishing regulatory control on downsizing, subcontracting and outsourcing. However, a large 'unused' potential for developing and expanding 'good' working conditions exists in all advanced and rapidly developing economies where the benefits of implementing 'good' work include medium-term and long-term increases in return on investment, enhanced productivity, health and commitment of workers, and reduced costs related to sickness absence and work compensation claims.

### Summary

- Good work is characterised by a living wage, having control over work, in-work development, flexibility, protection from adverse working conditions, ill health prevention and stress management strategies and support for sick and disabled people that facilitates a return to work.
- Both the psychosocial and physical environments at work are critical.
- Lack of control and lack of reward at work are critical determinants of a variety of stress-related disorders and more prevalent among lower occupational status groups.
- Combining work environment change with healthy lifestyle interventions in employees increases the probability of them adopting health-promoting behaviour.
- Preventive and rehabilitative efforts need to be strengthened, as health-promoting work environments improve return to work.

## C.3 Policy Recommendations

### Time period: 2011–2015

- 1 Develop active labour market programmes to achieve timely interventions to reduce long-term unemployment.
- 2 Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of work across the social gradient, including:
  - Ensuring that public and private sector employers adhere to equality guidance and legislation
  - Implementing guidance on stress management and the effective promotion of well-being and physical and mental health at work.
- 3 Develop greater security and flexibility in employment by:
  - Improving flexibility of retirement age
  - Encouraging/incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

### Time period: 2016–2020

- 1 Make wider use of active labour market programmes to intervene early to reduce long-term unemployment.
- 2 Improve implementation of measures to improve the quality of work across the social gradient by:
  - Improving job security built into employment contracts and ensuring employers adhere to equality legislation
  - Extending stress management and the effective promotion of well-being and physical and mental health at work.
- 3 Extend greater security and flexibility in employment by:
  - Continuing to improve flexibility over retirement age
  - Widening availability of jobs suitable for lone parents, carers and people with mental and physical health problems.

### Time period: 2020 and beyond

- 1 Use active labour market programmes to achieve timely interventions to reduce long-term unemployment.
- 2 Continue to implement measures to improve quality of work across the social gradient, including by:
  - Building job security into employment contracts and monitoring employers' adherence to equality legislation
  - Monitoring stress management and the effective prevention of physical and mental health problems at work.
- 3 Continue to achieve flexibility in employment by providing:
  - A tax and benefits system that promotes flexibility of employment
  - Jobs that are suitable for lone parents, carers and people with mental and physical health problems.

## Policy Objective D

### Ensure healthy standard of living for all

#### Priority objectives

- 1 Establish a minimum income for healthy living for people of all ages.
- 2 Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
- 3 Reduce the cliff edges faced by people moving between benefits and work.

#### D.1 Introduction

Having enough money to lead a healthy life is central to reducing health inequalities. The Commission on Social Determinants of Health (CSDH) showed that poverty and low living standards are powerful determinants of ill health and health inequity.<sup>360</sup> The generosity and coverage of established social protection systems and the way they are administered have important implications for a nation's health.<sup>361</sup> This policy objective aims to address the situation of the worst-off and, at the same time, the role of the tax/benefit system in perpetuating inequalities.

Since the 1980s, UK tax policy has been based on work incentives, wealth creation and enterprise; however, these policies frequently have not benefited the poorest in society. In fact, as Figure 4.3 shows, the overall impact of direct and indirect taxation does not achieve any redistribution of gross income across the income gradient. Redistribution, as was indicated in Section 2.6.4, is entirely dependent on the benefit system (see Figure 2.36). According to Jones *et al* (2009):

*Direct taxes reduce[d] income inequality and their impact became a little stronger over the period between 1977 and the mid-1990s, remaining fairly constant thereafter. Indirect taxes increase[d] income inequality, and their impact became slightly stronger between 1977 and the early 1990s, then remained relatively constant. [D]irect and indirect taxes had opposite impacts, and even the ways in which those impacts changed over time largely cancelled each other out. The distribution of post tax income was remarkably similar to the distribution of gross income over the last 30 years.*<sup>362</sup>

The progression from original to final income was described more fully in Section 2.6.4.

Since 1997, social inclusion has been a major policy objective of the Government, notably in the form of its commitment to tackling child poverty. In this respect, it has led the way in Europe. However, the proportion of the UK population living in poverty remains stubbornly high, above the EU average and with a worse performance than France, Germany, the Netherlands and the Nordic countries. Employment policy has helped, but the UK welfare state remains inadequate.

Social protection schemes are designed to smooth income flows across the life course and act as a buffer against those times when it is harder to obtain and

maintain secure employment or adequate pay. Ideally, a social protection system offers people the opportunities to maintain a decent standard of living while ensuring that it:

- gives assistance and encouragement to people to remain in work when they experience poor health or other life-changing events such as divorce or new caring responsibilities and facilitates the transition into work or self-employment as their health improves or other responsibilities change
- enables and incentivises people to move into retirement at a pace that reflects their health and wider capabilities
- creates opportunities for people to prepare for alternative careers through access to training and re-skilling
- provides the support required by families when bringing up their children.

However, most current social protection systems, fail to fulfil the above criteria. A first key difficulty is that benefits are inadequate to provide a healthy standard of living or fail to reach those in need. A second key difficulty is that they tend to create a black and white distinction between being reliant and non-reliant on various components of support. The distinction between being in work and out of work is too distinct, leading to a ‘cliff edge’. This cliff edge may discourage people from seeking work or from staying in work with, say, reduced hours if they could otherwise be signed off as ill.<sup>363</sup>

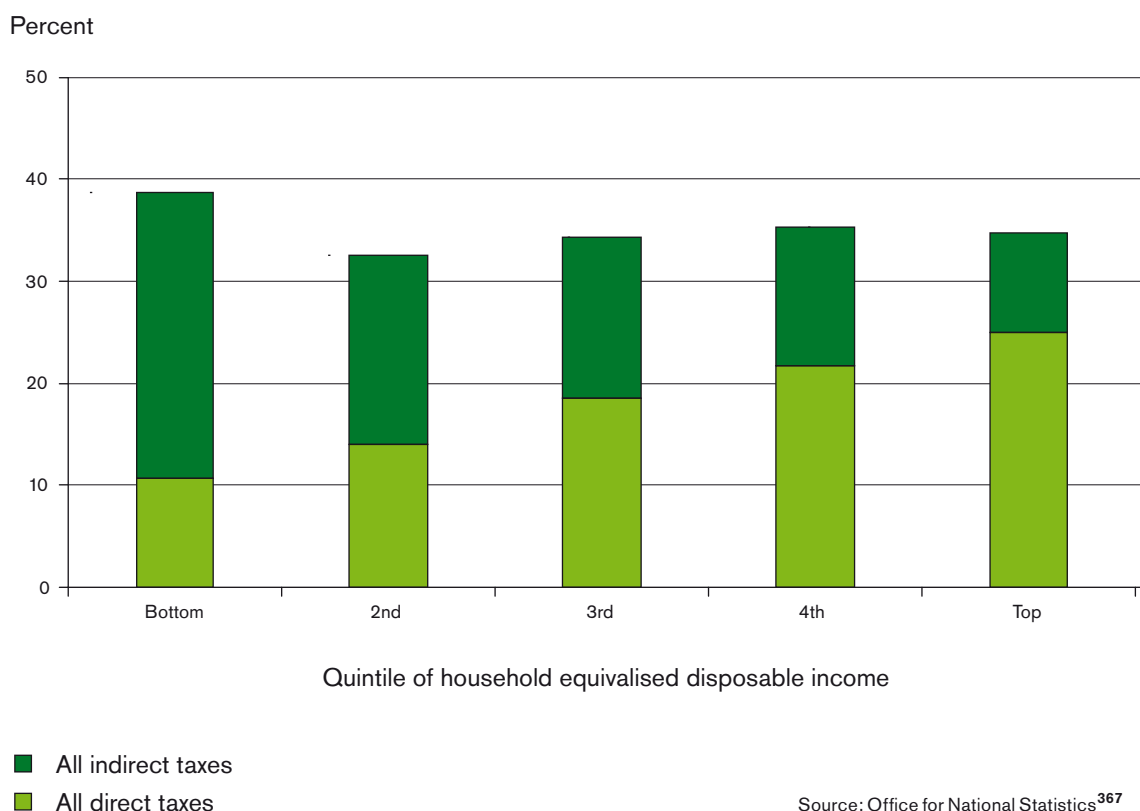
In the UK, as the current benefits system stands, many find their income plus benefits is inadequate to support a healthy life: even maximum entitlements for some benefits fall well short of many individuals and families being able to have a healthy standard of living. The requirements for a minimum income for healthy living are described under Recommendation D.2. This shortfall contributes to social exclusion and associated health risks.

First-time pregnant mothers dependent on Income Support find their level of income particularly challenging. The Government has responded to concerns about pregnant women’s health with a new universal health-in-pregnancy grant. However, pregnant women in receipt of benefits remain vulnerable, especially if they are under 25 and only receive lower age benefit rates for themselves, making it difficult to maintain a healthy standard of living.<sup>364</sup>

In London, successive mayors have accepted the need for a living wage substantially above the minimum wage. While the mayor has no powers to impose an increased minimum wage, set at 16 per cent above the current minimum wage in 2009, the current mayor argues a living wage of £7.60 per hour is ‘morally right’ and helps to retain staff.<sup>365</sup>

In high-income countries where evidence is available, more generous social protection systems are shown to lead to better population health outcomes and to increased life expectancy.<sup>366</sup> Welfare regimes may also differ with regard to their ability to provide a buffer against the adverse health effects

**Figure 4.3** Taxes as a percentage of gross income, by quintile, 2007/8



of economic crises and substantial job instability. There is some evidence that social inequalities in health have tended to remain stable in Nordic states during periods of economic crisis whereas they are widening in European states with both more liberal and conservative regimes.<sup>368</sup>

In England, numerous government policies seek to reduce poverty and improve public services to reduce the wider disadvantage associated with poverty. Policy aims to help people back to work and has concentrated on improving skills, aptitude and motivation, for example, Flexible New Deal, Pathways to Work and Jobcentre Plus. In addition to these programmes and the minimum wage, the introduction of tax credits has increased support for working people on low incomes, but these initiatives have not succeeded in reaching all those who are entitled. As such, more efforts are needed to ensure that all citizens have a sufficient income to live a healthy life.

Alongside policies to improve minimum incomes has been an increase in the conditionality of benefits, now applied to lone parents, those in ill health and with disabilities. Conditionality, the requirement that benefits are dependent on satisfying certain conditions, has been an increasing part of UK policy for over 20 years. A number of problematic areas in the benefits system were identified by the Gregg Report, particularly that the conditionality for those not receiving Jobseeker's Allowance is too strict, as these people often have genuine limitations (for

example, child caring) to working; that there is wide variation in support offered across the country; and that there is a lack of transparency to sanctions. The report argued that conditionality pushes people outside of the benefit system entirely, leading to their disconnection from both work and welfare, and that the system fails to recognise the wider contributions that claimants are making. The Gregg Report recommends support be based on individual *need* rather than the type of benefit received. This method better reflects the reality of the complexity of people's lives.

Conditionality is being used in many other countries and learning from these programmes is being used to pilot programmes in England. The Child Development Grant, started in New York, is currently being piloted in England. In this programme, low-income eligible parents who have not been in touch with Children's Centres will be given £200 if they 'engage or re-engage' with the advice and help available there. Before roll-out of this or other incentive-based programmes, the impact of conditionality needs to be better understood. In 2001–2 over 8,000 claims were disallowed because of the failure to attend a child health clinic, often for valid reasons.<sup>369</sup>

To achieve a healthy standard of living for all will require a minimum income standard that includes health needs as well as reprioritising the tax and benefits system.

**Figure 4.4** Effect of tax credits on taking children in working families out of the low income bracket, 1997–2008

Children in families where at least one of the adults is working (millions)

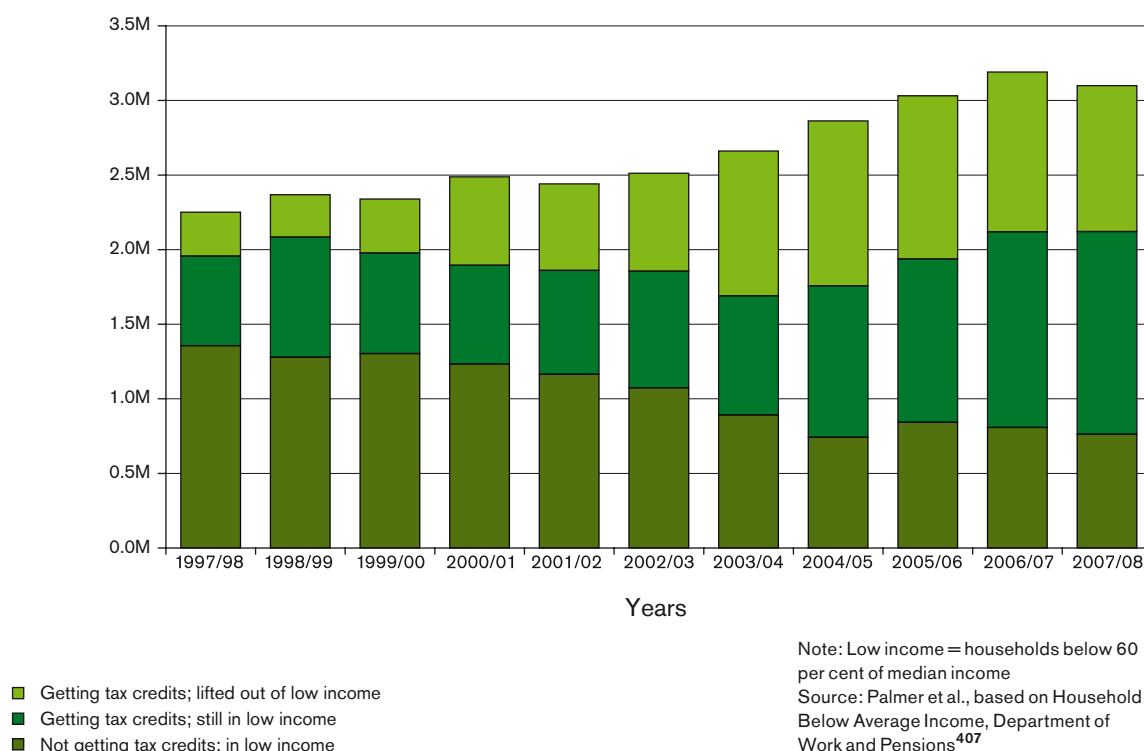




photo: Abbas/Magnum

## D.2 Recommendations

### D.2.1 Implement a minimum income for healthy living

**Recommendation:** Develop and implement standards for minimum income for healthy living.

An adequate and fair healthy standard of living is critical to reducing health inequalities. Insufficient income is associated with worse outcomes across virtually all domains, including long-term health and life expectancy. When governments increase incomes and implement pro-poor family income strategy, the impacts on children's and others' health are significant. Combined measures implemented since 2000, for example the Working Families Tax Credit, increases in income support for children and the minimum wage, have increased the spending of low-income families, improving children's future health and well-being. Family spending by parents living in poverty rose on items like fruit and vegetables, children's clothing and footwear, books and newspapers.<sup>371</sup> Since 1998 tax credits have lifted 500,000 children out of poverty.

The introduction of the Working Family Tax Credit was associated with a reduction in single parents' anxiety and malaise in the period after the onset of single parenthood. Families' improved income had a particular impact on adolescent children in those families and gaps between them and

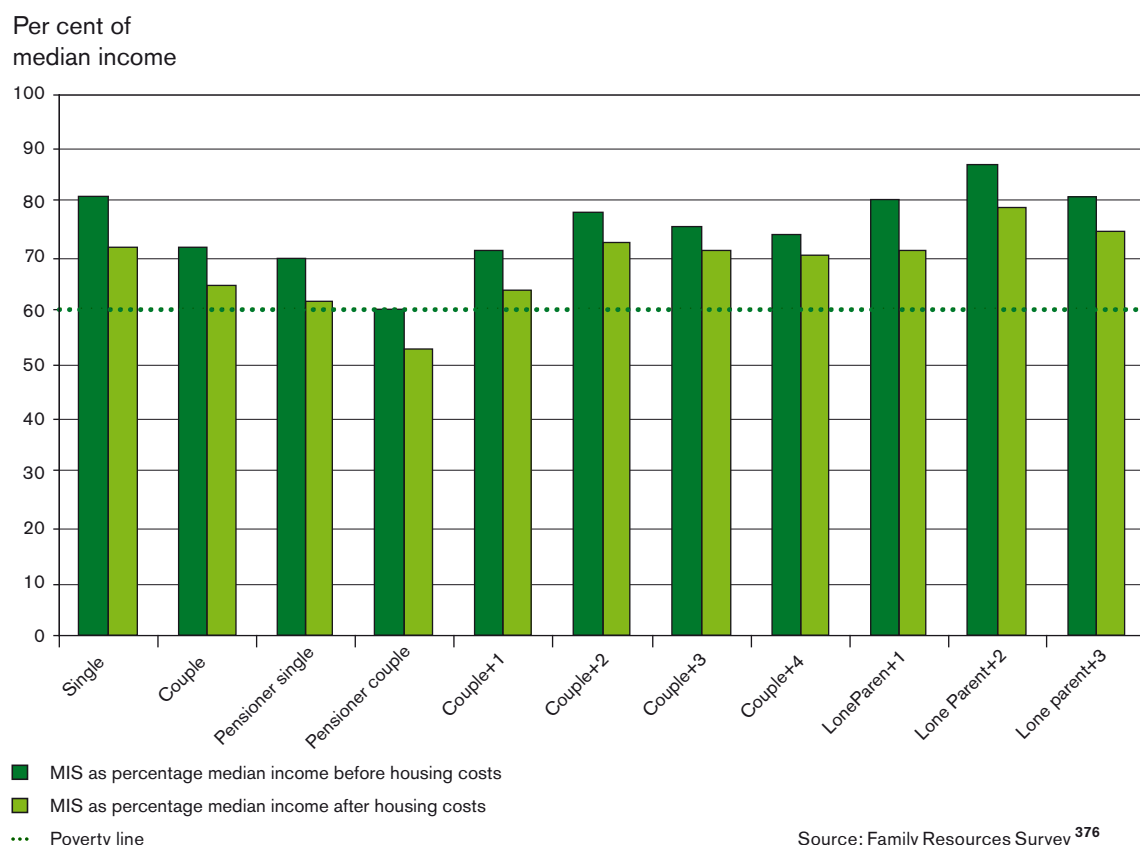
other teenagers' behaviour narrowed. Rates of poor self-esteem, unhappiness, truancy, smoking and the desire to leave school at 16 all halved.<sup>372</sup>

However, the total number living with low relative income (the sum of the first two blocks in Figure 4.4), after falling for a number of years, has begun to rise again since 2003. But these policies need to be maintained; when governments take their foot off this policy accelerator, budget improvements cease and by implication so do their impact on health.<sup>373</sup>

The development of the concept of a minimum income for healthy living (MIHL) was sparked by the absence of health needs in the existing minimum income requirements.<sup>374</sup> The MIHL includes consuming a healthy diet, for example five portions of fruit and vegetables a day, two portions of fish a week; expenses related to exercise costs, for example, the cost of trainers, bicycles and swimming in a local leisure centre; and costs related to social integration and support networks, for example those for telephone rental, television and presents.

A minimum income for healthy living will improve the standard of living for those on low incomes. It would ensure that all would receive an appropriate income for their stage in the life course, and would reduce overall levels of poverty as well as child poverty. A minimum income estimates the level needed to purchase a given basket of goods and services whereas a MIHL is more realistic and accepts that as a society becomes richer, the levels of income and resources that are considered to be

**Figure 4.5 Minimum Income Standard as a percentage of median income, April 2008<sup>375</sup>**



adequate also rise, otherwise the poor do not keep up with the rest of society. As a participant in a discussion held by the Joseph Rowntree Foundation about minimum incomes said, ‘Food and shelter keeps you alive; it doesn’t make you live.’

The calculation for a MIHL includes needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, medical care and hygiene. Using these calculations, there is a deficit between the state pension, supplemented with pension credit guarantee and winter fuel allowance, and the calculated MIHL.<sup>377</sup> Two models of a MIHL were developed. These addressed the needs of healthy young men and older people.

York University has since developed a similar calculation but with wider coverage – the MIS. Like the MIHL, the MIS includes more than food, clothes and shelter; instead it considers what are the sufficient ‘resources to participate in society and to maintain human dignity, consuming those goods and services regarded as essential in Britain’.<sup>378</sup> Based on discussions with both members of the public and experts, York’s analysis concludes that a full-time earner on the minimum wage cannot achieve a minimum income standard and that people of working age without children still receive less than half the amount required, and those with children about two-thirds.<sup>379</sup>

The minimum income approach is an appropriate way to begin to judge what levels of income might be taken as the basis for healthy living.<sup>380</sup> Figure 4.5 shows that in most cases the income ‘needed’ by each family type to have a minimum healthy standard of living is higher than that implied by the poverty line set at 60 per cent of median income, the EU at-risk-of-poverty standard.

The minimum income standard distinguishes different levels of need for people in different circumstances. For pensioner couples or single pensioners the minimum income standard is slightly lower than the poverty line, after housing costs, meaning these groups require less income to subsist than, for example, a couple with two children. For other groups, the current poverty line is below what is recommended as a minimum income standard and thus their incomes need to increase in order to see a related improvement in physical and mental health.

Using the MIS, only two fifths of those with no children meet the MIS income support levels. For couples and single parents with children, income support levels are roughly two thirds of MIS levels and 80 per cent of the poverty line. Whether the MIS or MIHL is used, the striking result is how different the scale is of social ‘protection’ for different groups in the population (Table 4.2).

A MIHL needs regular revision; as stated by the Joseph Rowntree Foundation ‘those goods and services that people on the minimum income spend proportionately more on than average tend to be items whose prices are rising fastest’.<sup>381</sup>

### Summary

- A certain minimum level of income is necessary to lead a physically and mentally healthy life.
- Many people have insufficient income for healthy living.
- Current minimum income definitions do not include health needs.

### D.2.2 Remove ‘cliff edges’ for those moving in and out of work and improve flexibility of employment

**Recommendation:** Remove ‘cliff edges’ for those moving in and out of work and improve flexibility of employment.

Even with numerous systems of support, there remain cliff edges between those in work and out of work with too rapid a fall in support. These affect physical and mental health. Getting rid of the cliff edges means withdrawing benefits more slowly as people move into work and adjust to new ways of living; this is particularly the case for low earners and those working part-time.<sup>382</sup>

Those who move in and out of employment risk falling into poverty, as the benefits system fails to respond rapidly to changing situations. The rules do not reflect how swiftly people’s circumstances change and how medical conditions fluctuate. Loss of work through unemployment or retirement can have a significant impact on household income and health.<sup>383</sup> Many of those who become unemployed

**Table 4.2** Income Support levels in relation to poverty thresholds and Minimum Income Standards, by family type, 2008/9

| Family type                      | % of poverty line | % of MIS |
|----------------------------------|-------------------|----------|
| Single, aged 25, no children     | 50                | 42       |
| Couple, working age, no children | 46                | 42       |
| Couple, 1 child aged 3           | 66                | 62       |
| Couple, 2 children aged 4, 6     | 75                | 62       |
| Couple, children aged 3, 8, 11   | 81                | 61       |
| Single parent, 1 child aged 3    | 81                | 67       |
| Pensioner couple aged 60–74      | 94                | 106      |
| Single pensioner aged 60–74      | 107               | 109      |

Source: Department for Work and Pensions<sup>384</sup>

## Case Study Improving finance and improving health

The relationship between finance and health has been tackled by a number of small projects throughout England and the Citizen's Advice Bureau (CAB) plays a key role in providing many of these services. 37 per cent of the CAB's 2,030 regular outreach projects take place in health care settings. In some areas there is comprehensive financial support delivered in health care settings, but in other areas, there is none. For example, more than half of Derbyshire Primary Care Trust's GP surgeries have regular CAB sessions and in 2008/9, they helped more than 2,050 clients to secure over £2 million in additional benefits. Derbyshire PCT estimates for every £1 invested, the project secured £6.50 in additional income.

In North East Essex the local PCT has developed a local service to offer financial support. The Tendring ReachOut project helps people receive advice and assistance in deprived areas. Instead of waiting for people to come to Jobcentres or ask for advice (as in traditional CAB programmes), ReachOut provides advice and support by knocking on doors, meeting people in the street and at local community venues. It offers support on a range of issues, such as finance, employment, housing, training opportunities and accessing services. The project seeks to address the wider determinants of health, such as low income, poor housing, low education, training or employment opportunities.

ReachOut is a partnership with the local Citizens Advice Bureau, North East Essex NHS, Essex County Council, and the Interaction Partnership.

This ReachOut project is based on one started by Wirral Borough Councils. The original Wirral ReachOut programme aims to increase employment rates within priority wards. The service is also delivered by an outreach team who visit residents directly in their own homes, knocking on doors. The project emphasises employment, training and education for hard-to-reach groups in the local communities. Although there are a

number of services that have a remit of improving the quality of life for the local community, Wirral Borough Councils found a large proportion of the community still do not feel able to access services. The Wirral ReachOut programme has, in three years, knocked on over 83,000 doors, engaged over 160,00 clients on the doorstep, referred 6,000 clients and had over 2,000 people start jobs.

In Salford, the Mental Health Services Citizens Advice Bureau (SMHS) has offered services for over 20 years. SMHS works throughout the community at mental health in-patient units, community mental health centres, offering support by telephone, home visits, outreach sessions, appointments and drop-in sessions. The majority of services are provided via outreach sessions throughout Salford. In addition, they offer support to those in the adult forensic mental health services. They offer assessment, treatment and rehabilitation in conditions of medium security, and provide holistic individual care for patients with multiple and complex needs outside a secure hospital. In 2007-8 SMHS saw 696 clients and had 117,090 contacts with those clients. They helped to write off over £15,000 in debt, secure more than £25,000 in benefit back pay, and increase income through benefits by over £290,000.

These programmes recognise that the tax and benefits systems are complex and those in most need require additional help both to secure benefits and to get back into work. Many of these programmes are offered on a project by project basis and receive short-term funding. Few financial support interventions are mainstreamed into PCT or local authority budgets yet many are consistently effective in improving incomes and reducing debt.

For more information see  
[www.involvenorthwest.org.uk/employment.html](http://www.involvenorthwest.org.uk/employment.html)  
& [www.citizensadvice.org.uk/bureau\\_detail.html?serialnumber=100535](http://www.citizensadvice.org.uk/bureau_detail.html?serialnumber=100535)

or retired face a major drop in their income without a sufficiently graduated system of benefits to enable them to adjust to their changed circumstances. Benefits need to be maintained or withdrawn more slowly to enable and encourage more people into work, particularly those earning low wages or working part-time. For example, recipients of housing benefit and council tax benefit who move into work can be subject to steep marginal deduction rates – up to 85 per cent – and parents or carers of disabled children face even greater disincentives.<sup>385</sup>

Currently, incentives are weakened through some of the tests applied to benefits and tax credits. Over two million workers in Britain would lose more than half of any increase in earnings to taxes and reduced benefits. Some 160,000 would keep less than 10p of each extra £1 they earned. Lone parents face some of the weakest incentives to work of all, and weak incentives to earn more, because many will be subject to withdrawal of a tax credit or means-tested benefit as their earnings rise.<sup>386</sup>

Yet surveys consistently demonstrate that most people want to work but systems stop them. Half of non-working parents said they would work if they could arrange good-quality childcare which was convenient, reliable and affordable, rising to 65 per

cent of those with a household income below £10,000 and 66 per cent of lone parents.<sup>387</sup> Several policies have attempted to ameliorate this anomaly, such as increasing the earnings disregard – the amount of money that can be earned before it is deducted from benefits. However, the earnings disregard acts as a structural barrier to moving people into work. Despite several incentives to work in jobs of less than 16 hours per week, the numbers have changed little.<sup>388</sup>

The lack of flexibility in both the nature of employment and the benefits/tax credit system is a barrier to employment and upwards mobility. This is particularly true for those in lower paid jobs and those working part-time.<sup>389</sup> Recent policies have sought to ameliorate this situation but will need close analysis in order to understand if these changes increase the numbers in work across the social gradient.<sup>390</sup>

### Summary

- There are significant financial cliff edges between being in and out of work, which need to be reduced.
- The benefits system should not act as a disincentive to returning to work.

## Case Study Providing a minimum income and addressing worklessness in East London

The London Borough of Newham (LBN), in East London, has levels of unemployment well above the London and national averages. The Borough recognises the impact that worklessness is having on numerous other indicators such as education and health and as a result, has developed two employment support services to address these needs: the Mayor's Employment Project and Workplace. These two services are locally developed and offer innovative support to help the long-term unemployed to get back to work.

The Mayor's Employment Project (MEP) assists the long-term workless and those who are hardest to help. Established in October 2007, it is aimed at people who have been unemployed for at least three years, residents who have never worked and those who come from workless households. The MEP is delivered by a dedicated set of advisers who offer expert benefit advice and financial support. The MEP offers a guarantee to residents that they will not be worse off in work and the MEP will top up housing benefit for a year if necessary. The team includes a LBN benefit adviser who advises residents of their financial situation after moving into work. They can also offer help in setting up in-work benefits and looking for childcare.

The MEP placed 110 residents into work in its first year and 110 in its second. None of the residents has needed the in-work subsidy as all have been better off in work but the guarantee of a minimum income, alongside the benefit advice,

has proved useful in allaying people's fears when moving into work.

Workplace was developed as a one-stop-shop in May 2007 to support residents in accessing the opportunities available in the local economy. Workplace is based on two sites but also delivered in six hubs and in outreach services such as Sure Start Children's Centres. Designed to help all residents, Workplace seeks to offer a personalised service to meet the individual needs of each client. This includes careers advice, jobs brokerage (construction and non-construction recruitment teams build and maintain links with employers, manage accounts and secure jobs), application support, training (closely aligned to the skills needs of local employers), business start-up and the Mayor's Employment Project.

Workplace also works with a number of partners to offer expert and integrated support on other issues: Jobcentre Plus officers work on site to provide access to their local vacancies and the Citizens Advice Bureau advisers are available on site to help with debt issues and any other concerns.

In its first year Workplace helped 641 people into work against a target of 600. In 2008/9 it placed 1,560 residents into work, beating its target of 900. In 2009/10 Workplace has placed 995 individuals into work against a target of 650.

For more information see  
[www.newhamworkplace.co.uk](http://www.newhamworkplace.co.uk)

### D.2.3 Review and implement systems of taxation, benefits, pensions and tax credits

**Recommendation:** Review and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards.

A more progressive tax and benefit system is needed to create a fairer distribution of income and remove anomalies for those on lower incomes. The current tax credit and benefit system should be fundamentally reviewed to be fairer, work incentives for people on low incomes strengthened and simplicity and certainty for families increased. Recommendations for other policy objectives will also contribute to this goal: for example, reducing the numbers not in work, improving education and skills, encouraging and enabling a longer working life and enabling a higher proportion of the working age population to enter the labour force.

The complexity in the benefit system is partly attributable to the fact that the Government is trying to meet complicated needs and because people lead complex lives. However, the current complexity is unnecessarily worrying to families whose circumstances change week by week.<sup>391</sup> The system needs to

better correspond to people's complex lives, be more inclusive of flexible working and better help people navigate the system. David Freud's review for the Department for Work and Pensions found that '(a) range of international evidence suggests that complexity in the benefit system acts as a disincentive to entering work, and that badly designed systems create unemployment and/or poverty traps.'<sup>392</sup> There has been some improvement of take-up rates under the present system, but an estimated 20 per cent of money due under the Working Tax Credit still goes unclaimed, and 40 per cent of entitled claimants do not take it up.<sup>393</sup>

Numerous suggestions have been made to move to a single system of benefits, including by the Government's own Welfare Reform Green Paper.<sup>394</sup> Support systems need to respond more quickly to external events that have a striking impact in the short term. For example, over the period 2004–2007 older households faced average price increases of 55 per cent for gas and 36 per cent for electricity. In the same period these households increased their fuel spending by an average of 21–22 per cent and reduced their fuel consumption by around 10 per cent.<sup>395</sup>

#### Case Study Addressing financial needs during illness

During certain periods, such as following diagnosis of a serious illness, income can be an unnecessary additional worry. A cancer diagnosis, for example, frequently results in a drop in income as jobs are lost and savings are eroded. Ninety per cent of people affected by cancer in the UK experience a significant drop in income and an increase in daily living expenditure as a direct consequence of a diagnosis.

For many people affected by cancer, financial concerns are a significant cause of stress. Macmillan Cancer Support provides information to support people affected by cancer in the process of claiming the money they are entitled to, or simply to empower them to manage their financial affairs, which can be a complex matter. Many people affected by cancer diagnosis require financial advice and support on a wide range of issues, including employment rights, saving and borrowing, pension rights, fuel poverty, prescription charges, hospital travel costs and insurance, as well as how to access welfare benefits and meet all the extra costs associated with a cancer diagnosis. Services are offered in partnerships with colleagues in NHS, local government, the Pension Service, CAB and other voluntary sector organisations.

Macmillan's projects are dotted across the UK and are not offered as part of a mainstream service.

There are over 60 benefits advisers in England but Scotland has been at the forefront of expanding this service. In Scotland, Macmillan Cancer Support has, over a period of five years, built a network of benefits and financial advice services for people affected by cancer which covers all parts of the country, working in partnership with local government, the NHS and other advice providers. The network aims to reach all of the 27,000 Scots who are diagnosed with cancer each year, and has generated over £30 million in client financial gains for people and their carers. The Scottish Government is currently funding Macmillan Cancer Support to expand the model of in house financial advice services piloted at Beatson West of Scotland Cancer Centre to all of Scotland's tertiary cancer centres (Beatson, Western General, Ninewells, Aberdeen Royal Infirmary and Raigmore) and to pilot extending the cancer model to those with other long term conditions, working with NHS Tayside and NHS Forth Valley. The combined services are expected to provide a total client financial gain of around £5.6 million a year.

For more information see [www.macmillan.org.uk/HowWeCanHelp/FinancialSupport/BenefitsAdvisers/MacBenefitsAdvisers.aspx](http://www.macmillan.org.uk/HowWeCanHelp/FinancialSupport/BenefitsAdvisers/MacBenefitsAdvisers.aspx)

### Summary

- Current tax and benefit structures should be adapted to be fairer with greater work incentives.
- Benefits systems are complex and should improve to better correspond with flexible working patterns.

## D.3 Policy Recommendations

### Time period: 2011–2015

- 1 Develop standards for minimum income for healthy living.
- 2 Review the role of the tax and benefits systems to facilitate adherence to minimum income for healthy living standards.
- 3 Conduct a review of the systems of taxation, benefits, pensions and tax credits to achieve the reduction of ‘cliff edges’ faced by those in and out of work and facilitate flexibility of employment.

### Time period: 2016–2020

- 1 Initiate the coordination of social support, tax systems and minimum wage levels necessary to:
  - Enable full implementation of minimum income for healthy living standards
  - Maintain minimum levels of income for those in and out of work
  - Remove ‘cliff edges’ faced by those in and out of work and facilitate flexibility of employment.
- 2 Prioritise the introduction of tax and fiscal measures that are progressive across the income gradient.

### Time period: Beyond 2020

- 1 Full implementation of minimum income for healthy living standards.
- 2 Extend tax and fiscal measures that are progressive across the income gradient.

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# Policy Objective E

## Create and develop healthy and sustainable places and communities

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| Priority objectives                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div><div>1</div><div>Develop common policies to reduce the scale and impact of climate change and health inequalities.</div></div> <div><div>2</div><div>Improve community capital and reduce social isolation across the social gradient.</div></div> |

**E.1 Introduction**

The health and well-being of individuals is influenced by the communities in which they live. People’s health is affected by the nature of their physical environment; living in poor housing, in a deprived neighbourhood with a lack of access to green spaces impacts negatively on physical and mental health, as described in Chapter 2.

As well as physical places, the communities and social networks to which individuals belong over their life course also have a significant impact on health and health inequalities. The links that connect people within communities, often described as social or community capital, can bring a range of benefits. Social capital can provide a source of resilience, a buffer against particular risks of poor health, through social support and connections that help people find work or get through economic and other difficulties. The extent of people’s participation in their communities and the added control over their lives that this brings, has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes. As the CSDH pointed out, we live, grow, learn, work and age in a range of environments, and our lives are affected by residential communities, neighbourhoods and relational communities and social structures.

The creation of healthy, sustainable places and communities should go hand in hand with the mitigation of climate change and have a shared policy agenda. Access to good quality air, water, food, sport-ing, recreational and cultural facilities and green space all contribute to reducing inequalities as well as helping to create sustainable communities. Policies concerning sustainable places and communities and designed to mitigate climate change prioritise the environment, and should, and sometimes do, include strategies to improve diet, physical activity, and mental health. Aligning the sustainability and climate change agendas can help to frame the way healthy communities and places are created and developed and create conditions that enable everyone to flourish equally, within the limits of finite ecological resources.

Aligning these two agendas requires a conscious effort and will not happen automatically. For example, widening access to green spaces has to occur in all communities, across the social gradient and not just where it might be ‘easy’. Measures intended to respond to climate change must not widen health inequalities.<sup>396</sup> Poorer groups suffer disproportionately from

regressive taxing and pricing regimes. For example, green taxes, fuel consumption taxes and road pricing can be proportionately more expensive for those on low incomes. Any policies to reduce carbon emissions or promote sustainability should carry out a health equity impact so that health inequalities do not increase as a result. If regressive consumption taxes were introduced then a more progressive income tax system should make up for the regressive effects of consumption taxes on the poorest in society.

Numerous policies instigated across several government departments have aimed to improve the quality of community environments, such as: the New Deal for Communities, Bikeability, the London Congestion Charge, The Housing and Regeneration Act, Green Flag Awards, and World Class Places, the Government's strategy for improving quality of place. Yet few of these policies examine their impact on health inequalities and only concentrate on overall improvements to health. For example, campaigns to improve cycling more often aim to increase cycling rates in an area, across the whole population of that area. Only infrequently do they look at reducing the social gradient in cycling. Figure 4.6 depicts the percentage of people cycling each week, by social grade (where A is high) and shows a clear social gradient in cycling rates even as rates increase for everyone from 2006.

Pursuing policies for healthier and more sustainable places and communities involves making choices about how funding is allocated. The Commission for

Architecture and the Built Environment (CABE) estimates that the budget for new road building, £10.2 billion to 2014 for Highways Agency and local authority roads, would, if it were spent differently, provide 1,000 new parks at an initial capital cost of £10 million each. That would enable the creation of two new parks in each local authority in England. Creating 1,000 new parks could save approximately 74,000 tonnes of carbon from being emitted (based on a 10 hectare park with 200 trees).<sup>397</sup> Which choices we make depends on our commitment to building healthy and sustainable places.

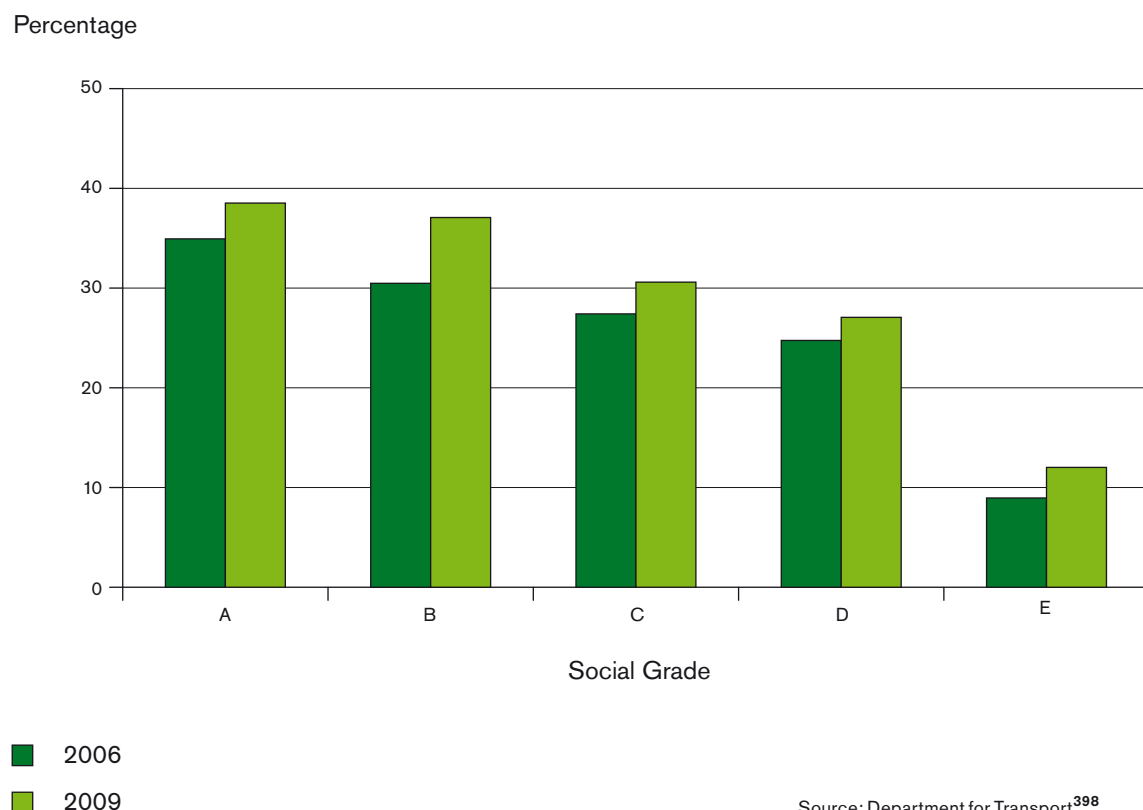
## E.2 Recommendations

### E.2.1 Prioritise policies and interventions that reduce both health inequalities and mitigate climate change

**Recommendation:** Prioritise policies and interventions that both reduce health inequalities and mitigate climate change by:

- Improving active travel across the social gradient
- Improving good quality spaces available across the social gradient
- Improving the food environment in local areas across the social gradient
- Improving energy efficiency in housing across the social gradient.

**Figure 4.6** Proportion reporting any cycling in a typical week in the previous year, by social grade, 2006 and 2009



Climate change is a fundamental threat to health and reducing emissions to mitigate climate change will also make people healthier. As Chan (2009) says, 'Health protection should therefore be one of the criteria by which mitigation measures are judged.'<sup>399</sup>

By 2020 the UK will have to dramatically reduce greenhouse emissions if the country is to succeed in playing its part in tackling climate change. Under the Climate Change Act 2008, the Government has set a legally binding target to reduce UK emissions by at least 80 per cent by 2050, and at least 34 per cent by 2020 (against 1990 levels). The Act also establishes a system of five-year 'carbon budgets', limits on UK emissions that set the trajectory towards these medium and long-term targets. The Government's policy for meeting the 2020 target, in all sectors including electricity generation, homes and communities, workplaces and transport, was set out in the UK Low Carbon Transition Plan, published in July 2009. The Plan also described a system of departmental carbon budgets to ensure all Government departments share responsibility for emissions reduction.

It is important that Government leads by example

in tackling climate change, by reducing its own emissions. Sustainable Operations on the Government Estate (SOG E) is an outcome-focused target to reduce carbon emissions in central government. This approach is unique to the UK, and supported by all main political parties. These targets apply to all central government departments, executive agencies, and to non-departmental public bodies on a case-by-case basis. SOGE aims to make the government office estate carbon neutral by 2012 but goes beyond carbon to address sustainability more widely. SOGE seeks to reduce the Government's total emissions from buildings by 30 per cent, recycle 75 per cent of waste, reduce the waste generated by 25 per cent, reduce water consumption by 25 per cent and increase energy efficiency by 30 per cent per square metre.

While overall progress towards these targets is good, the need to raise the level of ambition is currently being considered and should go further. The most significant contribution that Government can make is through policy development that supports and incentivises a reduction in carbon emissions and improves sustainability. The establishment of

### Case Study 'Greening' kidney care in the NHS

'Green Nephrology' is a programme to improve the sustainability of kidney care. Set up by the Campaign for Greener Healthcare in response to the call for the NHS to reduce its carbon footprint, the programme funds a Green Nephrology Fellowship, in which a nephrology trainee is seconded to work on climate change mitigation issues within kidney care. The Green Nephrology Programme aims to align the provision of more sustainable health care with higher quality care at lower financial costs.

Renal medicine is among the first specialties to begin to pursue the changes that will be required when carbon rationing starts to reshape how the NHS delivers its services. Renal medicine is likely to contribute disproportionately to the overall footprint of the NHS. The most common form of renal replacement therapy involves thrice weekly return travel (nearly always by car), large amounts of plastic and packaging waste, and large amounts of energy and mains water consumption. In addition, clinic appointments for newly transplanted patients involve frequent long distance journeys.

The Green Nephrology Fellow explores the environmental impacts of kidney care and investigates initiatives and interventions to reduce carbon emissions. Examples of the work being undertaken include efforts to raise awareness, including developing champions in local units, carbon footprinting studies of aspects of kidney care, the development of case studies of good environmental practice, and collaboration with the renal industry to develop sustainable procurement.

The Green Nephrology Fellow is sharing best practice case studies, such as the conservation of water during haemodialysis. Patients typically require three four-hour sessions of dialysis per week. Each of these three sessions requires nearly 500 litres of mains water and of this 500 litres, up to two thirds are discarded during the purification process. Recycling this water would save thousands of litres, yet only a few hospitals currently do, using the water in laundry or sanitation, for example. Kent & Canterbury Trust is leading the field in this area. The Trust diverts the water normally destined for the sewers to a recovery tank that supplies the toilets in the operating theatres and the accident centre and a similar installation in a satellite unit supplies the laundry. From a £14,000 capital investment for the recovery tank, it is now making savings of approximately £7,000 a year and the tank has also resulted in a 38 per cent reduction in mains water usage.

Other examples from around the world show how hospitals are reducing their environmental footprint; one Australian unit recycles this water in a commercial car-wash, reducing water use as well as bringing money into the unit.

The programme is supported by NHS Kidney Care, the Renal Association, the British Renal Society, the NHS Sustainable Development Unit, the National Kidney Federation, and the Association of Renal Industries.

For more information see [www.greenerhealthcare.org/green-nephrology-programme](http://www.greenerhealthcare.org/green-nephrology-programme)

departmental carbon budgets provides a good basis for this but it is vital that this opportunity is used to build the necessary momentum to achieve the ambitious targets set out in the Climate Change Act.

A starting point for a more effective strategy is to develop a more integrated approach between policies aimed at tackling climate change and policies aimed at creating healthier communities and addressing health inequalities. This includes improving the sustainability of government services, including those of the NHS. While the NHS is one of the leading contributors to the UK's carbon emissions, emitting more than 18 million tonnes of CO<sub>2</sub> a year, as the largest public sector employer in Europe it has the potential to be a leader in addressing the issue. There are signs it has started to act as a leader, with the establishment of the NHS Sustainable Development Unit and publication of a Carbon Reduction Strategy which seeks both to reduce carbon emissions and save the NHS money.<sup>400</sup> The NHS Sustainable Development Unit shows that if health care trusts meet their target to cut primary energy consumption by 15 per cent between 2000 and 2010, the NHS will save £50 million per year on its current energy bills.

While this Strategy provides robust guidance, the NHS is not yet on track to meet these targets, nor is carbon reduction included in NHS performance management, apart from on a voluntary basis. Inclusion in core frameworks for commissioning, reporting and performance management would enable the NHS to make the necessary carbon reductions. Reports also show that Primary Care Trusts and Acute Trusts can cut carbon and costs by co-locating services to reduce their carbon emissions.<sup>401</sup>

### *Improving active travel across the social gradient*

Transport accounts for approximately 29 per cent of the UK's carbon dioxide emissions and significantly contributes to some of today's greatest challenges to public health in England: the burden of road traffic injuries, physical inactivity, the adverse effect of traffic on social cohesiveness and the impact of outdoor air and noise pollution. The relationship between transport and health is complex and socioeconomically patterned. Transport also enables access to work, education, social networks and services that can improve people's opportunities.<sup>402</sup> The EU also regards transport as central to improving health and its action on sustainable urban transport seeks to create healthy environments and reduce non-communicable diseases such as respiratory and cardiovascular diseases, and to prevent injuries from occurring.

Active transport can be an important contributor to overall levels of physical and mental health but it is not an easy solution to implement. The number of children walking to school is declining, decreasing from 62 per cent in 1989 to 52 per cent in 2006.<sup>403</sup> However, our understanding of solutions is improving as research explores what impedes us from making healthier choices and decisions. For example, understanding how to increase the numbers walking to school is improving; attitudes and perceptions play a significant role in the decision to walk and

cycle. In a rural area in East England with high levels of deprivation, children whose mothers who walked or cycled to work were also more likely to walk and cycle to school.<sup>404</sup> Getting children to walk to school may also mean getting their parents and families to increase their level of active travel.

Improving active travel across the social gradient includes providing incentives to increase levels of active travel as well as initiatives to improve safety to encourage active travel. Interventions may include increasing investments to encourage more walking and cycling, reducing car speed, improving quality of and access to walking and cycling routes and improving public transport. Interventions need to both improve road safety and improve parental and peer support, as recommended in the NICE guidance 'Promoting physical activity in children and young people'.<sup>405</sup> The provision of cycling infrastructure can lead to a long-term increase in cycling and a reduction in cycle casualties.<sup>406</sup> Numerous studies find that opening new sections of cycling trails leads to long-term increases in cycling, especially when located in highly populated areas.<sup>407</sup> Substantial increases in the number of cyclists also leads to reductions in the numbers of cyclists killed or seriously injured.<sup>408</sup>

The presence of pavements or footpaths that are well maintained with good surfaces, cycle paths, and street lighting increases the number of walking and cycling trips.<sup>409</sup> Lowering speed limits improves quality and access for active travel and improves safety for pedestrians and cyclists. Lower speed limits reduce risk of death and serious injuries.<sup>410</sup> Area-wide traffic calming, such as 20 mile per hour zones, is associated with absolute reductions in injury rates and, if appropriately targeted, can help achieve relative reduction in inequalities in road-injuries and deaths.<sup>411</sup> Traffic calming measures reduce speed as well as the volume of traffic, and the frequency and severity of traffic accidents, leading to increased walking and cycling.<sup>412</sup>

In London, where 20 mph zones have been introduced, injuries have decreased by 40 per cent, with cyclist injuries falling by 17 per cent and pedestrian injuries by a third.<sup>413</sup> Modelling exercises concluded that 20 mph zones halved the number of casualties (580 deaths in one year) in the most deprived quintiles.<sup>414</sup> Lower speed restrictions are often targeted in collision areas, but should not only be limited to these areas.<sup>415</sup> Targeting zones in deprived residential areas would help lead to reductions in health inequalities.

Other factors are also important in improving pedestrian access, such as the location and accessibility of crossings. The risk of having a collision while crossing the road increases with age, especially after 79 years, with injuries to older people (over 65 years) tending to be more serious and more often fatal than injuries to other age groups. Surveys of older pedestrians in the UK found particular concerns about crossing busy roads. While only 35 per cent of roads crossed by older pedestrians were main roads, 85 per cent of this group's injuries were on these roads.<sup>416</sup> People over 65 tend to find traffic a serious problem that inhibits their own travel patterns.

In addition to improving active travel and the quality and access to cycling and pedestrian routes, better public transport has been shown to result in significant changes in travel patterns and improving health. A health impact assessment in Edinburgh suggested potential health and health inequality benefits from increased use of public transport.<sup>417</sup>

All policies seeking to improve active travel, such as Cycling Demonstration Towns, should be required to measure their impact on health inequalities. Increasing the number of cyclists, as the Cycling Demonstration Towns initiative seeks to do, will not reduce health inequalities unless communities are targeted progressively across the social gradient.

#### *Improving good quality spaces available across the social gradient*

Green space and green infrastructure improve mental and physical health and have been shown to reduce health inequalities.<sup>418</sup> Green infrastructure networks reduce urban temperatures and improve drainage, reducing the risks to health associated with heat waves and flooding. Well designed and maintained green spaces can encourage social interaction, exercise, play, and contact with nature. Well designed, car free and pleasant streets encourage feelings of well-being, chance interactions and active travel; good quality and good access to public spaces contributes to pride in the community, integration and social cohesion.

Over 95 per cent of people believe it is very or fairly

important to have green spaces near to where they live and this value placed on green space is consistent across the social gradient. However, Figure 4.7 shows that there is a social gradient relating to the frequency of use of green spaces. The highest social group, A, are most likely to visit green spaces frequently, while over 35 per cent of social grade E visit green spaces infrequently (several times a year or less).<sup>419</sup>

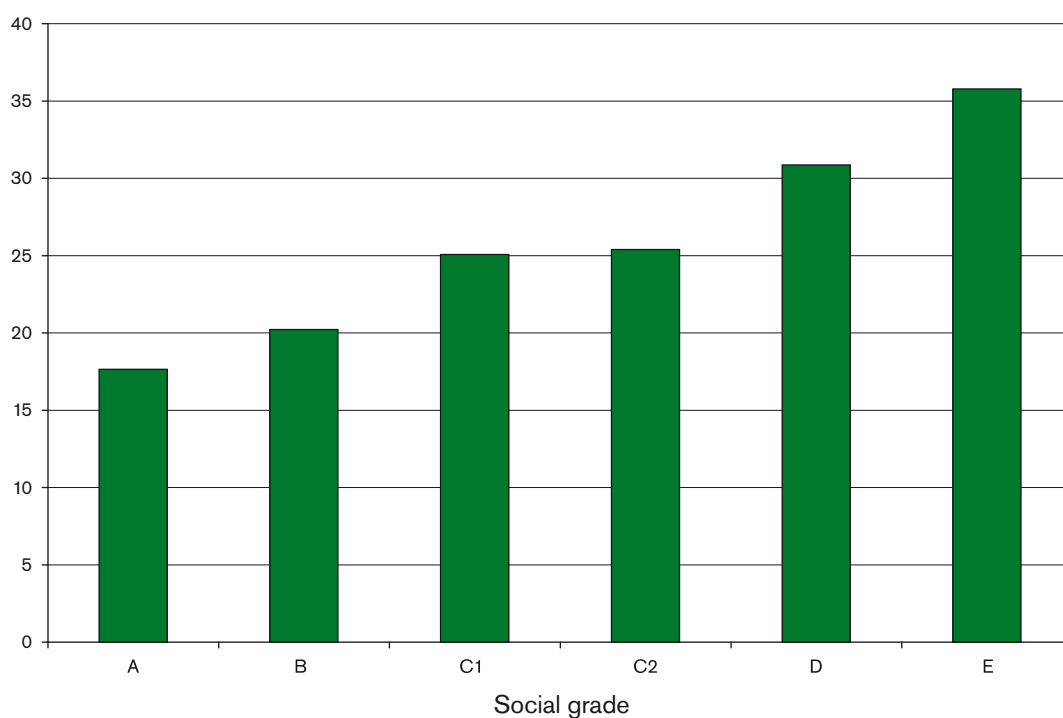
A UK study found that income-related inequality in health is affected by exposure to green space. Health inequalities related to income deprivation in all-cause mortality and mortality from circulatory diseases were lower in populations living in the greenest areas. It is not precisely known why exposure to green space affects health in this way but the effect remained after controlling for known confounding factors.<sup>420</sup> Green spaces also have important effects on community capital. Natural features can create enclosed areas to promote play between different groups and create varied activities suitable for different age groups leading to better overall concentration and motor skills.<sup>421</sup>

Exercising outside can have more positive mental health benefits than exercise of other kinds.<sup>422</sup> The psychological benefits of jogging in an urban park outweigh those of street jogging.<sup>423</sup> ‘Green gyms’, keeping fit by engaging in activities in the open air, have been shown to result in positive physical and mental health outcomes.<sup>424</sup>

Simply providing more green spaces is not enough – attention also needs to be paid to their

**Figure 4.7** Percentage of population by social grade who visit a green space infrequently in a year, 2009

Percent of population



Source: Department for Environment, Food and Rural Affairs, Energy Savings Trust<sup>426</sup>



design and quality.<sup>425</sup> Children and older people in particular often feel excluded from public spaces. Design and proximity to home can improve the use of green spaces. For example, marking school playgrounds with designs that stimulate active games is associated with a 20 per cent long-term improvement in physical activity.<sup>427</sup> A natural play environment at school also helps reduce bullying, increases creative play, improves concentration and a feeling of self worth in children.<sup>428</sup> Well designed green and open spaces can benefit communities in a variety of ways including increasing levels of social contact and social integration, particularly in underprivileged neighbourhoods.<sup>429</sup> In one study, green space in a housing complex encouraged more social activity and more visitors. Residents also knew more of their neighbours and said that their neighbours were more concerned with helping and supporting each other.<sup>430</sup>

Designing neighbourhoods well can also increase their 'walkability': how geared they are to enabling people to walk or cycle to destinations.<sup>431</sup> People are more likely to be physically active if they live in neighbourhoods with many destinations, such as shops and other facilities, and where they have a number of reasons for walking, including walking to work, for recreation and to fulfil other tasks.<sup>432</sup> In contrast, dense vegetation, unmaintained areas, dog fouling, graffiti and vandalism all contribute to a perceived lack of safety which reduces the use of green spaces.<sup>433</sup>

Many government policies have sought to encourage improvements in local green spaces. For example, the Green Flag Awards are given annually to those spaces judged against criteria including

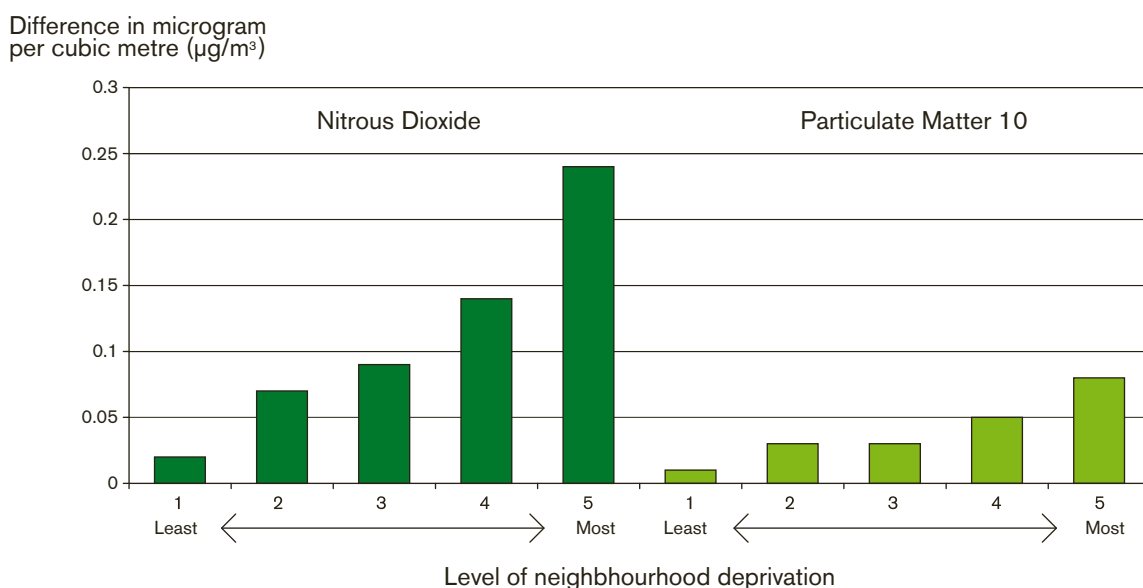
health, safety and security, community involvement, access and sustainability. The Green Flag Awards are well placed to help develop the public health role of parks and park staff across all local authorities by focusing more on their role in reducing health inequalities in all areas across the social gradient.

Proximity to space is also important and understanding the relationship between proximity to green space and its impact on health is improving. Children's physical activity levels are increased when they live closer to parks, playgrounds, and recreation areas.<sup>434</sup> In densely populated urban areas, green space located within walking distance is more likely to promote physical activity outside the home.<sup>435</sup> The survival of older people increases where there is more space for walking near their home, with nearby parks and tree-lined streets. Prevalence rates for diseases such as diabetes, cancer, migraine/severe headaches and depression are lower in living environments with more green space within a one kilometre radius and mental health may be particularly affected by the amount of local green space.<sup>436</sup>

A 2009 study examined the difference between green space being three kilometres or one kilometre from one's home, and found that having green spaces within one kilometre reduced disease prevalence. Those with lower education levels living in these zones had lower annual prevalence rates of chronic obstructive pulmonary disease.<sup>437</sup> As research in this area improves, we are gaining a better understanding of the level of proximity and access to green space required to lead to better health outcomes.

Population-wide interventions can have significant effects on the social determinants of health, particularly when there are such wide variations

**Figure 4.8** Modelled changes in air pollution concentration due to London Congestion Charge, by area of London and level of socioeconomic deprivation, 2003–07



Note: Post – pre difference  $\mu\text{g}/\text{m}^3$  = change in air pollution concentration measured in micrograms per cubic metre  
Source: Tonne et al.<sup>438</sup>

in these determinants. The London Congestion Charge is applied across central London only, but it has reduced the gradient in air pollution proportionately across the social gradient, with increasing impact in the more deprived areas – Figure 4.8.

#### *Improving the food environment in local areas across the social gradient*

Dietary change can also play a key role not only in mitigating climate change and adaptation strategies, but also in promoting health by reducing the consumption of saturated fat from meat and dairy sources. Food preparation and production contributes around 19 per cent of the UK's greenhouse gas emissions; half of these emissions are attributable to the agricultural stage.

Food systems have the potential to provide direct health benefits through the nutritional quality of the foods they supply.<sup>439</sup> Improving the food environment involves addressing issues concerning the accessibility of affordable and nutritious food that is sustainably produced, processed and delivered.

Internationally, studies show that among low-income groups price is the greatest motivating factor in food choice. In the US, price reductions have seen positive increases in the sales of low-fat foods and fruit and vegetables.<sup>440</sup> The era of cheap food may be approaching its end, but consumer expectations are still of low prices, which fail to include the full environmental costs.<sup>441</sup>

There are studies that show association between proximity, or lack of, to healthy food, and health outcomes such as obesity or malnutrition, but these studies should be approached with caution. They are most often observational and so do not show *causality* between inadequate access and health outcomes.<sup>442</sup> One study in the UK on the greater access to unhealthy food has shown this *may* disproportionately affect those in more deprived areas.<sup>443</sup> Data from the US shows more substantial links between schools and proximity to fast food outlets, as well as proximity to fast food outlets and obesity but the food environment in the US is very different to the UK's.<sup>444</sup>

#### **Case Study Working in partnership to reduce fuel poverty**

The UK Public Health Association (UKPHA) brings together individuals and organisations from all sectors who share a common commitment to promoting the public's health and it is leading the delivery of an innovative and integrated fuel poverty programme. Starting with understanding the current evidence, engaging with key partners then implementing a pilot, the project is a good example of the delivery of integrated and evidence-based interventions to reduce health inequalities.

The programme originates from the UKPHA's Health Housing and Fuel Poverty Forum, funded by DEfRA. The forum, made up national figures from the health, housing and energy sectors, and practitioners from across England, developed the 'Central Clearing House' model. Their research concluded that a model of local area partnerships that linked health, housing and fuel poverty services was the most effective approach for directing services to the vulnerable. The CCH model identified the key systems and processes necessary to access the vulnerable fuel poor, identify high risk groups, streamline referral and delivery systems and implement monitoring and evaluation processes.

The CCH model was first piloted in Manchester, with the implementation of the Affordable Warmth Access Referral Mechanism (AWARM). Funded by the Department of Health, the pilot was a partnership with Salford City Council and Primary Care Trust. Manchester Business School is evaluating the programme for the mismatch between theory and practice and an assessment of what 'fit for purpose' should look like.

Greater Manchester invested approximately £100,000 each year into AWARM. Since April 2008 AWARM activity resulted in over £600,000 of investment and majority of cases are still open so many households will receive further investment. AWARM resulted in a dramatic increase in referrals from across the social and care sectors, but the number of referrals from health professionals (mainly GPs) remains low. In 12 months the programme trained 1,359 professionals, a third in health, with the remainder in social services, voluntary/community services, local government and housing.

The lessons learned from the pilot include:

- There are numerous opportunities to share data between local authorities, GPs and PCTs to improve how referrals are targeted
- A pop-up system on GP patient electronic records would help to immediately direct referral to a one-stop-shop
- Involving energy companies as active project partners can help identify novel ways to target vulnerable individuals and neighbourhoods.

The funding received ends in 2010, yet the project is improving local delivery systems, increasing the numbers receiving funding to reduce fuel poverty. Like many other ill health prevention projects, funding only invests in a pilot, regardless of the outcomes. In this case, this means a project showing successful short-term outcomes may not be rolled out.

For more information see  
[www.ukpha.org.uk/fuel-poverty.aspx](http://www.ukpha.org.uk/fuel-poverty.aspx)

Availability of healthy food, and in particular fresh produce, is often worse in deprived areas due to the mix of shops that tend to locate in these neighbourhoods.<sup>445</sup> A study of the location of McDonald's outlets in England and Scotland showed per capita outlet provision was four times higher in the most deprived census output areas than in the least deprived areas.<sup>446</sup> Low-income groups are more likely to consume fat spreads, non-diet soft drinks, meat dishes, pizzas, processed meats, whole milk and table sugar than the better-off.<sup>447</sup>

The creation of food deserts is likely to be a by-product of a complex interaction between local planning, regulatory and economic factors and the national location policies of large supermarket companies.<sup>448</sup> In a controlled 'before/after' study following the opening of a new supermarket in Scotland, there were no differences between the control and experimental groups: both increased their daily intake of fruit and vegetable portions.<sup>449</sup> However, there is still a suggestion that residents of deprived areas could benefit from policies aimed at low-mobility groups, increasing their access to better shopping facilities and healthier food alternatives.<sup>450</sup>

#### *Improving energy efficiency of housing across the social gradient*

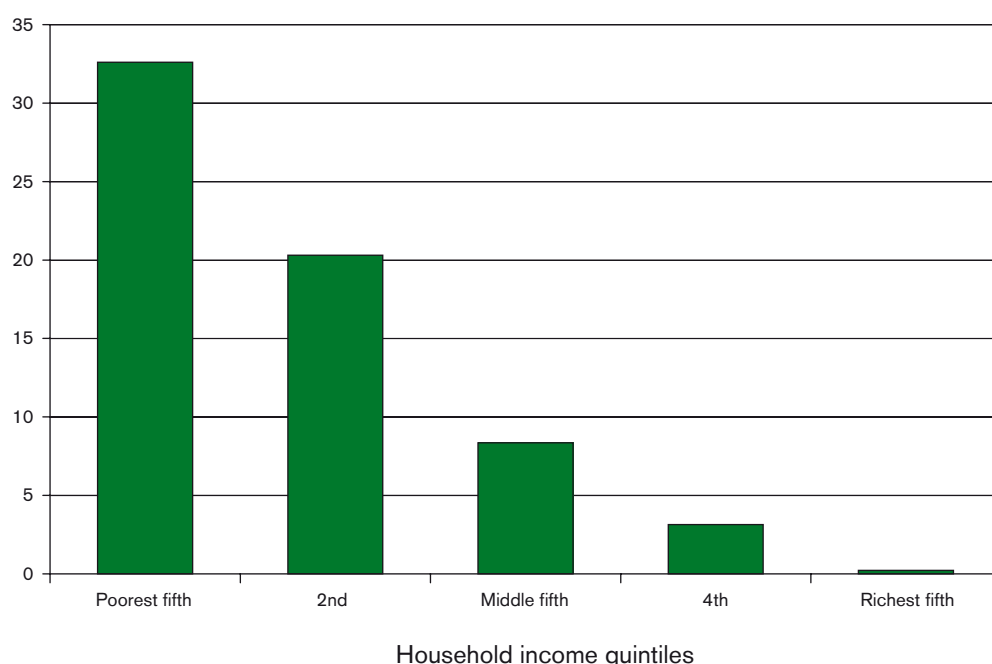
The existing housing stock emits 13 per cent of our carbon dioxide and as such, there is a compelling case for improving the environmental standards of housing across all sectors. Poor housing conditions

and design have substantial impacts on health inequalities. It is estimated that reducing household energy emissions but examining the effects of fabric, ventilation, fuel switching, and behavioural changes, could lead, in one year, to 850 fewer disability-adjusted life-years (DALYs – a method of estimating the negative lifetime impact of premature mortality and disability) and a saving of 0.6 megatonnes of CO<sub>2</sub> per million population.<sup>451</sup> The annual cost to the NHS of both cold homes and falls is estimated to be over £1 billion. The ageing housing stock requires consistent reinvestment, particularly to reduce the carbon emissions from older homes.<sup>452</sup>

Living in cold conditions is a health risk. A household is in fuel poverty if it needs to spend more than 10 per cent of its income on fuel to sustain satisfactory heating. In 2006, 11.5 per cent of households in England were fuel poor, either spending more than this 10 per cent or under-consuming energy to save money; over half of these households were single persons. The Government set statutory targets to eradicate fuel poverty among vulnerable households in England by 2010 and all households in England by 2016 as far as is reasonably practicable. It is estimated that these targets will not be met and the most recent figures state that 2.8 million households in England are in fuel poverty.<sup>453</sup> The risks of fuel poverty are higher in rural areas – in 2006, 21 per cent in rural areas were in fuel poverty compared with 11 per cent in suburban and 10 per cent in urban areas.<sup>454</sup> The risk of fuel poverty rises sharply as household income

**Figure 4.9** The risk of fuel poverty according to household income, 2009

Percent of households in fuel poverty



Source: English House Conditions Survey, Department of Communities and Local Government<sup>455</sup>

Note: Percent in fuel poverty relates to households in fuel poverty after deducting housing costs

falls. Very few households with above-average incomes are in fuel poverty – see Figure 4.9.

Other factors besides household income affect whether a household is in fuel poverty or not, such as housing costs and type of ownership. As a proportion of the total number of households for a given tenure, for example private rented, owner occupier or social housing, households living in private rented accommodation have higher likelihood of living in fuel poverty – 16 per cent of which were in fuel poverty compared with 11 per cent in other tenures.<sup>456</sup> However, more of the fuel poor live in owner-occupied properties, with over two thirds of fuel poor household living in that sector.

The government programme Warm Front, which provides a package of insulation and heating improvements to qualifying households, has been shown to have a positive impact on mental health, alleviating respiratory problems in children and reducing deaths among older people.<sup>457</sup> Despite this policy and others such as the Winter Fuel Payment, the number of fuel poor households in England dramatically increased between 2004 and 2008. The cold winter of 2008/9 saw the highest number of extra deaths in England and Wales since 1999/2000, with 36,700 excess deaths. Much of the increase in fuel poverty in 2008/9 was due to the increased costs of energy and it is estimated that in the long term, energy costs will increase.<sup>458</sup>

Improvements in housing conditions have been shown to have a number of positive impacts on health, including lower rates of mortality, improved mental health and lower rates of contact with GPs. Significant improvements in health-related quality of life were found in a randomised controlled trial of home insulation, which concluded that targeting home improvements at low-income households significantly improved social functioning and both physical and emotional well-being (including respiratory symptoms).<sup>459</sup> Adequate heating systems improve asthma symptoms and reduce the number of days off school.<sup>460</sup>

Following the introduction of the Housing Health and Safety Rating System by the Department for Communities and Local Government (CLG) a number of the initiatives addressing the problems of cold homes and the impacts of housing on health. Many of the difficulties in addressing the issue of cold homes is that the *effects* of the problem are the responsibility of one government department, the Department of Health, but the responsibility for *solutions* lies with the CLG and with the Department of Energy and Climate Change (DECC).

The 2004 Housing Act gave local authorities the powers to tackle poor housing, setting out statutory minimum standards. The Housing Health and Safety Rating System evaluates the potential risks to health and safety from any deficiencies identified in dwellings. The introduction of the Housing Health and Safety Rating System, together with other developments in calculating the cost of the impact of poor housing on health, has led to increased activity between local housing authorities and health partners in reducing health inequalities. This work is at

a relatively early stage but it has the potential to help reduce the numbers of people in fuel poverty, to help maintain independence and lead to improvements in health and well-being.

Health inequalities also relate to the shortage of new homes. It is estimated that three million new homes are needed by 2020 to meet the rate of new household formation. Many are waiting for new homes. Close to two million are on council waiting lists, with 500,000 in overcrowded conditions and 70,000 in temporary accommodation.

The Decent Homes programme sought to improve the quality of homes and by 2010, 95 per cent of social housing will reach the Decent Homes Standard. The programme had invested over £40 billion by 2010 and work has been completed on 3.6 million social homes, with improvements for 8 million people in total, including 2.5 million children. Continued investment is needed to maintain this standard; housing associations will need funding to continue to invest in the ageing housing stock. The impact of this investment on health needs to be better understood; it is important that these policies and investments are assessed for their impact on health inequalities.

### Summary

- There are co-benefits to addressing both health inequalities and climate change.
- The NHS has implemented some strategies to reduce carbon emissions and improve environmental sustainability but can go further.
- Strategies are needed to enable access to good quality, active transport across the social gradient.
- Good quality green and open spaces improve physical and mental health.
- Green and open spaces have more of an impact if they are close to where people live.
- Fuel poverty is a significant problem and likely to grow as the cost of fuel increases.
- Investments to improve housing need to be sustained.

### E.2.2 Integrate planning, transport, housing, environmental and health policies to address the social determinants of health

**Recommendation:** Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.

An important step in tackling the social determinants of health at a local level would be greater integration of health, planning, transport, environment and housing departments and personnel.

At present, the planning process at local and national levels is not systematically concerned with impact on health and health equity.<sup>461</sup> Currently, Policy Planning Statement (PPS) 17 deals with health issues, ‘Planning for open space, sport and recreation’. However, the lack of attention paid to

health and health inequalities in the planning process can lead to unintended and negative consequences. A policy planning statement on health would help incorporate health equity into planners' roles.<sup>462</sup>

The Healthy Urban Development Unit and CABE demonstrate in numerous reports how good planning can have a positive impact on public health and that designers can influence people's well-being and design neighbourhoods in a manner that promotes health and well-being.<sup>463</sup> A new Planning Policy Statement on health could ensure that new developments are assessed for their impact on health inequalities, for example limiting the number of fast food outlets in a Super Output Area. This tool could help to provide a lever for local authorities to change the way neighbourhoods are designed.

Existing tools such as the Joint Strategic Needs Assessments are another lever to facilitate integrated approaches at a local level. However, as CABE reports,

'producing needs analysis data does not in itself lead to change'.<sup>464</sup> Integrated working, such as making PCTs statutory partners in local planning decisions, should be decided at local levels.

Training local authority managers and officers in planning, housing, environment and transport in health equity issues could improve commitments to local development frameworks.<sup>465</sup> Related professional bodies can make health equity mandatory in professional development.

Equally, local planning should ensure services are easier to access and more joined up locally. The design of neighbourhoods can have an impact on community participation – good neighbourhood design can avoid putting up barriers to participation, and actively encourage it, for example through ensuring accessible transport, well-located services and amenities, and the provision of facilities and activities which encourage integration.

### Case Study Improving private rented housing in Liverpool

Liverpool City Council's Healthy Homes Programme (HHP) seeks to prevent premature death and ill health caused by poor housing conditions and accidents in the home. It is aimed at the rented sector and seeks to help the most vulnerable residents in Liverpool. Based on national estimates, poor housing conditions are a significant contributor in up to 500 deaths and around 5,000 illnesses needing medical attention in Liverpool each year. The city has one of the highest rates of excess winter deaths in the UK; between 2004 and 2007, there were 242 excess winter deaths per year.

Liverpool PCT commissioned the City Council to assist in the reduction of health inequalities and improve morbidity and mortality statistics through the HHP. The HHP proactively targets and surveys a large number of the worst properties that house the most vulnerable occupants. In tackling sub-standard housing conditions and knitting together the wide range of health-related services the city has to offer, the hardest to reach and most vulnerable residents are actively engaged and encouraged to take advantage of available health services from a single point of contact. This partnership confronts head-on health inequalities in a city that has some of the worst levels of deprivation and health disparity in the country.

The programme will identify approximately 15,000 properties for an initial survey, and prioritise 2,750 for full health and safety inspection to develop a personalised home improvement plan. Following the inspections of the properties, the necessary improvements are secured by the team's Environmental Health Officers through advice and enforcement. This programme is delivered initially over three years and is controlling the most significant and life threatening hazards in these homes, including: poor heating and insulation; bad internal

arrangements (to prevent accidents); dampness and mould (combating respiratory illness).

In addition to inspecting housing conditions, the health and well-being needs of all occupants are investigated and advice on accident prevention and health promotion provided. Referrals to relevant agencies are also made where specific health and well-being problems are identified.

The programme works in partnership with a number of related agencies such as Merseyside Fire and Rescue Service and initiatives such as energy efficiency and making neighbourhoods cleaner and healthier. HHP also works with primary care by increasing awareness of the programme in neighbourhood General Practices and creates referral systems for clinicians. Health professionals can then actively address the causes of some respiratory complaints and other chronic diseases.

Advice and education on health promotion and home accident prevention are also integral to the programme. Vulnerable households such as those housing black and minority ethnic groups, the elderly and young are being specifically targeted.

The programme is designed to:

- Prevent up to 100 premature deaths when fully implemented
- Reduce the number of GP consultations and hospital admissions by an estimated 1000 cases
- Improve clinical understanding of poor housing on local health via communication with GPs and other clinical services
- Reduce reliance on secondary and tertiary treatment
- Increase community capacity to support housing improvements.

For more information see [www.liverpool.gov.uk/healthyhomes](http://www.liverpool.gov.uk/healthyhomes)

## Summary

- Integrated planning, transport, housing, environmental and health systems are needed.
- Training in health for planning, transport, housing and environmental professionals should be implemented.
- A Policy Planning Statement on health is needed.

## E.2.3 Create and develop communities

**Recommendation:** Support locally developed and evidence-based community regeneration programmes that:

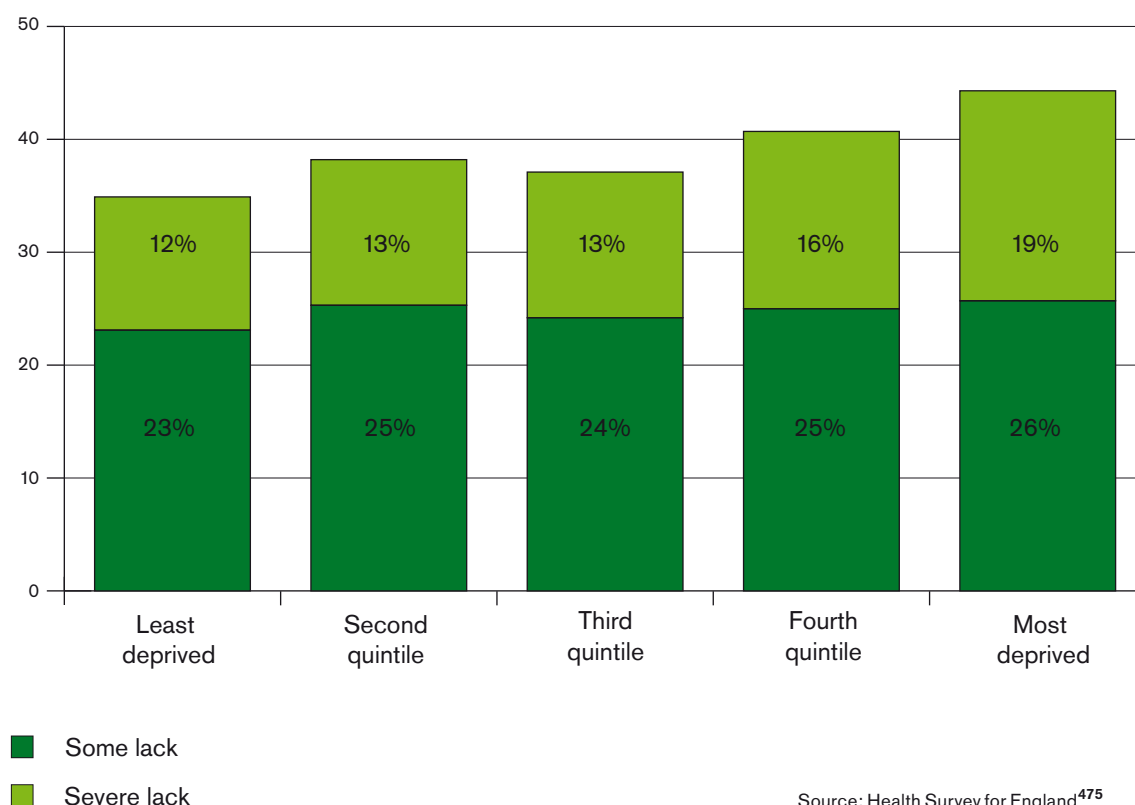
- Remove barriers to community participation and action
- Reduce social isolation.

Community or social capital is shaped both by the ability of communities to define and organise themselves, and by the extent to which national and local organisations seek to involve and engage with communities. It is comprised of different factors in different communities, and can include community networks, civic engagement, a sense of belonging and equality, cooperation with others and trust in the community. Community capital needs to be built at a local level to ensure that policies are drawn on and owned by those most affected and are shaped by their experiences.

Communities with less community capital differ from stronger communities in many ways. For example, there is less volunteering/unpaid work in neighbourhoods that are perceived to be less safe, and less socialising and less trust in others.<sup>466</sup> In the last decade, the level of volunteering/unpaid work has remained fairly constant. According to the Joseph Rowntree Foundation, '[b]etween 35 per cent and 40 per cent engaged in some form of civic participation, around 20 per cent in civic consultation and 10 per cent in civic activism. Around 35 per cent volunteered informally, and 25 per cent formally over the period.'<sup>467</sup>

Evidence for causal associations between social capital and health is improving. In many communities facing multiple deprivation, stress, isolation and depression are all too common.<sup>468</sup> Residents of busy streets have less than one quarter the number of local friends than those living on similar streets with little traffic.<sup>469</sup> The most powerful sources of stress are low status and lacking social networks, particularly for parents with young children.<sup>470</sup> Low levels of social integration, and loneliness, significantly increase mortality.<sup>471</sup> Several longitudinal studies have shown that social networks and social participation appear to act as a protective factor against dementia or cognitive decline over the age of 65 and social networks are consistently and positively associated with reduced morbidity and mortality.<sup>472</sup> There is strong evidence that social relationships can also reduce the risk of depression.<sup>473</sup> People with stronger networks are

**Figure 4.10** Percentage of those lacking social support, by deprivation of residential area, 2005



Source: Health Survey for England<sup>475</sup>



healthier and happier. Making resources available to address the association between poor health and poor social networks and break the cycle of deprivation can also decrease costs of health care.<sup>474</sup>

### *Remove barriers to community participation and action*

Addressing the psychosocial effects of neighbourhood deprivation is a difficult task as identifying methods to improve community capital can be difficult. Those living in deprived areas often find their communities lack social support (Figure 4.10) and, according to the Joseph Rowntree Foundation, ‘people in more deprived areas [are] more likely than others to think that certain issues [represent] a serious problem in their area. For example, over half of people in the most deprived areas [feel] that drug use or dealing, litter and vandalism [are] serious problems where they [live]. This compare[s] to between one-quarter and one-third in other areas.’<sup>476</sup>

In the UK, neighbourhood regeneration programmes have demonstrated improvements in average employment rates, educational achievements, household income and housing quality, all of which may contribute to a reduction in inequalities in health, but they can also increase housing costs, rendering residents poorer, as regeneration displaces the original residents.<sup>477</sup>

Numerous policies across government departments have sought to improve community capital and to tackle concentrated deprivation in deprived neighbourhood, such as Communities for Health (Department of Health) and the National Strategy for Neighbourhood Renewal (CLG). The latter was underpinned by investment in area-based regeneration and community renewal, primarily through the Neighbourhood Renewal Fund (NRF – refocused since 2008/9 on employment as the ‘Working Neighbourhoods Fund’), but also through the New Deal for Communities (NDC) and the Neighbourhood Management Pathfinders (NMP) programmes.

Evaluation evidence from across these programmes identified some positive trends – for example, the proportion of young people getting good GCSEs and residents’ satisfaction with local services, such as police and street cleaning. A review of the NDC<sup>478</sup> found more than half of residents said the area improved as a place to live. The feeling of being part of a local community increased from 35 per cent in 2002 to 42 per cent in 2006, still below the national average at 53 per cent, but nonetheless showing an increase in deprived communities, where improvements are more difficult to achieve. Self-reported health rose slightly from 77 per cent feeling that their health was good or fairly good in 2002 to 80 per cent in 2006 (still below the national average at 87 per cent).

Overall, despite these efforts, the proportion of people who do not feel they could affect decisions locally has not changed since the start of the decade and in the last 20 years a consistent number of adults, around two-fifths, have felt that their neighbourhood was not the type of area where people would help

each other.<sup>479</sup> Other evaluations have identified that a failure to commit to mainstreaming and a lack of ability to think strategically about how core services could work better in regeneration areas meant that progress was limited.<sup>480</sup> While the NDC programme highlighted some real challenges on engaging and developing communities, it did provide long-term funding, which alleviates funding stresses from local communities who often survive on year-to-year funding programmes.

Engagement of residents tends to have been most successful at the neighbourhood level and where there is engagement in individual projects and initiatives rather than at strategic or general consultative level. The National Strategy for Neighbourhood Renewal has had most success in influencing mainstream services to adopt a greater focus on deprived neighbourhoods where complemented by existing national policies and targets.

The experience of these programmes offers some important lessons for the future and what has and has not been most effective in supporting deprived neighbourhoods. For example:

- A need to focus more on underlying economic drivers of deprivation, such as the wider labour market, which will most likely operate at a higher spatial level than the neighbourhood
- A need to engage with mainstream agencies and ensure core services work better in regeneration areas

Communities need to be involved in developing and delivering their own regeneration programmes and initiatives – but that involvement needs to be real and fit for purpose (i.e. at the right spatial level and reflecting the capacity of local communities). Interventions work best with national guidance but accompanied by local freedom to develop relevant local programmes. As indicated in section E2.2, the design of neighbourhoods can also have an impact on community participation.

To achieve sustainable change it is necessary to take an integrated and appropriately sequenced approach that considers the social, economic and physical problems of an area and the interactions between them, and how best to complement the interventions of other agencies.

### *Reduce social isolation*

Reducing social isolation, and increasing individual and community empowerment and health outcomes, is challenging but much needed as the number of one-person households increases. In 1991 26.3 per cent of households contained one person, rising to 30 per cent in 2001, but social isolation and exclusion concerns more than just those living alone. Social exclusion encompasses social, political, cultural and economic dimensions and has different impacts at different stages in a person’s life. It is the multiple disadvantages experienced by particular groups and individuals existing outside the ‘mainstream’ of society.<sup>481</sup>

Social isolation impacts on health: social networks and social participation act as protective factors against dementia or cognitive decline over the age

of 65.<sup>482</sup> Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill.<sup>483</sup>

Four pathways suggest the interventions and policies that could reduce social isolation and exclusion:

- 1 First, identifying population needs better quality information from communities. In theory this can lead to health improvements and reduced health inequalities through an increased uptake of more effective services, particularly preventative services, and/or more effective interventions.
- 2 Second, improving governance and guardianship and promoting and supporting communities to participate in directing and controlling local services and/or interventions. This will help to improve the appropriateness and accessibility of services and interventions, increase uptake and effectiveness and influence health outcomes.
- 3 A third way to reduce social isolation is to develop social capital by enhancing community empowerment. This helps to develop relationships of trust, reciprocity and exchange within communities, strengthening social capital.
- 4 Lastly, increasing control and community empowerment may result in communities acting to change their social, material and political environments.<sup>484</sup>

### Summary

- Understanding of the relationship between social and community capital and health is growing.
- Communities facing multiple deprivation often have high levels of stress, isolation and depression.
- Social networks and participation can improve mental health inequalities.
- Area-based initiatives have demonstrated some limited successes.
- Social isolation can lead to increased risk of premature death.
- Including communities and individuals in designing interventions to address social isolation will help improve their effectiveness.

### Time period: 2011–2015

- 1 Prioritise policies and interventions that reduce both health inequalities and mitigate climate change, by:
  - Increasing active travel across the social gradient
  - Improving access and quality of open and green spaces available across the social gradient
  - Improving local food environments across the social gradient
  - Improving energy efficiency of housing and reducing fuel poverty.
- 2 Prioritise integration of planning, transport, housing, environmental and health policies to address the social determinants of health in each locality.
- 3 Support locally developed and evidence-based community regeneration programmes, that:
  - Remove barriers to community participation and action
  - Emphasise a reduction in social isolation.

### Time period: 2016–2020

- 1 Implement policies and interventions that both reduce health inequalities and mitigate climate change, including:
  - Maintaining active travel across the social gradient
  - Maintaining access and quality of open and green spaces available across the social gradient
  - Sustained and continued upgrade of housing stock.
- 2 Implement greater integration of the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- 3 Increase development of locally designed and evidence-based community regeneration programmes, by making long-term funding available for evidence-based community regeneration programmes.

### Time period: 2020 and beyond

- 1 Monitor policies and interventions that both reduce health inequalities and mitigate climate change for complementarity:
  - Maintain and monitor active travel across the social gradient
  - Monitor access and quality of open and green spaces available across the social gradient.
- 2 Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- 3 Make sustainable investments in community engagement and neighbourhood renewal.

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## Policy Objective F

### Strengthen the role and impact of ill health prevention

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#### Priority objectives

- 1 Prioritise prevention and early detection of those conditions most strongly related to health inequalities.
- 2 Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

#### F.1 Introduction

As outlined in Chapter 2, the conditions most strongly related to health inequalities, such as cancer and cardiovascular disease, are associated with smoking, alcohol, drug use and obesity. Policy Objectives A to E are concerned with the causes of the causes, of addressing ill health prevention and tackling the social determinants of health in ways not traditionally associated with modifying health behaviours. The purpose of this final Policy Objective is to address health behaviours.

Ill health prevention and health promotion are not the sole domain of the NHS, so it is not the only player in addressing health inequalities. Similarly, public health departments should not be the only part of the NHS responsible for tackling health inequalities. Reducing health inequalities is a responsibility shared between a range of different sectors and services, as described in Chapter 5. Local and national decisions made in schools, the workplace, at home and in government as well as across the NHS, all have the potential to help or hinder ill health prevention.

Wide-ranging definitions can be made of ‘ill health prevention’ and ‘health promotion’. Health England adopts a broad definition of ill health prevention, as ‘a clinical, social, behavioural, educational, environmental, fiscal or legislative intervention or broad partnership programme designed to reduce the risk of mental and physical illness, disability or premature death and/or to promote long-term physical, social, emotional and psychological well-being’.<sup>485</sup> This definition underlines the importance of viewing ill health prevention and health promotion as a shared responsibility across local and national governments and in a range of sectors and services. We recommend government adopt a shared and clearer definition of prevention across government departments.

In the words of Starfield *et al*, to ‘ensure better health for populations...and better distribution of health...demands a (re)focus on health rather than on preventing specific diseases’.<sup>486</sup> Investing in ill health prevention can, if implemented effectively, improve health and life expectancy as well as reduce spending over the long term, as NICE agrees: ‘Promoting good health and preventing ill health saves money... Increased investment in public health is key to increasing efficiency in the health service. A small shift in resource towards public health prevention activity would offer significant short, medium and long term savings to the service and to the taxpayer.’<sup>487</sup>

The evidence base relevant to public health interventions to reduce health inequalities is growing but remains modest. In 2005 it was estimated that of the research published on public health, only 0.5 per cent of articles were related to interventions, with most research *describing* inequalities rather than providing evidence on how to reduce them.<sup>488</sup> The evidence that does exist suggests that ill health prevention generally does work and can reduce costs to the health system.<sup>489</sup>

NICE provides guidance to improve the cost-effective delivery of its public health guidelines. However, levels of evidence about the impacts and cost-effectiveness of interventions concerning ill health prevention are small in some areas.<sup>490</sup>

It is difficult to find methods to measure effectiveness as many effects are in the medium and long term. However, statins, paediatric immunizations, and smoking cessation have been found to be among the most cost-effective ill health preventions.<sup>491</sup>

A wide body of epidemiological and sociological evidence suggests that health inequalities are likely to persist between socioeconomic groups, even if lifestyle factors (such as smoking) are equalised.<sup>492</sup> As this Review has demonstrated, policies to modify health behaviours need to address the social determinants of health. Aiming interventions at individuals will not by themselves reduce health inequalities; ‘responsibility for better health should be shared between society and the individual’.<sup>493</sup>

Some individuals may require additional support and giving consideration to the specific health needs of certain populations is essential. For example, many population groups have additional health needs, such as the elderly, people living with disability or mental illness, ethnic minority groups, the homeless, refugees and asylum seekers, Gypsies and Travellers. Population-wide and individual interventions need to be adapted to meet needs within a universal framework.<sup>494</sup>

Some population-wide interventions, such as screening programmes, are taken up to the largest degree by advantaged populations, potentially widening health inequalities.<sup>495</sup> Ill health preventions that seek to change individual behaviours such as smoking, alcohol, what we eat and how we exercise, are more likely to be taken up by those who already aspire to or are in good health. Both population-wide and individually targeted interventions need to be proportionately targeted across the social gradient if they are to reduce health inequalities effectively.

## F.2 Recommendations

### F.2.1 Increased investment in prevention

**Recommendation:** Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.

Currently, most investment in ill health prevention and health promotion emanates from the NHS and

the Department of Health. However, nearly all the NHS budget goes, either directly or indirectly, on the treatment and care of illness rather than on ill health prevention. In the NHS, there is wide variation in spending on public health programmes in PCTs. For example, in 2006/7 spending on ‘healthy individuals’ ranged from £240,000 in one PCT to £10.6 million in another.<sup>496</sup> Not only is there a wide variation in spending, but public health budgets are also often seen as the first budgets to raid when wider organisational budgets are pressurised.<sup>497</sup> Public health budgets should not be regarded as optional extras; investing in public health and ill health prevention will help to ‘build the foundations of a healthier population for the future’, as the Chief Medical Officer reported in 2005.<sup>498</sup>

The absence of an agreement on what constitutes public health spending makes it difficult to assess how expenditure on ill health prevention is allocated and as a result, limits understanding the effectiveness of public health investment. In 2006–7, 4 per cent of the NHS budget, totalling £3.7 billion, was spent on ill health prevention and health promotion.<sup>499</sup> The OECD also measured spending on ill health prevention and public health and while its definition may not be ideal – for example, it includes spending to reduce incidence of MRSA – it provides a starting point for analysis. As Table 4.3 indicates, more ill health prevention spending goes towards secondary prevention, early disease detection and intervention than to the prevention of the onset of disease.

The OECD definition of ill health prevention only includes spending by the Department of Health; it fails to fully demonstrate the scale of all ill health prevention and health promotion investment. For example, it does not capture investment where ill health prevention is not the primary rationale (e.g. sport). As our recommendations show, investment in the social determinants of health is required across government departments.

This Review proposes increasing spending over 20 years, to 0.5 per cent of GDP. In 2008, this would have increased ill health prevention spending to £7,230,565,000. This figure would include expenditure on ill health prevention and health promotion across government departments. A widely accepted definition would help to calculate expenditure.

This recommendation echoes earlier recommendations to increase investment in ill health prevention. For instance, Derek Wanless recommended health promotion expenditure grow in line with expenditure on general practice and hospital care.<sup>500</sup> While expenditure on ill health prevention has increased in the last 10 years, the level of investment Wanless recommended for the ‘fully engaged’ scenario – where the health of the population improves, the use of resources is more efficient and the health service is responsive, with high rates of technology uptake – has not occurred.

Many policies have addressed ill health prevention, but too often they are detached from mainstream activities and funded as one-off initiatives.<sup>501</sup> Part of the problem for those working in public health is that many funding streams fund pilot projects but then

fail to respond to good evaluations. Many initiatives remain as pilots and cannot secure the necessary routine or mainstream funding to continue, even when they are shown to work. In addition to increasing the amount spent on ill health prevention, government funding at local and national levels needs to shift from short-term projects to longer-term interventions that are evidence-based and designed with robust evaluations. Many of the ill health prevention interventions and programmes are funded over short periods of one to three years, yet it often takes a number of years to witness the effects from these interventions. Failing to provide longer-term funding for small-scale projects that are found to be also effective leads to a loss of knowledge and skills.<sup>502</sup>

### Summary

- Investment in ill health prevention and health promotion needs to substantially increase to 0.5 per cent of GDP over 20 years.
- Public health budgets should not be regarded as optional extras.
- A common definition of ill health prevention is needed across government and delivery organisations.
- Increased funding for longer-term projects and follow-up funding for successful pilots is needed.

## F.2.2 Implement evidence-based ill health preventive interventions

**Recommendation:** Implement evidence-based programme of ill health preventive interventions that are effective across the social gradient by:

- Increasing and improving the scale and quality of drug treatment programmes, diverting problem drug users from the criminal justice system
- Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient
- Improving programmes to address the causes of obesity across the social gradient.

Public health guidance and research should consistently apply health inequalities as a filter. While NICE guidance includes an inequalities filter, systematic reviews would also benefit if they included an inequalities analysis. Many NICE systematic reviews find relevant research concerning the differential impacts of health inequalities on interventions but many include no health equity assessment, stating that the research does not exist. All researchers need to adapt their primary evaluation studies to assess the effectiveness of interventions to reduce health

**Table 4.3** Ill health prevention expenditure in England (£m), based on OECD definitions, 2006/7

| <b>Primary</b>   |              |                                                                                                                      |
|------------------|--------------|----------------------------------------------------------------------------------------------------------------------|
| £1,771 billion   | £840 million | Maternal and child health, family planning, counselling                                                              |
|                  | £248 million | Health Protection Agency                                                                                             |
|                  | £238 million | Immunization                                                                                                         |
|                  | £116 million | Obesity/diet/lifestyle                                                                                               |
|                  | £56 million  | Stop Smoking services                                                                                                |
|                  | £53 million  | NHS blood and transplant (BT)                                                                                        |
|                  | £47 million  | Quality and Outcomes Framework (QOF)                                                                                 |
|                  | £44 million  | School-based group health services, healthy schools programme                                                        |
|                  | £34 million  | Publicity for prevention activities                                                                                  |
|                  | £33 million  | Charitable expenditure on prevention                                                                                 |
|                  | £25 million  | National Biological Standards Board                                                                                  |
|                  | £24 million  | Other infectious diseases                                                                                            |
|                  | £4 million   | NICE public health guidance                                                                                          |
|                  | £4 million   | Occupational health for dentists                                                                                     |
|                  | £3 million   | Reducing MRSA                                                                                                        |
|                  | £2 million   | CJD surveillance                                                                                                     |
| <b>Secondary</b> |              |                                                                                                                      |
| £1.964 billion   | £937 million | Dental check-ups                                                                                                     |
|                  | £396 million | QOF (e.g. monitoring & reducing blood glucose levels, contraception)                                                 |
|                  | £289 million | Screening (breast, cervical and bowel cancer, Down's syndrome, sickle cell anaemia, retinal, neonatal, audiological) |
|                  | £208 million | Sight tests                                                                                                          |
|                  | £115 million | School-based individual health services                                                                              |
|                  | £19 million  | Public health in prisons                                                                                             |
| <b>Total</b>     |              | <b>£3.7 billion</b>                                                                                                  |

Source: Organisation for Economic Cooperation and Development (OECD)<sup>503</sup>

inequalities, whether they are carrying out clinical drugs trials or evaluating social policy initiatives. This is particularly the case for interventions that may take place outside the health domain.

The following section provides a sample of evidence-based interventions that can be implemented to reduce health inequalities across the social gradient. It is not an exhaustive list of interventions needed.

*Increasing and improving the scale and quality of drug treatment programmes, diverting problem drug users away from the criminal justice system*

Chapter 2 described inequalities in the harm caused by problematic drug use. The number of babies born to drug-addicted mothers (dependent on heroin or other opiates) has almost doubled in recent years. In 2006/7, 1,970 women were addicted to drugs at the time of the birth of their children, up from 1,057 in 2002/3.<sup>504</sup> Problem drug use is a problem across England but there are variations in its patterns. Many local authorities with high rates of deprivation also have high numbers of individuals in contact with structured drug treatment, particularly in the North West.<sup>505</sup> Efforts are being made to address the disproportionate effect drugs have on the most vulnerable individuals and communities.<sup>506</sup> In a study of the impact of drugs on four English communities, interviews with those involved in selling drugs showed that many had experienced unsettled early lives. Over half had lived with a foster family, in a children's home or in secure accommodation; many had a disrupted education and over half were excluded from school or left with no educational qualifications. Nearly all had been in contact with the criminal justice system, and over two-thirds had served a prison sentence.<sup>507</sup> Ten to fifteen per cent of the UK's prison population are charged with drugs offences and close to half, between 40 and 50 per cent, are drug dependent, 24 per cent being injecting drug users.

Drug prevention can be a mechanism for reducing inequalities and reducing social exclusion and drug treatment is an essential part of a successful drug policy and of reducing inequalities.<sup>508</sup>

Current treatment policies are based on getting problem drug users (PDUs) into treatment as quickly as possible. The National Treatment Agency (NTA), set up in 2001, is required to meet targets for treatment and waiting times. This has led to an increase in the number of individuals treated; however, the treatment received has not led to a reduction in the number of PDUs. Despite an increasing budget, fewer than three per cent of PDUs are drug-free after treatment, and this has fallen from 3.5 per cent.<sup>509</sup>

Part of the problem is that treatments depend on the use of pharmaceuticals. Less than two per cent of clients receive structured motivational interventions, and sessions typically last 11 minutes. Just over three per cent undergo in-patient treatment (short detoxification stays) and only two per cent have had residential rehabilitation.<sup>510</sup> Improving the reduction of problem drug use would involve investing more in early treatment in long-term programmes rather

than on pharmaceuticals or imprisonment.

Drug treatment interventions can be effective at reducing, and in some cases, ceasing an individual's drug use and work most effectively when they address the individual factors of each person.<sup>511</sup> For example, many homeless individuals are PDUs and lack of appropriate and stable accommodation is a barrier to their ability to access and remain in drug treatment services. Therefore, effective treatment for this group should focus on care that responds not only to drug use but also to the problems underlying their drug use.<sup>512</sup> A meta-analysis of drug treatment programmes found positive evidence that structured therapeutic community interventions for drug users in prisons and drug treatments (including drug courts) in the community produced a greater reduction in offending behaviour than standard treatment.<sup>513</sup>

An international review of the effectiveness of drug treatment interventions in reducing drug use or drug-related crime concluded that: 'There is strong evidence that the most effective interventions to reduce drug related crime are therapeutic communities and drug courts.'<sup>514</sup> Some countries have implemented radical policies to successfully reduce the numbers of PDUs. In 2001 drug use was medicalised in Portugal and instead of sending PDUs to prison, they go to specialist 'discussion commissions' (made up of psychiatrists, social workers and legal advisers), which encourage addicts to undergo treatment offered by the government. The effects of medicalising drugs has not led to a growth in the number of addicts in Portugal, but has increased the willingness of PDUs to seek treatment, and to more treatment being available.<sup>515</sup> The number of addicts registered in drug-substitution programmes rose from 6,000 in 1999 to 24,000 in 2008, reflecting a rise in treatment, not drug use.<sup>516</sup> There has been an increased uptake of treatment and a reduction in drug-related deaths.<sup>517</sup>

In addition to Portugal, six countries in Europe – Spain, Italy, the Czech Republic, Estonia, Latvia and Lithuania – have also decriminalised low-level drug possession. The UK rarely imprisons people for possession, particularly of cannabis (0.2 per cent of people found in possession of cannabis go to prison).<sup>518</sup>

Given the links between drug experimentation in childhood and problematic drug use in adulthood, an important part of drug prevention is reducing the number of children trying drugs initially, and preventing the shift from experimental use to addiction. Schools are well placed to reach children before they initiate drug use, or in the early stages of experimentation. Although UK-based studies are generally lacking, there is international evidence (mainly from the US) that school-based prevention programmes can delay the onset of substance use by non-users for a short time, and temporarily reduce use by some current users. A systematic review of school-based programmes found that those based on developing life skills were the most consistent at reducing aspects of drug use in school settings. These programmes also effectively increased drug

knowledge, decision-making skills, self esteem, and resistance to peer pressure.<sup>519</sup>

By proactively treating problem drug use as a medical issue, moving resources to fund evidence-based treatment programmes supporting long-term behaviour change and developing and investing in collaborative partnerships between police, schools, health and social care professionals, the NHS and partners agencies should be able to better address problem drug use and progressively reduce the impact of drugs on England's most deprived communities.

### *Reducing smoking and alcohol use across the social gradient*

As described in Chapter 2, the relationship between socioeconomic status and alcohol is complex. There is a social gradient in the *harms* from alcohol

consumption but not in alcohol consumption itself. Over 11 million people in the UK are dependent on alcohol or drink hazardously, yet treatment for alcohol related programmes is only available to six per cent of problem drinkers.<sup>520</sup> Unlike the drug strategy, there are no targets to meet for waiting times and few services are offered to people with alcohol-related chronic disease. There is strong evidence of the effectiveness across the social gradient of using brief interventions to address alcohol problems.<sup>521</sup>

The price of alcohol is also an effective lever for reducing alcohol consumption. Between 1980 and 2007 alcohol became 69 per cent more affordable and in some areas, it is less expensive than a bottle of water.<sup>522</sup> Research consistently shows a clear relationship between alcohol prices and taxes, and consumption.<sup>523</sup> While taxes are generally regarded

### **Case Study Reducing health inequalities for those with additional needs**

The Health Trainer Programme was launched in 2005 and since then, more than 3,100 Health Trainers (HTs) have seen in excess of 60,000 people. HTs help people from disadvantaged and hard-to-reach communities to access local health services and make healthier lifestyle choices. Half of clients are drawn from the most deprived 20 per cent of local authority areas. Many of the HTs come from, or are knowledgeable about, the communities they work with. In most cases HTs work from locally based services and with clients on a one-to-one basis to assess their health and lifestyle risks. Nearly 90 per cent of Primary Care Trusts have an HT Service.

There has been considerable enthusiasm for the concept among third party organisations, particularly to provide services for those with additional needs or those who are more difficult to reach. There are nearly 80 HTs working with offenders. The British Army has trained 450 Physical Training Instructor HTs, and Royal Mail has trained two cohorts of first aid staff as HTs. The Hampshire Probation Area Health Trainer Service established in late 2006 is an award-winning example of the HT service working with a third party and providing support for those on probation, a group that often requires additional support.

Portsmouth City Teaching PCT commissioned the first four HTs in offender health in January 2007. The PCT commissioned the service because it recognised the huge health inequalities suffered by people on probation, who could be reached and helped by health trainers. It also recognised the educational benefit and potentially improved employment opportunities gained by HTs as a result of the basic transferable skills they are taught.

Based in the Probation Office in Portsmouth and employed by Learning Links (a third sector organisation), HTs work alongside Probation staff. Their role is to give advice and guidance to offenders

on how to access local health services and work with the offender to facilitate and help motivate them to make healthier behavioural changes to their lives and lifestyles. For most of the ex-offenders the HT programme is their first employment experience. With the HTs often coming from a similar background, living in the same community and having experienced some of the same health issues, they are more effective in working with the offenders in addressing their needs and empathising with their particular issues.

In 2008/9 Portsmouth Probation HTs saw 162 offenders. Some of the issues they worked on included smoking cessation, alcohol reduction, diet and nutrition, physical activity and registering with NHS services. They have carried out a range of tasks including accompanying a client to the dentist for the first time in 20 years and accompanying another to the leisure centre to play badminton and meet new people. Probation staff value HTs' contribution to rehabilitation, and a survey of Offender Managers using the HT service for their offenders found that the HTs were extremely professional and capable.

The Portsmouth City Teaching PCT and the Hampshire Probation Service received the Butler Trust Health Improvement Award for Healthcare and Health Promotion Work, recognising the effectiveness of the partnership between the Probation Service in Portsmouth and the NHS. The award also recognised the innovation of introducing ex-offender Health Trainers into the Probation Service, the significant positive impact HTs have had on the health needs of offenders, and the life-changing experience that being trained and employed as HTs has provided for ex-offenders.

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as regressive, the social patterning of alcohol consumption, where those on lower incomes drink less, means having a minimum price for alcohol may disproportionately *benefit* lower socioeconomic groups.<sup>524</sup>

Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.<sup>525</sup> Efforts to address smoking across the social gradient have led to a better understanding of the effectiveness of interventions. These interventions involve measures at population level to prevent people from starting smoking and helping them to quit, such as smoking bans, reducing smuggling, restricting advertising and placement, workplace interventions, for example, group therapy, individual counselling, self-help materials, nicotine replacement therapy and social support, and abolishing prescription charges for nicotine replacement therapy.<sup>526</sup>

While there have been improvements in understanding how to improve smoking cessation interventions, Figure 4.11 demonstrates there are still substantial gaps in understanding the effectiveness across the social gradient. This ‘supermatrix’ assesses the impact of eight interventions on the gradient, by looking at six sources of inequality. In

the diagram, studies with hard behavioural outcome measures are indicated with black bars, and studies with intermediate outcome measures with grey bars. The highest bars represent the most suitable study designs and the lowest bars represent the least suitable. Each bar is annotated with the number of other methodological criteria (maximum six) met by that study. In this systematic review, for instance, price has the most impact on the gradient in smoking.

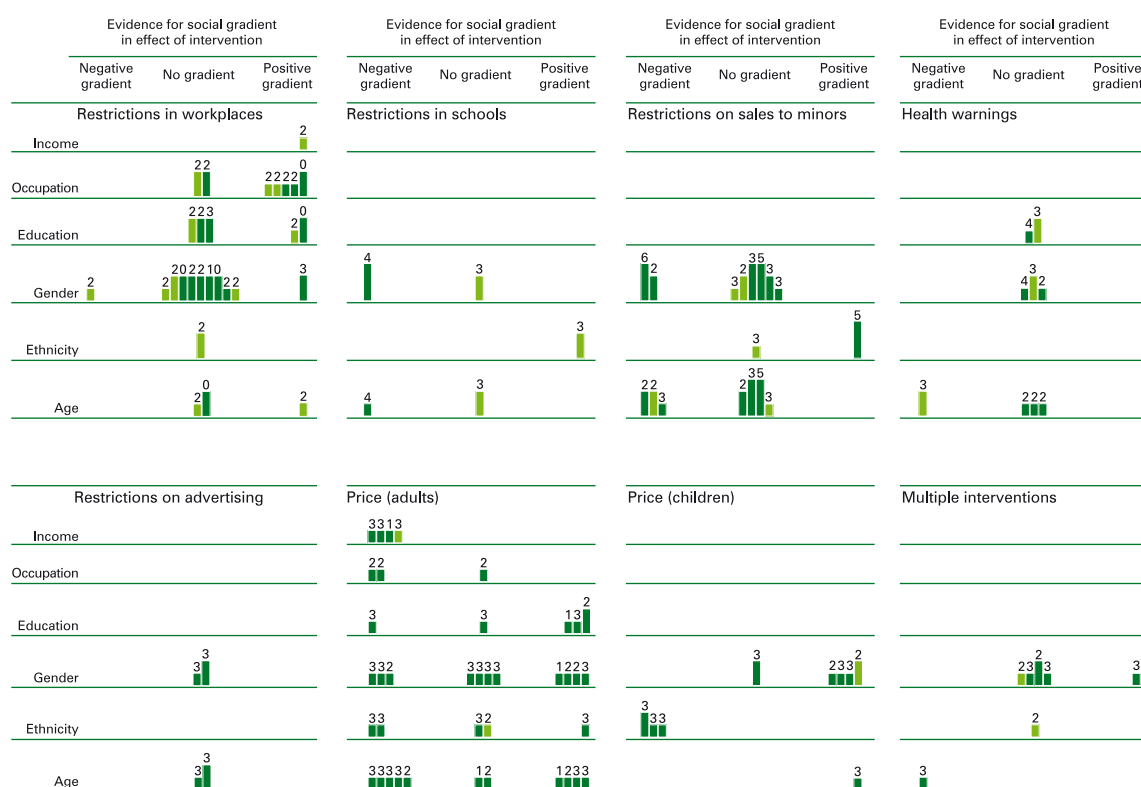
At local levels, greater emphasis in smoking cessation initiatives on the psychosocial reasons for smoking and prioritising deprived and marginalised groups is required, focused particularly on routine and manual socioeconomic groups, and people with mental health problems.<sup>527</sup>

In contrast to the impact of a minimum price on alcohol, increasing taxes on cigarettes is strongly regressive. While increasing the price of smoking is the most effective means of helping smokers quit, for those smokers who do not quit it can increase inequalities, particularly for less affluent smokers.<sup>528</sup>

### Addressing the causes of obesity across the social gradient

Tackling the causes of obesity is a complex task. The Foresight report of 2007 identified over 100 causes of obesity.<sup>529</sup> Policy Objective E also addresses issues related to obesity in recommending improvements to the access and quality of green space.

**Figure 4.11 Evidence of the effect of smoking cessation interventions across the social gradient<sup>530</sup>**



Source: Thomas et al<sup>531</sup>

At the beginning of the decade, obesity was directly responsible for over 9,000 premature deaths a year in England, a figure that has continued to rise each year despite a number of policy efforts.<sup>532</sup> In different ethnic groups obesity varies – see Figure 4.12, although measurement and classification is problematic, and the gradient among social classes is also growing – see Chapter 2. Modelled estimates predict that by 2015 obesity rates are expected to fall for girls from professional backgrounds and rise slightly for boys in this social group while rates among those from lower social classes are expected to keep rising faster for both boys and girls.<sup>533</sup>

Understanding the effectiveness of interventions to reduce obesity across the social gradient is improving. Teenagers' attitudes to diet and weight are partly shaped by their social class, levels of education and employment status.<sup>534</sup> Other studies have found that adults' physical activity increases and sedentary behaviours decrease according to socio-economic group but this relationship is less consistent in children and young people. Teenagers' levels of physical activity vary with income when physical activity is expressed as energy expenditure, but not when expressed in minutes of moderate to vigorous physical activity. Higher-income adolescents play more sport, which has a higher average intensity, but

participate less in active transport, which has a lower average intensity. At weekends, children from high income households participate in nearly twice as much sport as children from low income households – see Figure 4.13.<sup>535</sup>

Addressing obesity needs to be based on population-wide interventions.<sup>536</sup> Improving the availability of, and access to, healthier food choices among low-income groups involves population-wide interventions, such as reducing salt and saturated fat in products. Addressing the causes of obesity across the social gradient will require action across the life course and evidence-based interventions to tackle increased levels of obesity in particular social groups.

### Summary

- Research on health interventions should include health equity impact assessments.
- Drug policy should be based on medicalised treatment programmes.
- Population-wide interventions on smoking, alcohol and obesity are needed to reduce the social gradient but targeted interventions may be needed to target particular groups.

## Case Study Universal and targeted interventions to tackle obesity and reduce health inequalities

Tower Hamlets in East London has one of the highest ethnic minority populations in London. Tower Hamlets was selected as one of nine Healthy Towns in England and is the only London Borough to be part of the programme. It was awarded over £4.5 million to spend in 28 months (from December 2008 to April 2011). The programme aims to transform Tower Hamlets by promoting and supporting health and well-being, seeking to (for example) increase knowledge of healthy choices, improve walking and cycling routes and increase participation in walking and cycling, and improve access to healthier food choices.

The programme targets children and families, particularly Bangladeshi, Somali and low-income groups. The programme adopts a whole-system approach, working across three themes: healthy environments, healthy organisations and healthy communities. Projects supported by the programme are based on three cross-cutting strands – active lives, healthy food and active travel.

The Healthy Borough Programme (HBP) is comprised of 15 projects, covering all of the Borough and targeted programmes including:

- Green Grid to develop a comprehensive strategic plan for creating a network of high-quality walking and cycling routes
- Active Travel Routes and Active Travel Plans to provide better walking and cycling routes and increase levels of usage

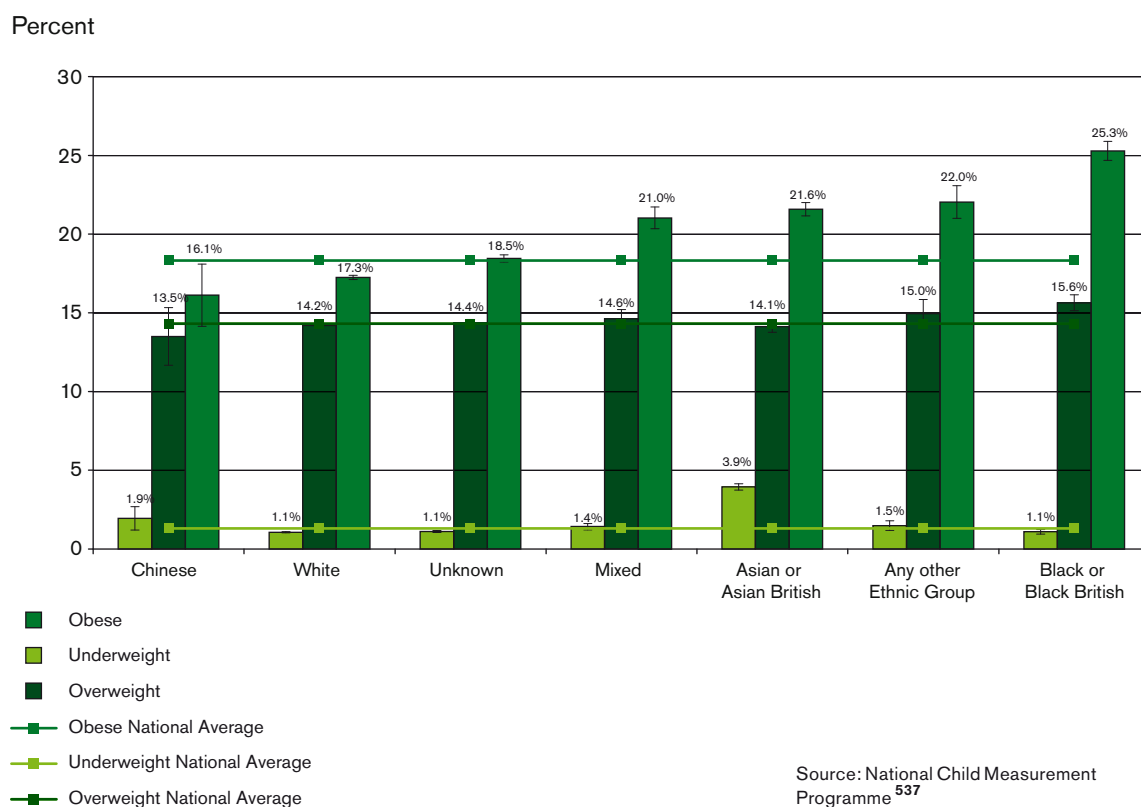
- Healthy Spatial Planning, to embed health and well-being objectives in the Local Development Framework
- Parks and Open Spaces, working with black and minority ethnic communities to promote greater use of parks and participation in activities that promote physical activity
- Active Play to ensure greater access and participation in active play
- Women and Girls Swimming Programme
- Healthy Food Outlets, Healthy Food and Healthy Families, to improve the provision of healthy food options and promote healthy diets and food choices in workplaces, schools, colleges, homes and early years settings.

The HBP seeks to ensure community engagement is embedded in all projects. One way of doing this is by offering funding grants (starting at £500) to local communities based on their own ideas and projects that will make healthy eating and physical activity easier.

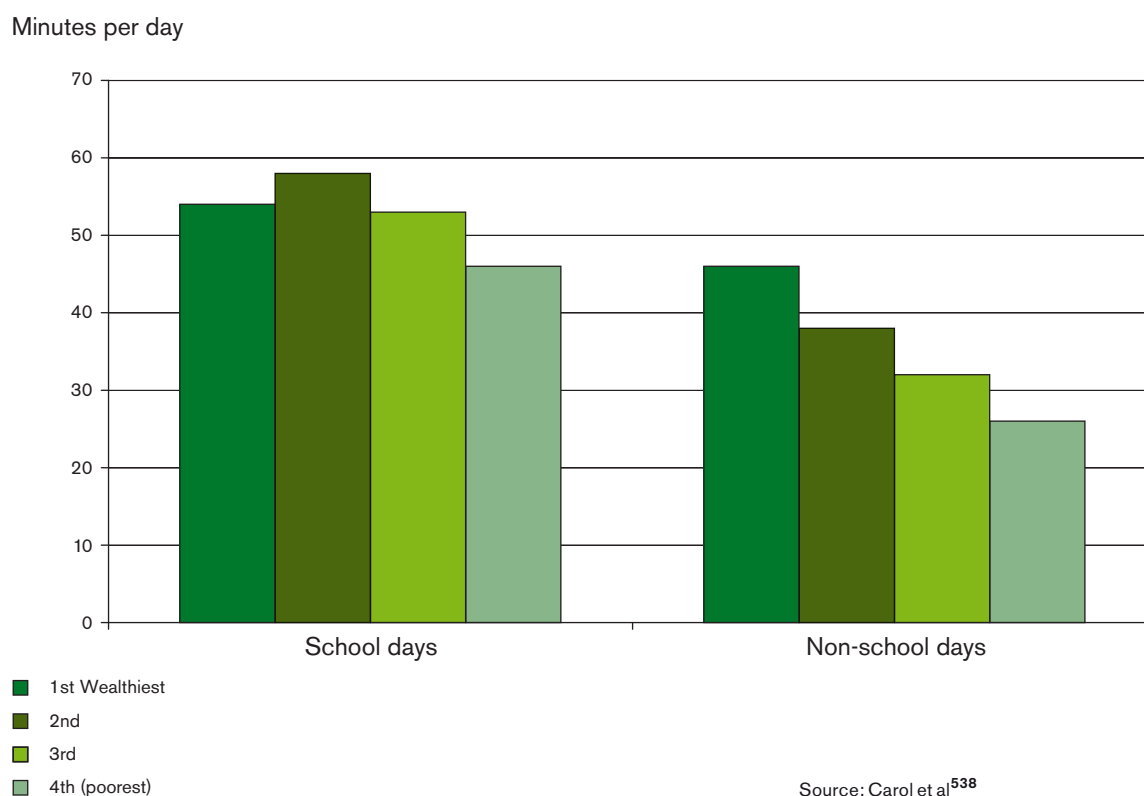
The HBP is being evaluated for its short-term outputs and longer-term outcomes. The HBP will also be part of the national evaluation of the Healthy Towns programme, which will assess how the Healthy Towns developed and are implemented.

For more information see [www.onetowerhamlets.net/healthy\\_borough.aspx](http://www.onetowerhamlets.net/healthy_borough.aspx)

**Figure 4.12** Prevalence of underweight, overweight and obese children in Year 6, by ethnic category, England, 2008/9



**Figure 4.13** Minutes per day spent doing sport, on school and non-school days, across four income bands, 2007



### F.2.3 Public health to focus interventions to reduce the social gradient

**Recommendation:** Core efforts of public health departments should be focused on interventions related to the social determinants of health, proportionately across the gradient.

The aim of this recommendation is to utilise the expertise of public health professionals to help develop local policies to tackle health inequalities. As established and also discussed in Chapter 5, in addition to the NHS, many sectors and professionals have key roles in addressing the social determinants of health.

Public health departments are responsible for a wide range of activities, including health protection,

ill health prevention and leading health inequalities strategies. Public health consultants lead the public health profession, but there is a much broader public health workforce, including:

- Health care professionals who are responsible for carrying out public health interventions or spend a great deal of time delivering this work, such as health trainers, health visitors, practice nurses
- Non-health professionals who communicate public health messages and carry out relevant interventions, such as those working in leisure centres, children's centres, housing, planning, transport and environmental departments, teachers and the broader schools workforce.

Many in the public health profession have championed health inequalities at a local level for a number of years. Across public health departments and in

#### Case Study Addressing the causes of the causes in ill health prevention and improving health

Hull, the eleventh most deprived local authority area in England, instigated a novel strategy to address ill health over the long term. Seventeen of Hull's 23 wards are in the most deprived 20 per cent of wards in England and in recent years poverty has worsened, with a 26 per cent increase in Jobseeker's Allowance claimants since October 2007. Over a third of children live in an income-deprived household and one fifth live in a house with no central heating. On any given day there are 3,000 young people not in school and 800 young people are classified as not in education, employment or training (NEETs). Hull's GCSE results are improving but remain well below the national average.

In light of the low levels of employment and educational attainment, NHS Hull introduced an *Earning and Learning Strategy* in 2009. Instead of planning short-term interventions, NHS Hull took a long-term and social determinants approach to ill health prevention.

The overarching model of the *Earning and Learning Strategy* (ELS) is to raise aspirations, particularly among the city's young people. All of the activity associated with the ELS seeks to support people to aim higher, not just to improve their health but also to improve educational and occupational attainment. The ELS takes a three-strand approach to address education, employment and health and well-being.

The project works with a number of partners including schools, colleges, health and social care, the NHS, Hull City Council, the local medical school, Jobcentres, Remploy, the third sector, Hull City Football Club and Hull rugby league team. The ELS works with primary and secondary school children and teachers, post-16 education providers, young people looking for work experience opportunities and employment, NEETs, lone parents, school leavers, ex-offenders and the unemployed.

The ELS includes a range of activities: a mentoring programme for Hull schools discussing careers in the NHS, collating an expertise database of health and social care staff willing to give presentations about their roles and services to schools and post-16 providers; a health award to support the promotion of health issues and develop the skills and knowledge of young people on health; a work experience placement coordinator post for a two-year fixed-term contract in partnership with Hull City Council; the creation of an NHS Job Shop in Hull that showcases health and social care careers while offering training and advice on a broad range of roles; development of apprenticeships and programme-led apprenticeships in various roles across the health community (NHS Hull has struggled to recruit and found many local people think the NHS only employs highly qualified staff).

Other activities address employment, education and health and well-being outside the NHS, such as contributing financially and strategically to the relocation of the Hull AFC training ground to within the Hull city boundary, commissioning projects with Hull City AFC and Hull Kingston Rovers (rugby), aiming to increase young people's levels of physical activity and raising life aspirations, and designing and commissioning a 'Better Baby Sitting' scheme for Hull. Programmes will also work closely with employers to improve the quality of work, such as supporting employers when dealing with mental health issues that impact on their workforce and planning a commissioned occupational health service for small businesses in Hull.

For more information see [www.hullpct.nhs.uk](http://www.hullpct.nhs.uk)

the wider NHS, more efforts can be made to more effectively address the social determinants of health, using evidence-based research. Public health professionals *at all levels* should consistently use evidence to develop local policies and interventions. For example, many public health interventions are based only on providing information, such as leaflets, posters and advertisements. However, this method has been shown to have limited impact across the social gradient. For example, surveys find that mothers are aware that they should give their children healthy meals with more fruit and vegetables, yet even so do not provide these types of meals to their children.<sup>539</sup> The problem is not just about information; in this case, other methods are needed to help encourage healthier cooking: ensuring the availability of cheap healthy food, and encouraging children to eat fruit and vegetables.

As this report has shown, research is needed in many areas to demonstrate effectiveness of interventions, particularly across the social gradient. As NICE guidance recommends, those who carry out interventions, at all levels, should ensure that evaluations include measures of: effectiveness, acceptability, feasibility, equity and safety. Wherever ill health prevention and health promotion take place, whether

in primary care, a school or in a leisure centre, evaluations should assess effectiveness across the social gradient. For example, free swimming initiatives and efforts to improve physical activity associated with the Olympics should be evaluated across the social gradient, which involves more than simply assessing the increase in numbers. The impact of interventions should be assessed by measurable indicators of reductions in health inequalities and separately assessed for cost-efficiency.

### Summary

- The public health workforce includes a wide range of public health and non-public health personnel.
- More efforts can be made by all working in public health to reduce health inequalities.
- All interventions and strategies should be evaluated.

## F.3 Policy Recommendations

### Time period: 2011–2015

In addition to the interventions made in Recommendations A–E, the following recommendations are put forward:

- 1 Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.
- 2 Increase the development and roll-out of a programme of preventive interventions that are effective across the social gradient, including:
  - Increasing the scale and quality of medical drug treatment programmes
  - Focus in a public health lifestyle interventions to reduce the social gradient in, for example, obesity, smoking, and alcohol.
- 3 Refocus the core efforts of public health departments on interventions related to the social determinants of health.

### Time period: 2016–2020

- 1 Refocus mainstream spending across government to increase spending on ill health prevention by 10 per cent per year to reduce health inequalities.
- 2 Continue the roll-out of a programme of preventive interventions that are effective across the social gradient:
  - Channel problem drug users through medical treatment programmes
  - Make an evidence-based increase in the intensity of lifestyle interventions aimed at reducing the social gradient.
- 3 Continue action to focus core efforts of public health departments on the social determinants of health.

### Time period: Beyond 2020

- 1 Investment in ill-health prevention to reach 0.5 per cent of GDP by 2030, with spending focused proportionately across the social gradient
- 2 Preventive interventions that are effective and evidence-based across the social gradient implemented.
- 3 Joined up local action to deliver ill health prevention proportionately across the social gradient.