Quality of Life

# Fair Society, Healthy Lives

## Marmot Review – Impact on the Housing Sector

NORTHERN Housing Consortium

THE VOICE OF HOUSING IN THE NORTH

## March 2010

February 2010 saw the publication of Sir Michael Marmot's Strategic Review of Health Inequalities in England post 2010. It was commissioned in November 2008 by the Secretary of State for Health to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The review had four key tasks:

- Identify (for the health inequalities challenge facing England) the evidence most relevant to underpinning future policy and action.
- Show how this evidence could be translated into action.
- Advise on possible objectives and measures, building on the experiences of current PSA target on infant mortality and life expectancy.
- Publish a report that would contribute to the development of a post 2010 health inequalities strategy.

The subsequent report provides a wealth of evidence around health inequalities and policy recommendations that will assist in reducing the devastating impact of health inequality. The policy areas addressed span from early years' interventions through to employment; healthy standards of living; sustainable and healthy places and communities, and strengthening the impact of ill health prevention.

This briefing paper is intended to provide Northern Housing Consortium (NHC) Members with key highlights from the Marmot review that impact on the housing sector.

**Why health inequalities matter in the North**

The scale of health based challenge facing us nationally is considerable -

- Demographic projections point to a rapidly ageing society, with the over 85 age group increasing by 85% by 2031.

- Last year saw over 36,000 excess winter deaths – every year we see over 20,000 excess winter deaths.

- Over 17.5 million people in the UK live with a long term condition – by 2025, at least half the population will have at least one long term condition

- Long term care costs are set to rise by 300% by 2051.

- Dementia is the main cause of disability in later life – with a case of dementia being diagnosed every 3 minutes.

And for the North, the picture is especially challenging. The association between deprivation and poor health has long been established and we see a consistent North/South divide in terms of health inequalities:

- Gaps in health inequalities have increased in 44 of the Spearhead Local Authorities – two thirds of which are in the North.

- Life expectancy rates in the North are lower than in the South by at least 2 years. Furthermore, the Marmot Review details how life expectancy in the poorest areas is 7 years less than in the richest neighbourhoods, and that disability is likely to impact on those in poorest areas 13 years before it does in richer communities.

- Twice as many families in the North East receive means-tested benefits than the South East, which affects their ability to have a "healthy standard of living".

- 97 of the top 100 super output, most deprived areas in terms of health are located in the North.

There is a social justice imperative to reducing health inequalities, but equally, there is an economic incentive…

> "If everyone in England had the same death rates as the most advantaged people, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed 1.3 and 2.5 million extra years of life. They would, in addition, have had a further 2.8 million years free of limiting illness or disability.
>
> It is estimated that inequality in illness accounts for productivity losses of £31-£33 billion per year, lost taxes and higher welfare payments in the range of £20– £32 billion per year, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year." *Marmot Review 2010, p 18.*

This picture of health inequality is not new to NHC Members, and so the focus from the Marmot Review on tackling the social determinants of ill health and health inequality is to be welcomed, as it enables the housing sector to demonstrate the positive impact it has on improving the health inequalities facing our communities and neighbourhoods.

**Social determinants on ill health**

The Review identifies key areas as being particularly powerful in shaping health and health inequalities. These are:

- Early years and health status
- Education and health
- Work, health and wellbeing
- Income and health
- Communities and health

There are social determinants of health relating to early years development and the relationship between health and education that will be of interest to several of our Members, however, for the purpose of this briefing, we have focused on the latter 3 policy areas.

*Work, health and wellbeing*

Insecure and poor quality employment is associated with an increased risk of physical/mental health deterioration. Principal issues amongst work related ill health are musculoskeletal disorders and mental health. In one study in Liverpool, mental health conditions accounted for 40% of all sickness absences from work.

Unemployed people incur increased health risks – including increased rates of mental illness and limiting long term illnesses. In addition, the unemployed face a multiplier effect as unemployment contributes to ill health and poor health increases the likelihood of unemployment. Getting people into secure employment is therefore an important process for improving health.

*Income and health*

There is a long accepted relationship between low income and poor health which operates in a variety of ways – impacting on diet, service consumption, exclusion from social activities and increased isolation. Furthermore, there is substantial evidence that particular social groups are at higher risk of having a low income – including disabled adults, people with mental health problems, those with caring responsibilities, lone parents and young people.

Income and wealth may be important for health strategy as they are markers for socioeconomic position which has a considerable impact on health. The housing sector has an established track record in tackling worklessness and supporting the development of enterprise and employment opportunities – we should consider how well we evaluate the health impact of this activity.

*Communities and Health*

The relationship between poor environment (deprived neighbourhood) and risk of ill health is well known. The relationship to social housing here is key. Over the past 20 years, the poorest groups have been concentrated in social housing. Longitudinal analysis of three British Birth Cohort studies (1946, 1958 and 1970 cohorts) shows that:

> "Being in social housing as a child increases the risk of multiple disadvantages in adulthood."

As the level of disadvantage has increased through these cohorts alongside the growth in owner occupation, it may suggest that it is not the product of social housing itself that is a causal factor – rather it is the relationship social housing as a sector has with other tenures, and the policy management decisions around social housing which impact on health inequalities.

Poor physical housing conditions (including homelessness and temporary accommodation) contribute to health risks – both physical and mental. Fuel poverty has also been identified as key risk area, leading in part to over 20,000 excess winter deaths each year.

Housing providers have long understood that it is not simply the bricks and mortar of a house that impacts on health and well being but wider environmental neighbourhood determinants – including green spaces, travel facilities and air quality. The Marmot Review further supports this assumption and should allow the housing sector to play a strengthened, more visible role in tackling health inequality.

**Barriers to reducing health inequalities**

The Review analyses a range of barriers that can negatively impact on attempts to reduce health inequalities. For this briefing we have identified those most likely to be:

- 'Quick wins' versus sustained policy direction
- Geography of interventions
- Local delivery and Partnership working
- Information and analysis

In examining each of these, we would welcome feedback from Members on recommendations for improvements or positive practice.

*Quick Wins v Sustained Policy Direction*

Across social policy, we have seen the growth of targeted programmes and initiatives. There is now a strong body of evidence that suggests tackling health inequalities effectively requires a longer horizon – not least because of the time lag of evidenced improvements. Such an approach will, in turn, require political will and sustained resource streams, community development and capacity building.

Furthermore, the Review states, it is the *intersection* between different domains that is critical – health and work, health and housing and planning, health and education.

> "Success is more likely to come from the cumulative impact from a range of complementary programmes than from any one individual programme and through more effective, coherent delivery systems and accountability mechanisms."
> *Marmot Review p 87*

**Do you have examples of effective long term integrated services across the housing, health and social care spectrum that can act as positive practice for others?**

**How can you build an evidence base to support sustained intervention without resorting to a "quick win" scenario?**

*Geography of Interventions*

We are used to seeing programmes or projects focus on specific geographic areas – within a health context, this is often the spearhead areas. However, it is not always the case that such initiatives target the *most appropriate* people within that geography. Indeed, there is some evidence to suggest that this lack of targeting, coupled with other factors, means that health inequality interventions are more quickly taken up by wealthier, more health aware elements of the population – for example, stopping smoking services.

**Is there a role for the housing sector to play in more nuanced targeting of health interventions? Do you have case study examples of improving health programmes through more effective customer profiling?**

**How effective is your customer profiling material – and how are you using this to commission (or inform the commissioning of) new services?**

*Local Delivery and Partnership working*

The Review highlights a perception amongst some agencies that responsibility for delivery lies with the local NHS. It further argues the Local Authority role has become unclear as there has been an artificial separation of health policy from other major policy areas that act as determinants on health (education, employment, housing etc).

Our own recent report exploring the contribution of the housing sector to the JSNA process highlighted similar concerns around partnership working - the value of engaging with senior personnel who will be able to drive forward partnership activity.

Furthermore, the complexity of agreeing common targets and approaches within the context of different organisations, roles, responsibilities and funding streams has been cited as a barrier to effective partnership working.

**What success have you had in building effective partnership, aligning or even pooling funding streams?**

*Information Analysis*

A factor which impacts to a significant degree on the success of partnership approaches is quality of evidence and data analysis. Progress in partnership is frequently hampered by an absence of shared information and lack of understanding of importance quality evidence.

We are currently working on a pilot in Halton which is seeking to create a common data set amongst the housing providers operating within the area. This common data set will then assist in shaping engagement with the health sector – supporting an improved data base and hopefully providing a more effective access point for health interventions to work within a community.

The Review states that more effective and improved needs identification of populations, coupled with better quality information from communities, should lead to better service commissions and subsequently health improvements and a reduction in health inequalities. This supports the NHC view that housing organisations have a very strong role to play – not just in delivering

services but through engagement in processes such as the JSNA – and can and should inform and influence health service direction.

Furthermore, the Review identifies community engagement and participation as effective routes for both shaping health services, but also directly impacting on health inequalities for example, reducing social isolation through effective community empowerment can be hugely beneficial in health terms – and is a key challenge as we have seen one person households increase from 26% of population in 1991 to over 30% by 2001.

Members' considerable experience of community engagement should provide at least a positive practice model for others to learn from – but it is more likely the case that the health sector will see housing providers as excellent gateways into communities – able to engage with people on health based issues in a non health setting – and in so doing being able to reach people who may not otherwise have engaged with healthcare providers.

**Policy Recommendations**

The Marmot Review explores six policy objectives as detailed earlier. Those recommendations which have a particular resonance to Consortium members include:

***Policy Objective C – create fair employment and good work for all***

- Prioritise active labour market programmes to achieve timely interventions to reduce long term unemployment.
- Develop greater security and flexibility in employment by:
    - Prioritising greater flexibility of retirement age.
    - Encouraging employers to create or adapt jobs that are suitable for loan parents, carers and people with mental and physical health problems.

***Policy Objective D – ensure a healthy standard of living for all***

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- Establish a minimum income for healthy living for people of all ages
- Reduce the cliff edges faced by people moving between benefits and work.

***Policy Objective E – create and develop healthy and sustainable places and communities***

- Improve energy efficiency in housing across tenures – reducing fuel poverty.
- Fully integrate planning, transport, housing, environmental and health systems to address health inequalities in each locality.
- Support community regeneration schemes that remove barriers to community participation and reduce social isolation.

***Policy Objective F – strengthen the role and impact of ill health prevention***

- Increase availability of long term and sustainable funding in ill health prevention.
- Refocus mainstream spending across government to increase spending on ill health prevention by 10% each year to reduce health inequalities.
- Investment in ill health prevention to reach 0.5% of GDP by 2030.
- Joined up action to deliver ill health prevention.

**Northern Housing Consortium – next steps**

Integration of housing, health and social care is one of the Northern Housing Consortium's key policy areas and we will continue to promote the valuable contribution that the housing sector is able to make to reduce health inequalities.

Ongoing projects that we are working on include:

***Role of housing sector in shaping JSNA's***

Mapping out the scale of integration (and influence) that the housing sector has had in the JSNA process to date.

***Creating a common data set to support a "housing to health" offer***

Exploring within a pilot setting how a common data across multiple housing providers within a Local Authority setting could impact on how services are commissioned and delivered and also how this data/needs analysis can be used to engage more effectively with the health sector.

***Integrated Living Network – Action Learning Group***

Cross disciplinary network which meets on a quarterly basis to explore, challenge and drive forward integration across housing, health and social care.

***Assistive technology evaluation model***

User friendly evaluation model which assists in demonstrating the impact of AT services both in terms of customers/carers, but also efficiency savings from using AT as a preventative service.

***Customer profiling***

Service to support members in identifying customer profiling needs and how to use this information to shape services.

***Mental health and housing***

What tools does the housing sector need to better support those with mental health problems?

***Adaptations – more efficient, more support***
Supporting members to shape effective adaptations services, promoting efficiency through effective procurement of adaptations equipment.

***Adaptations – national design competition***
We will be running a national design competition to drive up standards of design in adaptations to make them less clinical and institutional and more in line with 21st century lifestyles and aspirations.

***Age Friendly Communities***
We launched our groundbreaking report on Age Friendly Communities in January 2010 and continue to champion the age friendly design within neighbourhoods.

***Assistive Technology***
Our assistive technology procurement frameworks offer excellence, value for money and high quality support in meeting your assistive technology requirements

We are keen to hear from members about initiatives and programmes that you are working on with the aim of better integration between health, housing and social care. Similarly, do let us know if there is an issue you feel the Consortium should be supporting. For more information on the Consortium's work in the field of health and social care or to discuss any of the projects in more detail, please contact:

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