Fair Society, Healthy Lives

The Marmot Review

Strategic Review of Health Inequalities in England post-2010
Rise up with me against the organisation of misery

Pablo Neruda
Note from the Chair

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the ‘real’ concerns with health – health care and unhealthy behaviours – it should become the main focus. Consider one measure of social position: education. People with university degrees have better health and longer lives than those without. For people aged 30 and above, if everyone without a degree had their death rate reduced to that of people with degrees, there would be 202,000 fewer premature deaths each year. Surely this is a goal worth striving for.

It is the view of all of us associated with this Review that we could go a long way to achieving that remarkable improvement by giving more people the life chances currently enjoyed by the few. The benefits of such efforts would be wider than lives saved. People in society would be better off in many ways: in the circumstances in which they are born, grow, live, work, and age. People would see improved well-being, better mental health and less disability, their children would flourish, and they would live in sustainable, cohesive communities.

I chaired the World Health Organisation’s Commission on Social Determinants of Health. One critic labelled the Commission’s report ‘ideology with evidence’. The same charge could be levelled at the present Review and we accept it gladly. We do have an ideological position: health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice. But the evidence matters. Good intentions are not enough.

The major task of this Review was to assemble the evidence and advise on the development of a health inequalities strategy in England. We were helped by nine task groups who worked quickly and thoroughly to bring together the evidence on what was likely to work. Their reports are available at www.ucl.ac.uk/ghec/marmotreview/Documents. These reports provided the basis for the evidence summarised in Chapter 2 of this report and the policy recommendations laid out in Chapter 4.

Of course, inequalities in health are not a new concern. We stand on the shoulders of giants from the 19th and 20th centuries in seeking solutions to the problem. Learning from more recent experience forms the basis for Chapter 3.

While we relied heavily on the scientific literature, this was not the only type of evidence we considered. We engaged widely with stakeholders and attempted to learn from their insights and experience. Indeed, an exciting feature of the Review process was the level of commitment and interest we appear to have engaged in central government, political parties across the spectrum, local government, the health services, the third sector and the private sector. The necessity of engaging these partners in making change happen is the subject of Chapter 5.

Knowing the nature and size of the problem and understanding what works to make a difference must be at the heart of taking action to achieve a fairer distribution of health. We therefore propose a monitoring framework on the social determinants of health and health inequalities in Chapter 5 and Annex 2.

From the outset it was feared that we were likely to make financially costly recommendations. It was put to us that economic calculations would be crucial. Our approach to this was to look at the costs of doing nothing. The numbers, reproduced in Chapter 2, are staggering. Doing nothing is not an economic option. The human cost is also enormous – 2.5 million years of life potentially lost to health inequalities by those dying prematurely each year in England.

We are extremely grateful to two Secretaries of State for Health: Alan Johnson for having the vision to set up this Review and Andy Burnham for continuing to support it enthusiastically. When the report of the Commission on Social Determinants of Health was published in August 2008, Alan Johnson asked if we could apply the results to England. This report is our response to his challenge.

The Review was steered by wise Commissioners who gave of their knowledge, experience and commitment. It was served by a secretariat whose knowledge and selfless devotion to this task were simply inspiring. I am enormously grateful to both groups. One way and another, through excellent colleagues at the Department of Health, working committees, task groups, consultations and discussions, we involved scores of people. I hope they will see their influence reflected all through this Review.

I quoted Pablo Neruda when we began the Global Commission, and it seems appropriate to quote him still:

‘Rise up with me against the organisation of misery’

Michael Marmot (Chair)
In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy will include policies and interventions that address the social determinants of health inequalities.

**The Review had four tasks**

1. **Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action**

2. **Show how this evidence could be translated into practice**

3. **Advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy**

4. **Publish a report of the Review’s work that will contribute to the development of a post-2010 health inequalities strategy**

**Disclaimer**

This publication contains the collective views of the Strategic Review of Health Inequalities in England post-2010, chaired by Professor Sir Michael Marmot, and does not necessarily represent the decisions or the stated policy of the Department of Health. The mention of specific organisations, companies or manufacturers’ products does not imply that they are endorsed or recommended by the Department of Health in preference to others of a similar nature that are not mentioned.

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The work of the Review was championed, informed, and guided by the Chair of the Commission and the Commissioners.


The Marmot Review team was led by Jessica Allen. Team members included Peter Goldblatt, Mike Grady, Jason Strelitz, Ilaria Geddes, Sharon Fried, Felicity Porritt, Elaine Reinertsen, Ruth Bell and Matilda Allen.

The Department of Health supported the Commission in many ways. In particular we thank Una O’Brien, Mark Davies, David Buck, Ray Earwicker, Geoff Raison, Maggie Davies, Steve Feast, Martin Gibbs, Chris Brookes, Anne Griffin and Lorna Demming.

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We thank the stakeholders who participated in the policy dialogues and open space event and responded to the consultation; a list of participants and respondents can be found on the Marmot Review website at www.ucl.ac.uk/healthinequalities.

We thank our regional partners including Ruth Hussey, Mike Farrar and Danila Armstrong in the North West and in London Boris Johnson, Mayor of London, Pam Chester and Helen Davies.

The report was copy-edited by Georgina Kyriacou.

We are grateful to UCL for hosting and supporting the Review team and to the thousands of people and organisations who have contributed to discussions with the team, who have attended presentations, provided feedback, thought and comment and helped shape and inform this Review.
The Commissioners

Michael Marmot (Chair)
Tony Atkinson
John Bell
Carol Black
Patricia Broadfoot
Julia Cumberlege
Ian Diamond
Ian Gilmore
Chris Ham
Molly Meacher
Geoff Mulgan
# Executive summary

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Chapter 5

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Figure 5.2
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Key messages of this Review

1 Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.¹

2 There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health.

3 Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

4 Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

5 Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

6 Economic growth is not the most important measure of our country’s success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.

7 Reducing health inequalities will require action on six policy objectives:
   — Give every child the best start in life
   — Enable all children young people and adults to maximise their capabilities and have control over their lives
   — Create fair employment and good work for all
   — Ensure healthy standard of living for all
   — Create and develop healthy and sustainable places and communities
   — Strengthen the role and impact of ill health prevention

8 Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.

9 Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.
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.\textsuperscript{417}

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.\textsuperscript{418} 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).\textsuperscript{419}

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.\textsuperscript{420} 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.\textsuperscript{421}

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

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

\textbf{Figure 4.7 Percentage of population by social grade who visit a green space infrequently in a year, 2009}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure4.7.png}
\caption{Percentage of population by social grade who visit a green space infrequently in a year, 2009}
\end{figure}
design and quality. 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. A natural play environment at school also helps reduce bullying, increases creative play, improves concentration and a feeling of self worth in children. 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. 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.

Designing neighbourhoods well can also increase their ‘walkability’: how geared they are to enabling people to walk or cycle to destinations. 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. 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.

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. In densely populated urban areas, green space located within walking distance is more likely to promote physical activity outside the home. 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.

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. 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...
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. 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. 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.

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. One study in the UK on the greater access to unhealthy food has shown this may disproportionately affect those in more deprived areas. 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.

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**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
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. 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. 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.

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. 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. 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.

**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$_2$ per million population. 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.

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. 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. The risk of fuel poverty rises sharply as household income

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

Percent of households in fuel poverty

<table>
<thead>
<tr>
<th>Household income quintiles</th>
<th>Percent of households in fuel poverty</th>
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</thead>
<tbody>
<tr>
<td>Poorest fifth</td>
<td>35</td>
</tr>
<tr>
<td>2nd</td>
<td>25</td>
</tr>
<tr>
<td>Middle fifth</td>
<td>20</td>
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<tr>
<td>4th</td>
<td>10</td>
</tr>
<tr>
<td>Richest fifth</td>
<td>5</td>
</tr>
</tbody>
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Note: Percent in fuel poverty relates to households in fuel poverty after deducting housing costs

Source: English House Conditions Survey, Department of Communities and Local Government.
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. 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. 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.

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). Adequate heating systems improve asthma symptoms and reduce the number of days off school.

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. 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.\footnote{462}

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.\footnote{463} 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’.\footnote{464} 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.\footnote{465} 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.

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**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 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
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. 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.’

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. Residents of busy streets have less than one quarter the number of local friends than those living on similar streets with little traffic. The most powerful sources of stress are low status and lacking social networks, particularly for parents with young children. Low levels of social integration, and loneliness, significantly increase mortality. 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. There is strong evidence that social relationships can also reduce the risk of depression. 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
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.474

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 compares to between one-quarter and one-third in other areas.476

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.477

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 NDC478 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.479 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.480 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.481

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

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.
### E.3 Policy Recommendations

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<tbody>
<tr>
<td>1. Prioritise policies and interventions that reduce both health inequalities and mitigate climate change, by:</td>
<td>1. Implement policies and interventions that both reduce health inequalities and mitigate climate change, including:</td>
</tr>
<tr>
<td>— Increasing active travel across the social gradient</td>
<td>— Maintaining active travel across the social gradient</td>
</tr>
<tr>
<td>— Improving access and quality of open and green spaces available across the social gradient</td>
<td>— Maintaining access and quality of open and green spaces available across the social gradient</td>
</tr>
<tr>
<td>— Improving local food environments across the social gradient</td>
<td>— Sustained and continued upgrade of housing stock.</td>
</tr>
<tr>
<td>— Improving energy efficiency of housing and reducing fuel poverty.</td>
<td></td>
</tr>
<tr>
<td>2. Prioritise integration of planning, transport, housing, environmental and health policies to address the social determinants of health in each locality.</td>
<td>2. Implement greater integration of the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.</td>
</tr>
<tr>
<td>— Remove barriers to community participation and action</td>
<td></td>
</tr>
<tr>
<td>— Emphasise a reduction in social isolation.</td>
<td></td>
</tr>
</tbody>
</table>

**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.