"IF YOU COULD DO ONE THING..."

Nine local actions to reduce health inequalities

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Executive Summary

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Recent governments have made health, and often health inequalities, a priority. But, whilst health outcomes – certainly as measured by life expectancy – have been rising, health inequalities have not only persisted, but widened. A fresh perspective and new solutions are needed.

The Marmot Review showed that socio-economic inequalities affect health outcomes and confirmed that there is a social gradient in health. Those who are best off financially do best on health outcomes too, with the converse true for the poorest. The case for action is clear and the move of public health responsibilities to local government offers the opportunity for locally led, joined-up responses.

Analysis in America has suggested that as little as 20% of the influences on health are to do with clinical care and quality of care. Health behaviours account for 30% of influences and the physical environment for 10%, but it is socioeconomic factors that have the largest impact on health – 40% of all influences. The social sciences have an essential contribution to make if health inequalities are to be reduced.

This report seeks to facilitate that contribution and to start a process of better connecting public health and social science. The British Academy brought together a group of respected experts from across the social sciences. Each was asked to write a proposal focusing on one issue and one intervention that would reduce health inequalities, which could be adopted by local authorities and health and wellbeing boards. A tough ask, especially in the academic world. But we wanted to concentrate minds on the translation of academic understanding into local implementation.

In summary, the expert authors, topics covered and suggested interventions are:

1. **Kate Pickett on local social equity:** *Implement a living wage policy*

   In her proposal, **Kate Pickett** identifies how implementing a 'living wage' policy would have a direct impact on income inequality, which in turn is a root cause of health inequalities and other social ills. She argues that paying a living wage would help to address 'in-work poverty', reduce income inequality, provide an incentive to work and enhance health and wellbeing. For employers, she identifies it may benefit work quality and productivity, reduce absenteeism and have a positive impact on staff recruitment and retention.

2. **Edward Melhuish on early childhood interventions:**
   Focus resources on improving life chances in early childhood

   Edward Melhuish argues that the impact of social origins on child outcomes and wellbeing is strong and persistent and that, coupled with the increasing skills required in the modern labour market, the imperative for action is economic as well as social. Alongside a positive home learning environment, universal and high-quality Early Childhood Education and Care (ECEC) is identified as of particular importance in breaking the link between parental attainment and children's outcomes.

3. **Danny Dorling on transport planning and traffic management:** *Implement 20mph speed limits where 30mph ones have usually been in place*

   In his proposal, **Danny Dorling** demonstrates how implementing 20mph speed limits (where 30mph ones have been) could be one of the cheapest and most effective methods for improving public health today. Easily enacted at the local level, this very literal slow-down would reduce the risk of pedestrian – and especially child – fatalities and bring about wider benefits such as less pollution and stronger communities. He argues that this measure would reduce inequalities because people tend to be at most risk of being hurt or killed by cars in the poorer parts of towns and cities.

4. **Clare Bambra on worklessness:** *Take a 'health first' approach to tackling health-related worklessness*

   Clare Bambra outlines the relationship between ill health and unemployment and advocates a 'health first' approach to tackling worklessness: this would target root causes (i.e. health) first, in contrast to previous approaches that have focused on skills and employability. She uses the case study of the County Durham Worklessness and Health model to demonstrate the potential of such an approach and argues that this could be an important way for clinical commissioning groups, work programme providers and local authorities to work in partnership to reduce local worklessness and health inequalities.

5. **Kwame McKenzie on public mental health and mental capacity:** *Use a form of participatory budgeting to make decisions on public health priorities and interventions*

   In his proposal, **Kwame McKenzie** suggests that health and wellbeing boards could improve mental capital and decrease disparities by using a modified version of participatory budgeting in their decision making. Identifying that public health interventions to improve mental capital typically aim to change individual exposure to risk factors, or to build environments that promote resilience and health, he argues that the *process* of implementation could be designed to have an impact, as well as the intervention itself.

6. **Tarani Chandola and Andrew Jenkins on further and adult education:** *Utilise the substantive role of further and adult education in reducing social inequalities in health*

   Tarani Chandola and **Andrew Jenkins** consider how further and adult education can reduce social inequalities in health. Identifying that those who leave school without any

qualifications are far more likely than their better educated peers to be in poor health – and to have greatly reduced social and employment life chances, they argue that policy should have a focus on acquisition of skills and qualifications by disadvantaged adults. Their proposal suggests that courses not leading to a formal qualification should be subsidised because of their economic, social and health benefits and identifies the wellbeing benefits of non-vocational courses for older adults.

7. **James Y. Nazroo on health inequalities and ethnicity:** *Adopt local policies to improve the employment conditions of public sector workers*

   Analysing the complex issues of ethnicity and health inequalities, **James Nazroo** considers that this topic has been substantially neglected in policy discussions. His proposal summarises key elements of the available evidence and evaluates possible explanations for observed inequalities. He concludes that social and economic inequalities are the driving force for ethnic inequalities in health and that substantial policy development is required in this field. He argues for the improvement in employment conditions of public sector workers as a specific public health intervention.

8. **Hal Kendig and Chris Phillipson on older age-friendly urban development:** *Implement locally based 'age-friendly environments' that facilitate improvements in the independence, participation, health and wellbeing of older people*

   Hal Kendig and **Chris Phillipson** argue that place matters, and that older people living in urban areas face specific issues around social integration, access to services, leisure and mobility. They determine that taking action on behalf of (and ideally involving) older people can facilitate social wellbeing, enable them to continue to contribute to the communities in which they live and, crucially, influence healthy life expectancy. Their proposal identifies significant opportunities for action on ageing and the built environment that are emerging in the UK, such as the efforts of Manchester and York to become age-friendly cities.

9. **Alan Maynard on the importance of evaluation:** *Make good use of evidence of cost-effectiveness before choosing between competing interventions to reduce health inequalities*

   Alan Maynard's proposal makes clear the need for systematic evaluation and evidence of cost-effectiveness in informing choices between interventions. He argues that, without hard-nosed evaluation, scarce resources will be focused on proven and efficient interventions and health inequalities will persist or increase. Identifying that better use needs to be made of economists and economic analysis – with robust evidence also vital to overcoming any resistance to change – he advises that inequality will only be reduced successfully if new interventions are piloted and understood before roll-out, and evidence-based policy moves from rhetoric to reality.

As Jim McManus and Jane Roberts make clear in their introduction to this report, local authorities are major players in health. Their responsibilities within the fields of housing, planning, urban design, transport, early years and parenting, leisure services, education, skills and employment have always made that the case. The recent transfer

of responsibility for public health to local government and the creation of health and wellbeing boards only add to their influence.

Despite the considerable reduction in their resources, there exists a real opportunity for local authorities to make a difference. Realising this will depend upon the leadership of elected members, the quality of public health staff, the use of existing resources and the application of evidence to guide effective action.

Guidance on improving the population's health has often been focused on insights from biomedical or behavioural sciences and has tended to highlight interventions targeted at individuals. While valuable, the much trickier structural issues like housing policy or worklessness have had less focus. The two approaches are not mutually exclusive. It seems clear from the ongoing work of *The Marmot Review* that strategies that combine structural, societal-based approaches with individual approaches are essential if we are really going to make a difference to health inequalities.

Accordingly, this report does not focus on individual and behavioural interventions, including diet and physical activity. Instead, it features distinct contributions from contrasting, but ultimately connected, areas of the social sciences. Some readers will, understandably, ask why housing and its importance in a balanced public health strategy is not included in this collection. Jim McManus and Jane Roberts consider that the case for the importance of housing as a public health intervention is already well made, but they call for a more systematic treatment for policymakers of the health and place agenda, including housing, which is beyond the scope of this volume.

The great strength of local government is, of course, that it is local and thus in a far better position than Whitehall to understand the detail of its local area and its needs. It is better placed to know what local interventions may be possible, and how they may be best delivered. In doing so, there is much potential to draw upon national and international evidence from the social sciences. Engaging with local academic institutions on effective interventions to improve health offers exciting possibilities. The proposals from our nine authors set out some of the most promising.

The future

We hope that this collection of papers will fire the imagination of local authorities and energise their interest and enthusiasm in how they can most effectively improve local health. We suggest five steps for how its aspirations can be embedded in local policymaking:

1. Elected members need to understand and own the fact that what local government does every day profoundly influences the health of their population. They should hold *every* officer to account for the impact they have on public health, not just the Director of Public Health and her/his team.
2. Build good relationships with local academics in social sciences as well as biomedical and behavioural sciences and engage in a discussion about what policies, approaches and programmes can address the specific challenges of each local area.

3. Discuss across local authorities the contributions which each function can make to improving health and use these insights to generate discussion about opportunities and inform action.
4. Use this report, and other sources, to create a public health strategy which balances interventions aimed at individuals with those operating at the structural/societal level.
5. Discern the programmes needed, implement them well to get the best results and evaluate them properly to ensure lessons are learned for the future.

Academic input into local policymaking remains an opportunity and a challenge. Academics need to communicate their expertise in ways which local government can readily access and utilise. Local authorities, in turn, can seek out and embrace the intellectual vigour and evidence that academia can provide. Doing so will make them better positioned to make a difference to local health and wellbeing.

Our hope is that this publication and the proposals in it go some way towards being a bridge between academia and local government, and between social sciences and public health. The British Academy is keen to play its part in building such bridges, both with this report and in the future.

Evidence and guidance on improving the population's health has often focused on insights from biomedical or behavioural science and has tended to highlight interventions targeted at individuals. Despite widespread acknowledgement of the importance of the socioeconomic determinants of health, structural issues such as worklessness, early childhood intervention and transport planning have had less focus.

This report is a collection of opinion pieces from leading social scientists, each of whom has written an article, drawing on the evidence base for their particular area of expertise and identifying one policy intervention that they think local authorities should introduce to reduce health inequalities. These nine proposals present evidence from a wide range of social sciences and are intended to fire the imagination of local policymakers and support them in their mission to effectively improve the health of the population.

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