

A matter of justice

Local government's role
in tackling health inequalities

Acknowledgements

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This guide was written by Fiona Campbell for the Local Government Association

Foreword

In her first speech as Prime Minister in 2016, Theresa May spoke of the ‘burning injustice that if you’re born poor, you will die on average nine years earlier than others’. This publication is about that burning injustice, how social and economic factors lead to long-term ill health and premature death for the most deprived; and what local government can do about it.

We know that those living in the most deprived communities experience poorer mental health, higher rates of smoking and greater levels of obesity than the more affluent. They spend more years in ill health and they die sooner, as the Prime Minister pointed out. Reducing health inequalities is an economic and social challenge as well as a moral one. Since 2013, local government has been responsible for public health in England and has specific responsibilities to tackle health inequalities as well as improving the public’s health overall.

Local authorities and their public health teams have been on a journey together to understand how we can use councils’ traditional functions in conjunction with our newly acquired public health expertise to maximise our contribution to closing the unjust health inequalities gap.

Of course, central government has to play its part in reducing poverty and breaking the link between deprivation, ill health and lower life expectancy, but there is much that local government can do by reducing harm from what we know as the ‘social determinants of health’ – those factors in people’s social, economic and built environment which play the greatest part in determining how long and with what quality of life they will live.

These include many of local authorities’ core functions, such as planning, housing, environmental services, education, community regeneration and engagement, leisure and the arts. We hope that this publication will serve as an introduction to the issues and a useful resource for elected members in their struggle against the unacceptable inequity in health experienced by the most deprived people in our communities.



Councillor Izzi Seccombe OBE
Chair, LGA Community Wellbeing Board

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HEALTH INEQUALITIES AT A GLANCE

Almost 20

extra years of healthy life are enjoyed by those in the longest-lived areas compared with those in the shortest-lived areas.



If travelling east on the London underground from Westminster, each tube stop represents nearly one year of life expectancy lost.²

Children

in the most deprived areas are twice as likely to be obese as children in the least deprived areas.³

Babies

born into a poor family can expect to live up to 10 years less than those born into a wealthy family.



Those living in the most deprived areas are 10 times less likely to live in the greenest areas.



Poor neighbourhoods in the north tend to have worse health even than places with similar levels of poverty in the rest of England – this may be partly due to the chronic disease and disability left by the legacy of heavy industry and its decline.

The poorer people are,

the shorter they will live and the longer they will live with ill health



A baby girl in Manchester can expect to live 15 fewer years in good health than a baby girl in the London Borough of Richmond.

In England, the highest life expectancy



at birth for males is 83.4 years in Kensington and Chelsea, the lowest is 74.3 in Blackpool. The highest estimate for females is 86.7 years in Hart (South East of England); the lowest is 79.4 in Tower Hamlets.



Health inequalities are currently estimated to cost the NHS in England a total of at least £5 billion each year.¹

Men in England

are more likely to be overweight or obese than women. 68% of men were overweight or obese in 2015 compared with 58% of women.



White working class pupils

achieve the lowest grades at GCSE of any main ethnic group, with just a quarter of boys and a third of girls achieving five good GCSEs.



There are nearly 13 million disabled people in the UK. It has been estimated that over 1 million people in England have a learning disability.

Disabled people

are more than twice as likely to be unemployed as non-disabled people. The disability pay gap in Britain continues to widen. In 2015/16 disabled people earned £9.85 per hour compared with £11.41 for non-disabled people.



Life costs

on average £550 more on average a month for a disabled person.

Females with a learning disability

have an 18 year lower life expectancy than the general population, while males with a learning disability have a 14 year lower life expectancy.⁴

55%

More than half of lesbian, gay and bi pupils have experienced direct bullying.



Two in five (41%) have attempted or thought about taking their own life directly because of bullying.

On average, men with mental health conditions die 20 years earlier and women die 13 years earlier, than the general population.

The mortality rate

for prisoners is 50% higher than the rest of the population



Rates of smoking

during pregnancy – are higher in the UK than in many European countries and highest in deprived populations and in mothers under 20.



In Great Britain

smoking is more common among those earning less than £10,000.

In 2015

there were 8,758 alcohol related deaths in the UK – 65% of these were males



The UK has a higher infant mortality rate than nearly all comparable Western European countries.⁶

Each year

more than 1.4 million people miss, turn down or choose not to seek medical help because of transport problems.⁷



1. A matter of justice: understanding health inequalities

In 2014, the British Academy asked 10 professors from a range of subject areas to write an article, drawing on the evidence base for their particular area to identify one policy intervention that they thought could improve the health of the local population and reduce health inequalities. This is the list of actions that they chose:¹

- implement a living wage policy
- focus resources on improving life chances in early childhood
- implement 20mph speed limits where 30mph ones have usually been in place
- take a 'health first' approach to tackling health-related worklessness
- use a form of participatory budgeting to make decisions on public health priorities and interventions
- utilise the substantive role of further and adult education in reducing social inequalities in health
- adopt local policies to improve the employment conditions of public sector workers
- implement locally based 'age-friendly environments' that facilitate improvements in the independence, participation, health and wellbeing of older people
- make good use of evidence of cost-effectiveness before choosing between competing interventions to reduce health inequalities.

If any councillors need convincing that local government has a central role to play in reducing persistent health inequalities and their links to deprivation in this country, this list should surely convince them.

In this chapter, we present the key facts about health inequalities and which groups come off worst in this country on the ladder of health inequality. These facts explain why the solutions above have been proposed and why it is so important to tackle the 'social determinants' of health inequalities.

In chapter 2, we look in more detail at the type of health inequalities experienced by different groups. For each group we identify some basic information that councillors should find helpful in developing strategies and action plans to reduce health inequalities. For quick reference, this information is grouped together in coloured boxes, as below:

What councillors need to know

Key information councillors should have to understand health inequalities in their area and how they affect different groups

In chapter 3, we look at high-level, strategic policy commitments that can help councils embed a council-wide approach to reducing health inequalities and inform their partnership working.

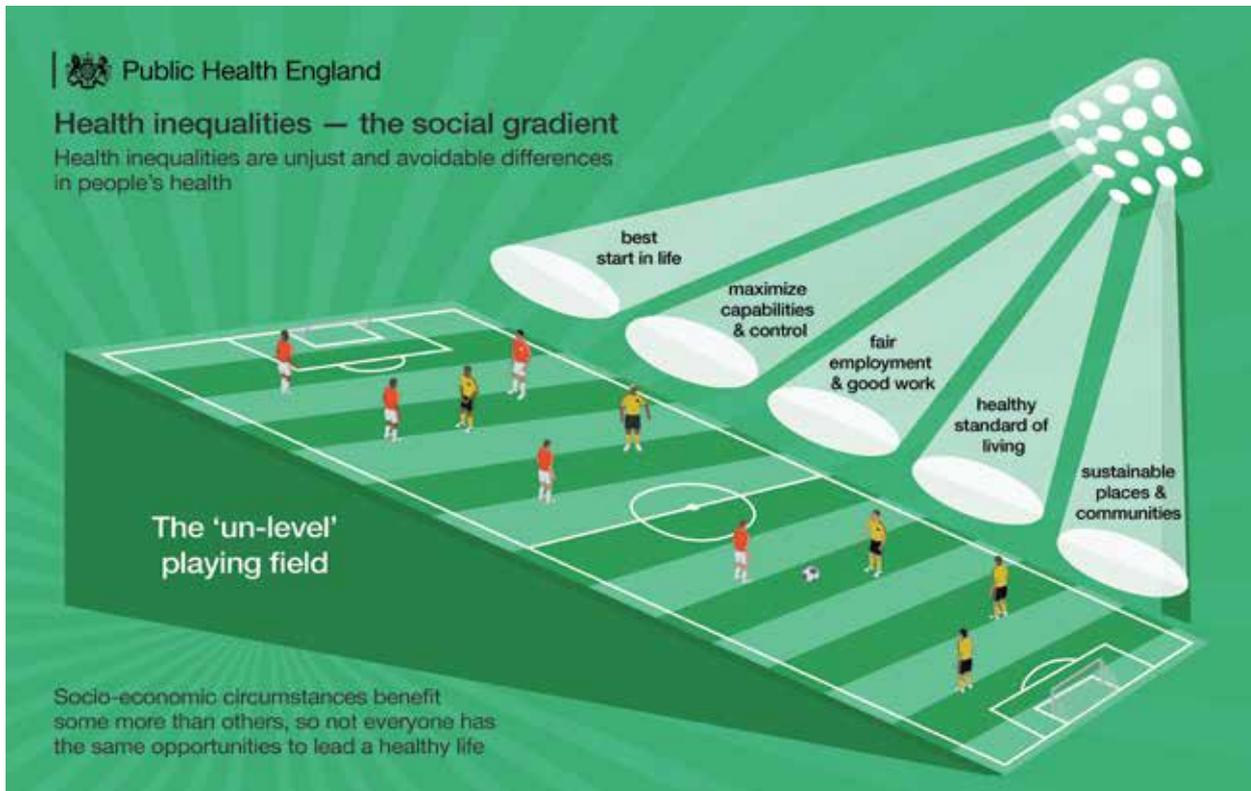
In chapter 4, we discuss some of local authorities' core functions, how they impact on health and suggest a number of questions for councillors to consider in making decisions in different policy areas to ensure that their authority is being as effective as possible in addressing these persistent inequalities. For quick reference, questions are grouped together in coloured boxes as below:

What councillors can do

Basic actions councils can take in using local government's functions to reduce health inequalities

Key messages

- Health inequalities exist both between and within local authority areas, with almost 20 extra years of healthy life enjoyed by those in the longest-lived areas compared with those in the shortest-lived areas.
- The 'North/South divide' exists in relation to health inequalities: people living in the north of England have persistently poorer health than the rest of the country.
- There are also significant health differences between men and women, between different ethnic groups, between people with and without different forms of disability and between other discriminated-against groups and the majority.
- Even in the longest-lived local authority areas there exist groups in the population whose life expectancy and years of healthy life are worse than the average. Health inequalities are an issue in all areas of the country.
- Health inequalities are highly correlated with general disadvantage, deprivation, poverty and social and economic inequality. Babies born into a poor family can expect to live up to 10 years less than those born into a wealthy family. Reducing health inequalities is therefore a matter of social justice.
- The very existence of inequalities in a society may itself be a cause of ill health, not just to those at the bottom of the heap but all along the social gradient.
- Health inequalities are not just caused by individuals' lifestyle choices: the choices available to people and the choices they make are affected by broader social factors – the 'causes of the causes' of ill health.
- Tackling the causes of the causes is both about reducing deprivation and disadvantage and also about breaking the links between deprivation and ill health.
- Local authorities can play a significant part in addressing and reducing health inequalities, although the role of central government and the rest of the public sector and voluntary and private sectors are also vital: a place-based approach is necessary.
- People's life chances and their likelihood of living a long and healthy life are determined in their very early years, but are affected at all stages throughout their life. Therefore local authorities need to take a 'lifecourse' approach to reducing health inequalities, influencing for the better the conditions in which people are born, grow, live, work and age.
- Within local government, public health is not just part of the remit of the public health team: almost every local government function has an impact on health, including early years services, education, housing, employment and welfare, social care, leisure and public amenities, environmental health and trading standards and partnerships with the voluntary and community sectors, business and other employers and the NHS.
- At a time of major cuts in local authority services, councils need to take a strategic, targeted approach, understanding the health impact of all their activities and making a commitment to 'health in all policies'. Reducing health inequalities makes sense at a pragmatic as well as a moral level because it can prevent people becoming and remaining ill and reduce the associated costs to local government, the NHS and the rest of the Government.



The facts about health inequalities

Some sections of society have poorer health than others. Most strikingly, in England people in those areas and those groups with the best health have almost 20 years more of healthy life than those with the worst health.² Some of these differences arise from chance, people's genetic make-up or from individual decisions, but the overwhelming consensus among public health specialists is that most health inequalities are determined by people's social and economic status over the course of their lives.

For councillors, the most important and relevant fact to note is that the length of time that people live and the number of years of ill health they experience in their lives are closely related to the extent of disadvantage and deprivation they experience. This shocking fact means that most health inequalities are unfair because they do not occur randomly or by chance, but are determined by circumstances largely beyond an individual's control.

Most inequalities are also avoidable because, as a society, we can change the social and economic circumstances in which people live.

The links between deprivation and health are shown in the following statistics.

- The 'life expectancy gap' which is one measure of unfair and avoidable inequality is 8.9 years for males born now and 6.9 for females born now. This means that the least deprived male babies can expect to live nearly a decade longer than their most deprived counterparts (nearly seven years longer for the least deprived female babies).
- Perhaps even more shocking is that the most deprived females at birth can expect 19.6 fewer healthy life years than their least deprived counterparts; for males, it is almost 19 years fewer. People in the least deprived areas can therefore expect nearly 20 years more of poor health than those in the most deprived areas. In the bottom half of the index of deprivation, the average healthy life expectancy is lower than the current lowest state pension age of 65.

- In England, dying prematurely as a result of health inequalities costs 1.3 to 2.5 million extra years of life each year.³
- The figures for life expectancy and also for healthy life expectancy follow a straight line gradient almost exactly: on average poor health increases with increasing socio-economic disadvantage. This means wherever you find yourself on the line from most to least deprived, you can expect to live longer and have more healthy years than those who are more deprived and you can expect to live for less time and have more ill health than those who are less deprived than you. In short, even in the first half of the 21st century, the poorer people are, the shorter they will live and the longer they will live with ill health.
- Societies with greater economic inequality appear to experience worse health and wellbeing than those that are more equal. This is true not just for those at the bottom of the socio-economic ladder, but all the way up to the top.⁴ For example, rates of mental illness and obesity are two to four times higher in more unequal societies.⁵

The significance of health expectancies

Based on individuals' assessments of their own health, the years of healthy life that are measured in the figures above are important indicators of the wellbeing of society. They provide context to the impacts of policy changes and interventions at both national and local level.

These health expectancy figures are used across public, private and voluntary sectors, in the assessment of healthy ageing, fitness for work, monitoring health improvement, fairness of extensions to the state pension age, pension provision, support for early years and health and social care need.

The importance of healthy life expectancy as a measure of population health is reflected in its inclusion in the national Public Health Outcomes Framework against which local authorities measure their achievements in relation to health improvement.

Life expectancy for the UK is higher in 2013 to 2015 (the latest available figures) compared to 2009 to 2011 but the proportion of life spent in good health is falling, due to the improvement in life expectancy exceeding that of healthy life expectancy.⁶ This is a very significant finding for local authorities as it means that not only is your population growing older but there is a higher proportion of that population living with long-term conditions and disability. Because of the link between health inequalities and deprivation, the number of people living with ill health will be disproportionately higher and is increasing disproportionately in the most deprived areas.

Directors of public health (DsPH) will be familiar with the life and healthy life expectancy figures for their own areas. You can check these figures for your authority and compare them to others on the website of the Office for National Statistics at www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/ Public Health England's health Profile for England also has a wealth of information by local authority area on health and health inequalities: www.gov.uk/government/publications/health-profile-for-england (See the downloadable pdf on this page.)

Health inequalities are currently estimated to cost the NHS in England a total of at least £5 billion each year.⁷ In the working-age population, health inequalities lead to productivity losses to industry of between £31 billion and £33 billion each year. Lost taxes and higher welfare payments resulting from health inequalities cost in the region of £28 and £32 billion.

The causes of health inequalities

Since the 19th century sanitation and housing reforms, elected members and officers of local authorities have been aware of the close link between social and economic factors and health inequalities. These factors, known as the ‘social determinants of health’ were given additional prominence and the backing of evidence based on research by the Review of Health Inequalities Post-2010 in England by Professor Sir Michael Marmot (the Marmot review).⁸

This review developed a systematic approach to addressing the conditions of everyday life that give rise to health inequalities, what Marmot calls ‘the causes of the causes’. It stressed the need to tackle the social determinants of health at all stages of people’s lives – a ‘lifecourse approach’ – since the evidence shows that people’s social and economic situation at each stage of their life has a cumulative effect on health inequalities.

The significance of deprivation

The statistics that show the link between deprivation, life expectancy and years of healthy life use the Index of Multiple Deprivation (IMD) with which councillors will be familiar. It measures relative deprivation between small areas known as Lower Super Output Areas. These are smaller than local authority areas because levels of deprivation and density can vary across a local authority’s area. The IMD measures deprivation on a range of social and economic indicators grouped into seven domains:

- income, including income deprivation affecting children and older people
- employment and unemployment
- health deprivation and disability – the measure is made up of:
 - years of potential life lost (premature deaths)

- comparative illness and disability ratio
- rates of emergency hospital admissions
- mental health (mood and anxiety disorders and suicide rates)
- education, skills and training deprivation
- barriers to housing and services
 - overcrowding, homelessness and affordability
 - distance services and facilities such as GPs, schools, post offices and shops
- crime – measures the risk of personal and material victimisation
- living environment
 - air quality and road traffic accidents
 - houses without central heating and in poor condition.

It is important to understand that the deprivation that is linked to lower life expectancy and health inequalities covers the above wide range of issues, all of which are relevant to local government’s functions.

It is not possible to sum up deprivation in just one measure – many factors contribute to one individual, one family or one group of people having a more impoverished life than another. If health is removed as a measure of deprivation, the other factors together will predict relative life expectancy and years of healthy life.

The relationship between health and deprivation is a complex one. Ill health can be both a cause and a consequence of inequality. For example, low income, debt, violence, stressful life events and unemployment are key risk factors for mental illness. In turn mental health problems in childhood and adolescence reduce educational attainment and employability and also increase the risk of impaired relationships, drug and alcohol misuse, violence and crime.⁹

Aren't health inequalities just a matter of lifestyle choices?

It has been suggested that since people choose to smoke and choose what they eat and drink and whether they take any exercise, that the ill health caused by factors such as smoking and obesity is a matter of personal choice and not an issue of social justice or a concern of society. However, lifestyle 'choices' are influenced and to a large extent limited by the social, economic and environmental conditions in which they live. The following examples illustrate this.

People's level of physical activity is an important determinant of how long they will live and how long they will have a healthy life. In the UK, physical inactivity directly contributes to one in six deaths.¹⁰ Someone's income will determine to a considerable extent where they can live and therefore the quality of the built environment around them, including their access to green spaces.

Those living in the most deprived areas are 10 times less likely to live in the greenest areas.¹¹ Children who live close to green spaces have higher levels of physical activity. Those living closer to green spaces tend to live longer than those with no green space. So something as apparently simple as the proximity of people's homes to a park can make a difference to the length of their lives.

Around 78,000 deaths and 475,000 hospital admissions a year are currently estimated to be attributed to smoking in England. People who work in 'routine and manual occupations' are more than twice as likely to be smokers as people in 'managerial and professional occupations'.¹² Smokers from disadvantaged areas find it more difficult to stop smoking than their more affluent neighbours, despite being just as motivated to stop smoking and just as likely to try and stop.¹³

Research on this issue points to a number of explanations, including lack of social support, higher nicotine dependency (because people in deprived groups start smoking earlier and smoke each cigarette more fully), challenging life circumstances and factors relating to stop smoking services themselves. Whatever the explanation, the more deprived you are, the more likely you are to die of a smoking-related disease.

Being obese can increase the risk of developing a range of serious diseases, including high blood pressure (hypertension), type 2 diabetes, cardiovascular diseases, several cancers, asthma, obstructive sleep apnoea (interrupted breathing during sleep) and musculoskeletal problems. There is growing evidence on the 'obesogenic environment' that makes it harder for people to attain and remain at a healthy weight.¹⁴ This is hardest of all for people living in the most deprived areas. Obesity disproportionately affects those in the most deprived social groups and evidence suggests that the inequalities gap in child obesity is widening.¹⁵ There is evidence that there are elevated levels of obesity in communities with high concentrations of fast food outlets and further evidence that such concentrations are highest in areas of greatest deprivation. There is also evidence that the type of food on sale nearest to schools may influence the diet of school children. Again, whatever the explanation, the more deprived you are, the more likely you are to have and to die of an obesity-related condition.

All of the above are examples of how deprivation and inequalities of income and of place can impact on the 'choices' available to people and on their health. In many cases, it is a moot question whether what some people call 'lifestyle choices' are really a matter of choice at all.

Don't people just need to be better educated about health?

The points above also show that educating children, young people and their families about issues like healthy eating and other aspects of healthy lifestyles, while this is obviously a good idea, is not enough to get at the root causes of health inequalities.

Education certainly has an important role to play in reducing health inequalities, but it is overall educational attainment at all ages and across the curriculum that can make the biggest difference. We know that academic success has a strong positive impact on children's subjective sense of how good they feel their lives are (life satisfaction) and is linked to higher levels of wellbeing in adulthood.¹⁶ It also enables people to earn more and thereby move higher up the ladder of affluence and away from conditions of deprivation.

Therefore increasing educational attainment among those who are doing less well could make a significant contribution to reducing health inequalities.

Isn't this a job for the NHS?

Social, physical and economic environments and conditions, collectively referred to as the 'social determinants of health' have a far greater impact than medical care on how long and how well people live. Recently public health specialists have made estimates of the contribution of different factors to people's health. Figure 2 below is an example. Others have given slightly different estimates (for example, giving a greater weighting to the contribution of housing in the UK), but all are agreed that health services (clinical care) make only a relatively small contribution to health.

Figure 2: Relative contribution of the determinants of health

Health behaviours 30%	Socioeconomic factors 40%	Clinical care 20%	Built environment 10%
Smoking 10%	Education 10%	Access to care 10%	Environmental 5%
Diet/exercise 10%	Employment 10%	Quality of care 10%	Built environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/social support 5%		
	Community safety 5%		

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

Under the Health and Social Care Act 2012, the NHS has a duty to have regard to the need to reduce health inequalities. Local authorities can contribute to this through their health and wellbeing boards (HWBs), their work on integration and their relationships with the local NHS. An important issue for the NHS is to ensure equality of access and quality of services to all. The recent inquiry into health inequalities in the north of England found that, although there are still inequalities in access to healthcare by deprivation, 'these could not account for the size and nature of the differences in health status' that the inquiry observed. On the contrary, it found that access to NHS care when people are ill has helped to reduce health inequalities and that the NHS helps to ameliorate the health damage caused by wider determinants outside the health sector.

The most significant contribution local government can make to tackling these wider determinants and to reducing health inequalities is to take a 'Health in All Policies' approach to all of its core functions and to its place-based partnerships. Health in All Policies (HiAP) is a collaborative approach to improving the health of all people by incorporating health considerations systematically and explicitly into decision-making.¹⁷ To ensure that your HiAP approach is aimed at reducing health inequalities as well as improving the health generally of your population, you need to understand the nature of inequalities in your area, who is affected by them and in what way.

2. A matter of justice: who experiences the worst inequalities?

Overall, ill health is linked to deprivation across the lifecourse. But to tackle health inequalities in their own areas, local authorities need to know more precisely which groups experience the worst health and the greatest impact of a range of the social determinants of health. A number of ways of identifying and classifying health and other social and economic outcomes of different groups can help elected members to understand their populations and where and how their efforts to tackle inequalities should be directed.

Inequalities of place

The Index of Multiple Deprivation (IMD) shows that where people live is a strong predictor of their place on the ladder of health inequalities. The reason for this will be obvious to local authority councillors – deprivation is highly linked to place.

People in the same socio-economic group tend to live in similar areas. This is not always true – for example, in rural areas there can be pockets of deprivation among areas of great affluence – a phenomenon which can be masked by statistics.¹⁸

However in the urban and semi-urban areas in which 90 per cent of the population live, where someone lives is an indication of how deprived they are.

As the statistics above show, there can be striking differences in health expectancies even between different areas within one city which reflect the levels of deprivation experienced in different parts of cities.

For example:

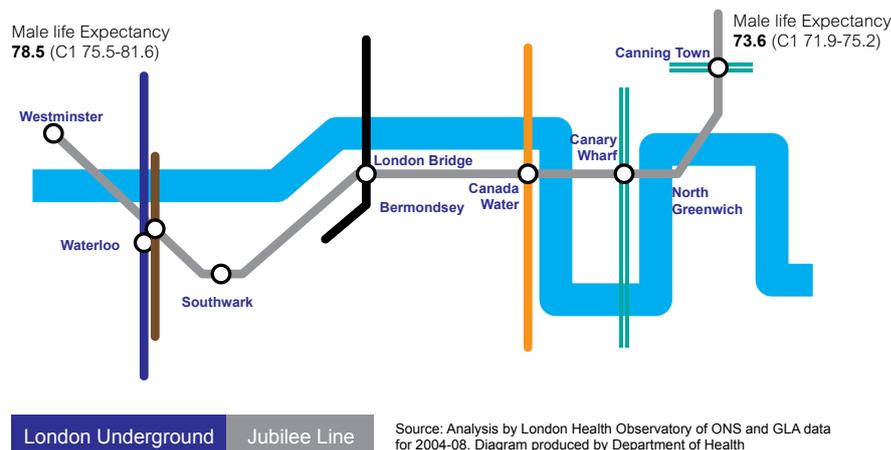
- if travelling east on the London underground from Westminster, each tube stop represents nearly one year of life expectancy lost¹⁹

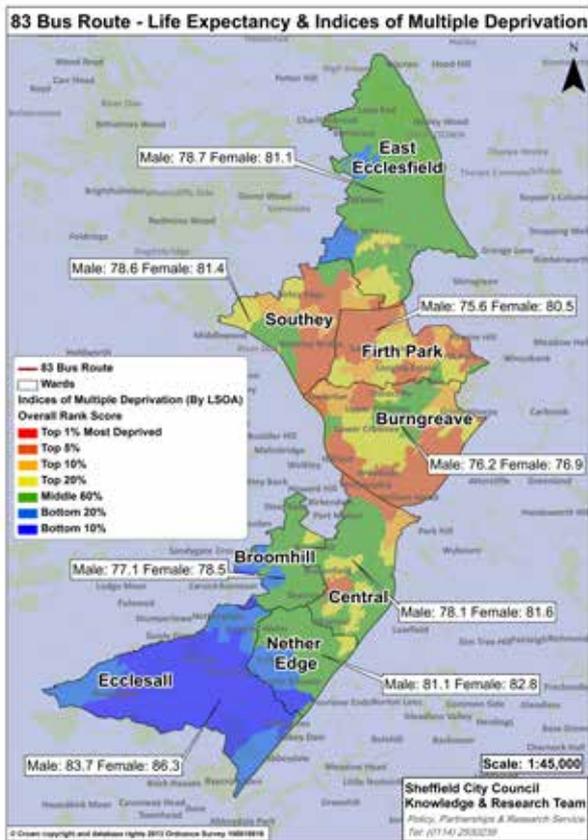
This slide showing a year of life lost for every tube stop travelling east on the London Jubilee Line has inspired many graphic representations of inequalities in life expectancy.

- a similar calculation for Sheffield shows that female life expectancy drops along the route of the city's number 83 bus from 81.6 years to 76.9 years, as it moves from more affluent through increasingly deprived areas.²⁰

Other health indicators are also correlated with deprivation and disadvantage.

Differences in Male life expectancy within a small area in London 2004-08





- there has been a north-south health divide in England for a long time and the gap has widened over recent decades: the burden of local authorities' reduced budgets and welfare reforms has fallen more heavily on the north than the south
- a baby girl in Manchester can expect to live 15 fewer years in good health than a baby girl in the London Borough of Richmond
- whilst the north represents 30 per cent of the population of England it includes 50 per cent of the poorest neighbourhoods and this is reflected in the health of the people who live there
- poor neighbourhoods in the north tend to have worse health even than places with similar levels of poverty in the rest of England – this may be partly due to differences in the chronic disease and disability left by the historical legacy of heavy industry and its decline
- there is a steeper social gradient in health within the north than in the rest of England, meaning that there is an even greater gap in health between disadvantaged and prosperous socio-economic groups in the north than in the rest of the country
- levels of excess weight are highest in the North East and Yorkshire and the Humber²⁷
- smoking prevalence in London, the South East and the South West (17 per cent) is significantly lower than the North East, North West and Yorkshire and The Humber (all above 19 per cent).²⁸
- The Social Mobility Commission report has been published since this draft. To bring it up to date, could add the following:
 - 'The north-south divide is not the whole picture, however. The Social Mobility Commission's State of the Nation report uncovers a striking geographical divide in relation to people's chances of succeeding in life – and therefore of living a longer, healthier life – with London and its surrounding areas pulling away from the rest of the country. In remote rural and coastal areas, and former industrial areas young people from disadvantaged backgrounds face far higher barriers to succeeding in life.'²⁹

- The proportion of current smokers in the two fifths of the population with the lowest income was double the proportion among those with the highest income.²¹
- Children in the most deprived areas are twice as likely to be obese than children in the least deprived areas.²² (Obesity is estimated to be the fourth largest risk factor contributing to deaths in England.) The deprivation gap has increased over time.²³
- In the England population, rates of alcohol-specific and related deaths increase as levels of deprivation increase and alcohol-related liver disease is strongly related to the socio-economic gradient. Alcohol-related deaths among the most disadvantaged men are 3.4 times higher than the least disadvantaged; for the most disadvantaged women this figure is 5.7 times higher.²⁴ This is despite the fact that the more deprived socioeconomic groups report lower levels of average alcohol consumption.²⁵

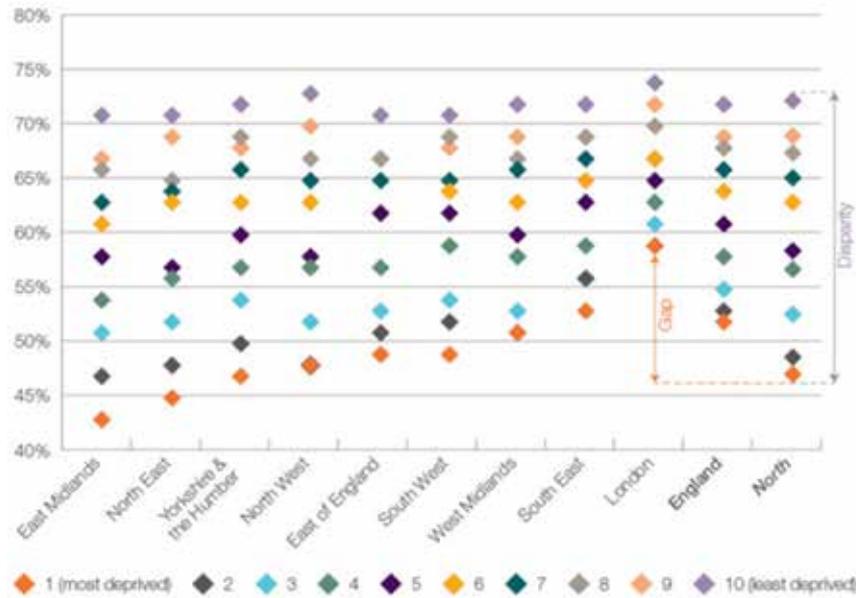
Although health declines with increasing disadvantage of socio-economic groups wherever they live in the country, there are still striking differences between health outcomes in the north and the south of England:²⁶

The wider determinants: place

Place and educational attainment

The Institute for Public Policy Research (IPPR) has correlated children's level of development in their early years with the Income Deprivation Affecting Children Index. This shows that by and large the more deprived an area is, the less likely its children are to have achieved a 'good' level of development in their early years.

Figure 2.1
Percentage of children achieving a 'good' level of development in their early years foundation stage profile teacher assessments, by decile of the Income Deprivation Affecting Children Index, 2014



Source: OCSI: <http://indicesofdeprivation.co.uk/2015/10/27/inequalities-in-early-years-attainment/>

Within regions, there are of course attainment gaps which also reflect levels of deprivation. Of particular interest is the case of London which has some of the most deprived areas in the country and yet many more children in the most deprived group achieve a 'good' level of development. This seems to show that it is possible to narrow the attainment gap to some extent, although it is still there in London and it still mirrors the deprivation statistics.

At a more advanced educational level, a similar pattern appears. Research by Oxford University found that pupils who were from a disadvantaged background and who live in a poorer neighbourhood were much less likely to take A-levels than disadvantaged pupils from better-off areas. Councillors will be able to assess for themselves what this finding means for their own areas and how they might address the issues it raises.

Place and employment

It is an interesting if depressing reflection of the impact of early years and education on people's later life chances that unemployment statistics between regions closely mirror childhood and youth deprivation and inequalities. At the time of writing, the average rate of employment in England is 75.2 per cent. The South East and the South West have the highest employment (78.4 per cent and 78.7 per cent respectively) and the West Midlands and the North East have the lowest at 71.4 per cent and 71.6 per cent respectively. London has a lower employment rate than the rest of the South East at 73.3 per cent.³⁰

None of this will be news to councillors reading these statistics, but the variations between regions are worth emphasising because of the close relationship between employment, worklessness, health and ill health (see the section on a healthy standard of living in Chapter 3 below).

Within regions, the employment available and how far people are able and willing to go to access employment can vary significantly from one town or area to another and from one socio-economic group to another. An understanding of the factors that determine employment and unemployment rates at the local level is an important consideration for councillors in reducing the harm from the wider social determinants of health.

Place and housing

Housing is one of many personal, social and environmental impacts on health inequalities. Poor conditions such as overcrowding, damp, indoor pollutants and cold have all been shown to be associated with physical illnesses including eczema, hypothermia and heart disease. Respiratory health has been shown to be particularly affected in both adults and children. Physical features of housing can also impact on mental health with the stress of living in cold, damp conditions.

Children in families who have to move frequently are at particular risk of poor outcomes and a range of health problems such as depression, eczema and asthma.

The association between living in bad housing and having health problems is particularly acute among those above retirement age. The type, quality and availability of housing in an area is therefore an important social determinant of health, with a knock-on effect on educational attainment of children and on health and social services for older people. A place-based approach to reducing health inequalities in all policies will certainly need to pay attention to housing.

Place and traffic

Road traffic collisions are the single largest cause of death for children and young people aged five to 25. Within urban areas, where the majority of the population lives, children and young adults are more at risk of death by road accidents within poorer localities than richer urban neighbourhoods.³¹

Furthermore, the Royal College of Physicians and the Royal College of Paediatrics and Child Health have concluded that air pollution, largely caused by traffic is contributing to about 40,000 early deaths a year in the UK. Their report also found evidence that poorer people tend to live in lower-quality environments and are more exposed to air pollution.³²

The above means that roads, traffic, speed and air quality issues are important issues for health inequalities and, of course, are core functions of local government and central to a place-based approach to reducing such inequalities.

Inequalities of place: what councillors need to know

1. What are the differences in life expectancy and years of healthy life across your authority's area. (Is there any striking or graphic way your public health team could describe these differences and show how they are correlated with inequalities of income – like the example of the London underground or Sheffield bus route?)
2. What are the differences in other health indicators (such as smoking, obesity, alcohol and drug misuse) across your area and where are the people with the worst and the best health outcomes living?
3. How are differences in health across your authority correlated with income distribution and with other social determinants of health such as educational attainment, rates of employment, type of housing tenure, proximity to accident hotspots, areas of high pollution and green spaces?

4. How do your council's high-level strategies across all its functions take account of and address the social determinants of health in relation to inequalities of place?
5. How can you make use of your knowledge of the health and socio-economic profile of your own ward to press for action to address health inequalities across your area through a 'health in all policies' approach?
6. How can you use your membership of any 'place-based' forums, such as a local economic partnership, area board or employers' forum to develop priorities and target funding to maximise health outcomes?

The local authority will support targeted regeneration and other interventions by identifying sites and proposals for development in terms of whether they deliver sustainable linked neighbourhoods, strengthen communities and address inequality, including where appropriate using planning powers to control the number of betting shops, fixed odds betting terminals and pay day lenders (a recommendation that emerged from the city's Fairness Commission).

The Plymouth Plan received a Royal Town Planning Award for Excellence in 2015 for its innovative approach to cross-professional working and service delivery, for instance integration between the planning, health and social care sectors.³³

Plymouth City Council

Integrating poverty and inequality into local plan-making: a place-based approach

The Plymouth Plan is a ground-breaking plan which looks ahead to 2031. It sets a shared direction of travel for the long-term future of the city bringing together, for the first time in Plymouth, a number of strategic planning processes in one place. Among many other themes, poverty and inequality is a strong focus across the plan, prioritising the importance of physical and financial access to facilities, services and opportunities and promoting community cohesion and "where inequality and fairness are addressed for those living and working in the city" and to "allow all residents to take advantage of economic growth delivered in the city".

The Plymouth Plan seeks to respond to the big questions the city is facing in health inequalities (including through reducing food poverty) the lack of enough affordable housing, the need to provide good quality jobs, climate change, increased demand on services, and reduced public sector resources.

Inequalities of gender

There are differences in the life expectancy of men and women. Even within the same socio-economic group and within the same geographical area, women live longer than men (although these figures are getting closer). However, women live a greater proportion of their lives in poor health than men do.

- If they experience the same health as the most recent figures observed between 2010 and 2012, newborn males in the UK can expect to live 78.8 years. Newborn females can expect to live 82.6 years, a gap of nearly four years.
- The same group of newborn males can expect to live 63.2 years (or 80.3 per cent of their lives) in 'Very good or good' health. Newborn females can expect to live 64.6 years (or 78.2 per cent of their lives, ie a smaller proportion of their lives than males) in 'very good or good' health. This means that males born now can expect on average 15.6 years of poor health, while females can expect 22 years of poor health over the course of their lives.

- If they live to age 65, men can expect to live a further 18.3 years with 9.1 years in 'Very good or good' health and women can expect to live 20.8 years with 9.6 years in 'Very good or good' health.
- If they reach the age of 65, the least deprived women can expect to enjoy 7.8 more healthy life years than the most deprived women. For men, it's 7.5 years more of healthy life.
- In England, the highest life expectancy at birth for males is 83.4 years in Kensington and Chelsea, the lowest is 74.3 in Blackpool. The highest estimate for females is 86.7 years in Hart (South East of England); the lowest is 79.4 in Tower Hamlets.
- For males at birth in England, Rutland had the highest estimates for health and disability-free life expectancy (71.1 and 70.8 years respectively). The lowest estimates are 54.0 years in good health in Tower Hamlets.
- For females at birth across the UK, the highest estimate of years in good health was 71.1 in Richmond upon Thames and the lowest was 52.4 in Tower Hamlets. Wokingham had the highest years spent disability-free with 71.8 and Tower Hamlets had the lowest with females on average living 53.4 years disability-free.
- Twenty per cent of men smoke compared with 17 per cent of women. Among secondary school pupils, girls are more likely to smoke (4 per cent) than boys (3 per cent).³⁴
- Men in England are more likely to be overweight or obese than women. Sixty eight per cent of men were overweight or obese in 2015 compared with 58 per cent of women. The biggest gap is among 45-54 year olds with 79 per cent of men overweight and obese compared with 63 per cent of women.³⁵
- Males accounted for approximately 65 per cent of all alcohol-related deaths in the UK in 2014.³⁶

The wider determinants: gender

Gender and employment

Rates of unemployment for men and women are similar on average at 5 per cent and 4.8 per cent respectively. However, there is still a significant gender pay gap with average pay for full-time female employees 9.4 per cent lower than for full-time male employees.

The gap for all employees (full-time and part-time) is 18.1 per cent. From this we can see that part-time working makes a big contribution to the pay gap. Forty-one per cent of women work part time, whereas only 12 per cent of men do. Another factor that affects the gender pay gap is that women tend to work in occupations which offer lower salaries. (Whether these occupations pay less because women work in them is another issue.) From age 40 upwards, the gender pay gap is much wider. This is likely to be connected to women taking time out of the labour market to have children.³⁷

Lower levels of pay are linked to deprivation which is in turn linked to worse health outcomes. The gender pay gap therefore puts women's health (and the health of families where women are the main or only earner) at risk. Pay rates and the gender pay gap vary across the country. It is important to understand men and women's working and unemployment patterns in their own area if councillors want to address the contribution of these factors to health inequalities and to know which groups they should be targeting and how.

Gender and educational attainment

Although men are paid more than women on average, boys perform worse than girls across primary, secondary and higher education and the gap is widening. In 2016, 67 per cent of girls in state-funded schools obtained English and maths A*-C grades, whereas 59 per cent of boys attained this standard.³⁸ In 2015, an 18-year-old woman was 35 per cent more likely to enter higher education than an 18 year old man.

Among university applicants who have been in receipt of free school meals, young women are 51 per cent more likely to make it to higher education (19.8) per cent compared to 13.1 per cent for men. Entry rates for disadvantaged boys are also relatively worse compared to non-disadvantaged boys than the equivalent picture for girls.³⁹

While boys and men underperform overall, poor white boys and men have the worst record of all. Reducing the educational underperformance of boys and men as well as disadvantaged young people of both genders is essential if we are to tackle other inequalities including health.

London Borough of Lewisham

Reducing the gender pay gap

Lewisham is overcoming, through its role as a large employer, the continuing gender pay inequality that persists in many organisations across the UK and contributes, for example, to the poverty in which many single-parent families live. Fifty-six per cent of those in senior grades at Lewisham Council are female and the pay gap across the council is slightly in favour of women. Human resources and diversity policies have played an important role in arriving at this position, as have training and the monitoring of diversity statistics. Equality targets are not rigidly enforced, but the data is monitored closely and regular equal pay audits have been acted on.

Lewisham also has a 'grow your own' senior talent policy, with 12 out of 26 of the most senior roles currently held by internal appointees.⁴⁰

Inequalities of gender: what councillors need to know

1. What are the respective life expectancy and years of healthy life of men and women in your area?
2. Are there any other gender differences in your area, for example in the type of long-term conditions experienced by women and men or in the causes of mortality?
3. How do any such differences relate to the social determinants of health – for example, are there significant gender differences in educational attainment, in employment rates or in the number of young men and women not in education, employment and training, or is there a history of different employment patterns of men and women with differential conditions and pay that could account for gender differences in health outcomes?
4. Do the council's health strategy and wider policies address gender inequalities in health? For example, are there 'second chance' initiatives to enable more boys to achieve educational qualifications, or initiatives to support women with childcare or other caring responsibilities?
5. Do local employers understand the impact of employment on the health of men and women and where employment is divided along traditional gender lines are there initiatives to address health issues that arise from such divisions?
6. Are there specific initiatives to reach out to women who may be largely confined to their homes because of caring responsibilities and/or role expectations – for example through children's centres and voluntary and community groups?
7. Similarly, is there recognition of men's well evidenced reluctance to visit health facilities – for example, by bringing services to workplaces and working with local employers to develop healthy workplaces?

Redcar & Cleveland Council

Recognising the impact of unemployment on men

Following a North of England Mental Health Development Unit (NEMH DU) 2015 Autumn Conference on Suicide Prevention a range of stakeholders set up a steering group to develop a new programme aimed at promoting mental resilience and wellbeing primarily amongst males. The programme was designed to use the football fan culture as a medium to support male mental health resilience in the local community. Redcar & Cleveland was chosen as a pilot area with a focus on targeting men over 40 who have been impacted by the recent closure of SSI Steelworks and the loss of their employment. 'Team Talk' was launched in 2016 in partnership with Middlesbrough Football Club Foundation and a number of local community 'boot rooms' have been developed. The model looks at mitigating social isolation and loneliness by supporting men to maintain latent functions such as time structure during the day, continued shared experiences with others, goal setting and continuing to be active, and adopting coproduction with participants. There is now a well-established group in central Redcar, attended by 20 men, and two more 'boot rooms' are currently in development.

Inequalities between ethnic groups

People from different ethnic groups also experience different health outcomes.⁴¹ Information from the most recent census (in 2011) shows that:

- Individuals from black and minority ethnic (BME) groups have generally been found more likely to report poor general health than the white British population, and those of black Caribbean, black African, Indian, Pakistani and Bangladeshi heritage have

also been found more likely to report a limiting long-term illness than the white British group.⁴²

- Persistent inequalities are seen in the health of Pakistani and Bangladeshi women – their illness rates are 10 per cent higher than white women.
- The 'white Gypsy or Irish Traveller' group, identified for the first time in the 2011 census has particularly poor health.
- Ethnic inequalities in health are most pronounced at older ages:
 - over 70 per cent of women in the above groups experience a limiting long-term illness as compared with 56 per cent of all women aged 65 or older
 - older women of Arab and Indian origin also experience high percentages of long-term illness (66 per cent and 68 per cent respectively)
 - 50 per cent of all men aged 65 or older reported a long-term illness, but 69 per cent of Bangladeshi and White Gypsy and Irish Traveller older men reported being ill.

There are also health inequalities among children from different ethnic groups:

- White children are generally more likely to get a good start in life, with better levels of infant mortality and low birthweight than other ethnic groups. Although inequality in low birth weight by ethnic group has narrowed in recent years, there has been little change in inequality in infant mortality.
- 43% of Bangladeshi children in 2014/15 in England had excess weight as compared with 33% of 10-11 year olds as a whole.
- Fifteen year-olds from white or mixed backgrounds are more likely to smoke than those from Asian or black backgrounds.⁴³
- White women are more likely to smoke than most other ethnic groups.
- People of Chinese origin have persistently better health – half or under half the white illness rates for both men and women.

- Ethnic health inequalities in London are more severe than elsewhere in England and Wales.
- Amongst men, white groups had the highest mean Body Mass Index (BMI: a measure of obesity) and Asian groups the lowest. Amongst women, black groups had the highest mean BMI and Asian groups the lowest in 2014.

The health inequalities between ethnic groups persist even after social and economic disadvantage are taken into account, although as with the general population, those who experience the most disadvantage also experience the poorest health. The fact that people from certain ethnic groups, particularly women, experience worse health even than those from other groups who are as socially and economically deprived means that special efforts need to be made to tackle health inequalities among these particular groups.

The wider determinants: ethnicity

There are relationships between different dimensions of inequality. For example, some ethnic groups are far more likely to live in deprived areas than others. For example, in 2011, over 50 per cent of people in the Bangladeshi and Pakistani ethnic groups lived in the most deprived 20 per cent of areas in England, much higher percentages than other ethnic groups.

Ethnicity and employment

Unemployment rates for all minority ethnic groups for which data is collected are higher than rates for the white group. The figure below shows the rates for a range of groups.

Unemployment by ethnic background UK: July 2015 to June 2016	Total (16+)	
	000s	Rate
White	1,310	5%
Black/African/Caribbean, Black British	120	12%
Indian	60	6%
Pakistani	50	10%
Mixed/multiple ethnical group	40	12%
Other ethnical group	40	9%
Bangladeshi	20	11%
Any other asian background	20	6%
Chinese	10	6%
Total	1,680	5%

Source: ONS Annual Population Survey microdata

Notes: All numbers rounded to nearest 10,000 and may not sum due to rounding. Estimates based on survey responses so subject to sampling error.

The unemployment rate for young black people aged 16-24 was the highest at 30 per cent in the year to June 2016. This compared to youth unemployment rates of 13 per cent for white people (the lowest) and 26 per cent for people from a Bangladeshi/ Pakistani ethnic background (the second highest).

White people had the lowest unemployment rate in all age categories. For all ethnic groups shown in the table the unemployment rate was higher among 16-24 year olds than for other age groups.

Young people of Black Caribbean, Bangladeshi and Pakistani ethnic backgrounds are more likely not to be in employment, education or training.

Ethnicity and educational attainment

Ethnic minority children face specific challenges, including disproportionate levels of deprivation, racism, language and cultural barriers. However, certain groups of ethnic minority children perform better than white students. Children of Chinese, Indian, Bangladeshi and black African origin did better on average in GCSEs than children in the category white British, although across all socioeconomic groups students of Pakistani and black Caribbean origin still do worse.

Figure 3

% of students with five or more GCSEs A*-C or equivalent, 2014-15



Source: University of Leicester www2.le.ac.uk/offices/press/think-leicester/education/2016/against-the-odds-ethnic-minority-students-are-excelling-at-school

White working class pupils achieve the lowest grades at GCSE of any main ethnic group, with just a quarter of boys and a third of girls achieving five good GCSEs. Disadvantaged Chinese pupils perform above the national average for all pupils, while Bangladeshi, Indian, black African and Pakistani pupils from poorer homes all perform well above the national average for disadvantaged pupils.⁴⁴

The fact that some ethnic groups have higher rates of youth unemployment despite young people in these groups having greater educational attainment indicates that people from minority ethnic groups are grappling not only with the disadvantages of poverty but also with racism and discrimination.

The way in which this double inequality is played out in their own area is something that councillors need to understand in developing strategies to combat health inequalities. Since educational attainment is one of the social determinants of health, efforts to improve educational attainment among those groups which have lower attainment is one way of reducing health inequalities.

Inequalities between ethnic groups: what councillors need to know

1. What is the ethnic profile of your area and how does it relate to disadvantage and deprivation?
2. Which ethnic groups in which age groups are worst off in terms of life expectancy and years of healthy life? How, if at all, do these figures differ from national averages?
3. Are there particular health conditions experienced by certain ethnic groups among your residents? For example, do you know what the prevalence of mental illness is among different groups? Where there is a high prevalence of a particular condition how is the council using its powers to combat this?
4. What are the educational attainment and employment statistics for the different ethnic groups represented among your residents? Are there other social determinants of health for which there is local evidence of particular disadvantage among certain ethnic groups?
5. How is housing tenure distributed across your population and is there a correlation between overcrowding, poor housing condition or fuel poverty and ethnicity?

6. Do your health policies and all the council's policies relating to the social determinants of health explicitly and systematically propose action to combat discrimination and disadvantage on the basis of ethnicity where they exist?
7. What is the council and its public health team doing to narrow significant gaps between ethnic groups?

Tower Hamlets

Working with parents and schools to empower communities

Consultation with parents, carers and other key stakeholders undertaken to explore reasons and solutions to the high levels of obesity in primary school aged children in the borough, identified that residents often lacked awareness of facilities and assets available. The public health team identified two communities with poor health outcomes around Cubitt Town Primary School on the Isle of Dogs, two thirds of whose pupils are of Bangladeshi heritage, and Marner Primary School in Bow, where almost all the pupils are from minority ethnic heritages with 86 per cent from Bangladeshi backgrounds. Making connections through parent liaison officers, the team attended meetings, lessons, existing walking groups and coffee mornings with parents to recruit a range of community investigators to examine:

- the physical activity assets of the community
- the good local environment
- walking to school.

Taking physical activity as an example – parents used a simple tool kit to visit all the spaces where they and their families could become active. They rated each space from A to E using a range of criteria around safety, accessibility and affordability.

At the end of the evidence collection process they came together to make recommendations.

The task was to come up with the sorts of activities that families want to get involved in and to pinpoint the most suitable venues, the times and days and so on – the real detail that makes all the difference in getting something sustainable off the ground.

Early successes include:

- establishment of a fresh fruit and vegetable cooperative operated by volunteer parents
- nine British Bangladeshi mothers trained as sailing leaders to enable community use of a water sports centre which had previously been seen by residents as being for the use of 'city people' (ie well-off people working in Canary Wharf)
- engagement of pupils, teachers and parents in measurement of air pollution levels around both schools, awareness raising around the impact of air pollution on health and measures that can be taken including identification of 'safer routes' to school
- a 16 per cent increase in travelling to school by sustainable means (walking, cycling, scooting) from 55 per cent to 71 per cent in Marner School
- identification of a piece of unused land near Marner School that could be redeveloped as a play area – Section 106 funding has been identified to carry out the work and the proposal is that it would then be maintained by local parents
- a 'discovery walking group' where parents visit and find out about exciting local spaces such as the Olympic Park and Tower Hamlets Cemetery and come back as communication champions to encourage wider use – this is a really important activity for a community with an average 'roaming distance' of 500 metres from home
- building on this work, Cubitt Town school secured a £10,000 award to work with NHS London on their Healthy Steps programme on reducing obesity in the community.

Inequalities and disability

There are nearly 13 million disabled people in the UK. Seven per cent of children are disabled. Seventeen per cent of working age adults are disabled. Forty five per cent of pension age adults are disabled. It has been estimated that over 1 million people in England have a learning disability. There is very limited data being collected by NHS providers and commissioners about health outcomes for disabled people generally, or by specific impairment. However some facts are known:

- In 2014, disabled adults in England were more likely than non-disabled adults to report their current health status as bad or very bad (28.2 per cent compared with 0.9 per cent), with no change compared with 2012. This included people with an impairment affecting their memory, dexterity, stamina or breathing or fatigue, learning or understanding or concentrating, vision or mental health (see the separate section on inequalities and mental health below).
- In 2014, disabled adults in England were more likely to be overweight or obese (71.2 per cent) than non-disabled adults (59.1 per cent). In several groups an even higher percentage of disabled people were overweight or obese, including adults with impairments affecting their hearing (75.7 per cent), stamina or breathing or fatigue (75.4 per cent) and mobility (74.3 per cent).⁴⁵
- Thirty-nine per cent of non-disabled adults regularly take part in sport, compared to 18 per cent of disabled adults.⁴⁶
- Females with a learning disability have an 18 year lower life expectancy than the general population, while males with a learning disability have a 14 year lower life expectancy.⁴⁷
- People with learning disabilities are many times more likely to have epilepsy, severe mental illness and dementia. They are almost twice as likely to suffer diabetes, heart failure, chronic kidney disease or stroke.

The wider determinants: disability

After housing costs, the proportion of working age disabled people living in poverty (30 per cent) is much higher than the proportion of working age non-disabled people (18 per cent). Social security reforms have had a disproportionate, cumulative impact on disabled people's standard of living.⁴⁸ The disability charity Scope's research suggests that life costs on average £550 more on average a month for a disabled person. Disabled people are significantly less likely to participate in cultural, leisure and sporting activities and to engage in formal volunteering than non-disabled people.⁴⁹

Disability and employment

Disabled people are more than twice as likely to be unemployed as non-disabled people. One in two (53 per cent) disabled people have experienced bullying or harassment at work because of their impairment or conditions.

One in five disabled people have felt they could not disclose their disability to their employer.⁵⁰ The disability pay gap in Britain continues to widen. In 2015/16 disabled people earned £9.85 per hour compared with £11.41 for non-disabled people. Disabled young people (16-24) and disabled women had the lowest median hourly earnings.⁵¹

Disability and educational attainment

Disabled pupils have much lower attainment rates at school than non-disabled pupils. In England and Wales, in 2014/15 the educational attainment of children with special educational needs (SEN) was nearly three times lower than for non-disabled children. Across Britain in 2015/16, disabled young people aged 16-18 were at least twice as likely as their non-disabled peers not to be in education, employment or training (NEET).⁵² Disabled people are half as likely to hold a degree-level qualification as non-disabled people.⁵³

Inequalities and disability: what councillors need to know

1. How many people with disabilities (both physical and learning disabilities) live in your area? How many children with special educational needs live there?
2. How does the council monitor and support the educational attainment of children and young people with disabilities, particularly those looked after by the council, as compared with non-disabled children and young people?
3. What are the employment statistics for disabled people in your area? How many young people with disabilities are not in employment, education or training (NEET)? How is the council working with local employers and what role is it playing as an employer in supporting disabled people into and in employment?
4. What advice and support is the council giving to disabled people in relation to claiming welfare benefits? For example, are you working with voluntary organisations to provide advice and support?
5. What is the housing provision for disabled people in your area? Is it adequate and appropriate? Is it included in your housing strategy?

Inequalities and mental health

The term 'mental ill health' covers a wide range of conditions that affect mood, thinking processes and behaviour, from mild depression and anxiety to severe, acute psychosis. Mental health conditions are among the largest single sources of disability and mental health can be more debilitating than chronic physical conditions. Mental health is both a cause and an effect of physical ill-health and a cause and effect of health inequalities. The life chances of people with mental health conditions in the UK are greatly reduced compared with the general population.

- Three children in every classroom are now thought to have a diagnosable mental health condition, with mental ill-health affecting roughly one in 10 children and young people. Facing these challenges at such an early age can cause young people's educational attainment, their ability to form healthy relationships and their family life to suffer. Mental ill-health during childhood and adolescence can dramatically impact outcomes later in life, affecting future earnings, physical health and even life expectancy.⁵⁴
- In 2015/15 there were just under 75,000 hospital admissions in England with a primary or secondary diagnosis of drug-related mental health and behavioural disorders (this is 9 per cent more than 2013/14 and over double the level in 2004/5).⁵⁵ There were 3,674 drug poisoning deaths in England and Wales, involving both legal and illegal drugs, the highest since comparable records began in 1993.⁵⁶
- In 2015, there were 8,758 alcohol-related deaths in the UK, 14.2 deaths per 100,000 population. For the UK as a whole, alcohol-related death rates have not changed in recent years, although 2015 is still higher than that observed in 1994.⁵⁷
- The number of older people between the ages of 60 and 74 admitted to hospitals in England with mental and behavioural disorders associated with alcohol use has risen by over 150 per cent in the past 10 years, while the figure for 15-59 years old has increased by 94 per cent.⁵⁸
- Smoking rates amongst people with a mental health condition are significantly higher than in the general population and there is a strong association between smoking and mental health conditions.⁵⁹
- On average, men with mental health conditions die 20 years earlier and women die 13 years earlier, than the general population.
- The majority of deaths in this group arise from preventable causes and could have been avoided by timely medical intervention.⁶⁰

The wider determinants: mental health⁶¹

Mental health conditions disproportionately affect people living in poverty, those who are unemployed and those who already face discrimination. In addition to poorer physical health, people with mental health problems are more likely to be homeless, are more likely to live in areas of high social deprivation, have fewer qualifications, and are less able to secure employment.

Mental health and employment

Employed adults are less likely to have a common mental health problem (14.1 per cent in full-time work, 16.3 per cent in part-time work) than those who are economically inactive (33.1 per cent) or unemployed (28.8 per cent). Unemployed women are more likely to have a mental health problem than unemployed men. Unemployment has been associated with an increased likelihood of suicide, with this association being greater for men than for women.⁶²

Mental health and educational attainment

Lower parental educational qualifications as well as their occupational group are strong predictors of mental health problems in children. In turn, poor mental health of children and young people is associated with lower educational attainment and with a higher probability of being not in education, employment or training at age 17 and 18.⁶³

Mental health, housing and environment

Poor-quality housing adversely affects mental wellbeing, with effects exacerbated by poor physical neighbourhood quality (eg public space, private gardens, security and access to amenities). People on housing benefit are more than twice as likely to have a common mental health problem than those not in receipt of it.

Mental health and financial insecurity

Living in financial stress can lead to mental health problems. The more debts a person has, the more likely they are to develop a mental health problem. Financial difficulty can also worsen and prolong mental health

problems. Reducing the number of people in financial insecurity will therefore have a public health benefit by helping to prevent the onset of poor mental health. For people with existing mental health problems, helping them to overcome their financial difficulty is a form of treatment, improving both recovery rates and patient outcomes.⁶⁴

Inequalities and mental health: what councillors need to know

1. Do you know the mental health profile of your community, including the numbers of children, young people and adults, women and men and members of minority groups experiencing mental health problems? Are there any groups experiencing particularly poor mental health to which you want to direct resources?
2. What is your council and your public health team and children's services doing to promote the mental health and wellbeing of children and young people, especially those looked after by the council? Do you understand and monitor the work of your local child and adolescent mental health service (CAMHS) teams?
3. What is the council doing to support people with mental health problems to find and retain work? What is it doing as a large employer itself and how is it working with other local employers on this issue?
4. What is the council doing to support vulnerable people in general and people with mental health problems in particular who are in financial difficulty? For example, is it working with the local NHS to commission welfare benefits advice and support services to enable people to get the welfare benefits they are entitled to?
5. What is the council doing to support and reduce numbers of people misusing drugs and alcohol? Does this include working with voluntary sector organisations, integrating health with your housing and homelessness strategies and provision for ex-offenders?

Inequalities and lesbian, gay, bisexual and transsexual (LGB&T) people

In 2015, the Annual Population Survey found 1.7 per cent of adults in the UK identified themselves as lesbian, gay or bisexual (LGB) (Figure 1). This comprised:

- 1.1 per cent who identified themselves as gay or lesbian
- 0.6 per cent who identified themselves as bisexual.

A further 0.4 per cent of the population identified themselves as 'Other' which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories. Some or all of these may identify themselves as transsexual, but the Office for National Statistics does not yet collect separate statistics for this group. Recent research by Public Health England that includes people with 'other' sexual identity estimates that 2.5 per cent (1.36 million) of the population of England may be members of the LGB and 'other' group.⁶⁵ This is likely to be an underestimate, as some people may choose to misreport their sexual identity and for technical reasons.

Despite anti-discrimination legislation and the recent introduction of same sex marriage, LGBT people continue to report a wide range of negative experiences related to discrimination and prejudice. There is evidence that these experiences are linked to health inequalities and may also constitute some of the barriers to addressing these inequalities.⁶⁶

There has been little research conducted on the health of LGBT people in England. However, LGB people have been found to be at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm when compared with heterosexual people (this information is not yet available for trans (transsexual) people).

A term used to summarise the psychological effect of discrimination, bullying, marginalisation, social isolation and stigmatisation of LGBT people is 'minority stress'.⁶⁷

- LGBT young people and adults are at higher risk of physical, emotional and sexual violence compared to heterosexual people
- one in six lesbian, gay and bisexual people have experienced a homophobic or biphobic hate crime or incident over the last three years
- LGBT students are also be more likely to experience victimisation and bullying at school
- research has demonstrated a higher risk of alcohol and substance dependence in LGB people compared to their heterosexual counterparts (PACE)
- the risk of alcohol and substance dependence is particularly acute in and bisexual women (PACE)
- alcohol misuse has been identified as a suicide risk factor in sexual minority young people.

The wider determinants: sexuality

Sexuality and education

Despite more enlightened attitudes and legislation, school and university are not a good experience for many young LGB&T people:

- more than half (55 per cent) of lesbian, gay and bi pupils have experienced direct bullying
- two in five (41 per cent) have attempted or thought about taking their own life directly because of bullying and the same number say that they deliberately self-harm directly because of bullying.

Sexuality and employment

The stress of bullying, discrimination and having to conceal part of one's identity also affects the mental health of LGB&T people in the workplace.

- One in five (19 per cent) lesbian, gay and bi employees have experienced verbal bullying from colleagues, customers or service users because of their sexual orientation in the last five years.
- Nearly half (42 per cent) of trans people are not living permanently in their preferred gender role. They are prevented from doing so because they fear it might threaten their employment status.⁶⁸
- Only 59 per cent of all health and social care staff think their employer is taking effective steps to prevent and respond to discrimination and poor treatment of lesbian, gay and bisexual people. This decreases to just 48 per cent for trans people.⁶⁹

Inequalities and LGBT people: what councillors need to know

1. Do you have an idea of the numbers of LGBT people in your area? (There are difficulties in gathering such statistics, as people need to self-identify and may fear discrimination and ill treatment, but local voluntary sector organisations may be able to help.)
2. What do local voluntary and campaigning organisations say are the biggest issues faced by LGBT people in your area? How does the council seek the views of LGBT people on its policies?⁷⁰
3. What is happening in local schools and colleges to develop inclusive anti-bullying policies and provide support for young LGBT people?
4. Can the council and its youth service provide support for such initiatives?

Hertfordshire County Council

Herts for Learning

Hertfordshire County Council and Herts for Learning Ltd have been recognised as leading the way in work to celebrate difference and challenge homophobia, biphobia and transphobia in schools as well as support LGBT young people in the local community.

Supported by Youth Connexions Hertfordshire, the Herts1125 Who not What (WnW) group is the voice of LGBT young people in the county, providing strategic input into the development of services and resources. Stonewall has trained these young people to develop their campaigning skills. They have since contributed to the Hertfordshire CAMHS Review, and they, along with LGBT young people's experiences collated for the Hertfordshire Young People's Manifesto 2015, are informing the Police and Crime Commissioner's work around hate crime and the forthcoming health and wellbeing strategy. WnW is also inputting into the professional training for youth workers, to enable them to work better with LGBT young people.

School governors are offered termly training on tackling bullying and a pupil welfare and wellbeing package has been developed which pays significant attention to the specific vulnerabilities of LGBT young people. Bespoke anti-bullying training, workshops and surgery sessions are provided to school staff. Early years providers have been trained on valuing difference and creating inclusive environments. A sex and relationship education (SRE) summit was held for local authority and school staff, resulting in a presentation for elected members on SRE provision in the county, and the importance of ensuring it is LGBT inclusive.

Inequalities and the criminal justice system

Over 9 million in the UK have a criminal record – one in five of the population. There are over 80,000 people currently in prison in England and Wales. People in prison and ex-offenders also face significant health inequalities, including multiple and complex health and social care needs. Poor individual health and social inequalities are associated and interlinked with an increased propensity to offend.⁷¹ Since April 2015, local authorities have been responsible for meeting the social care needs of people in prisons within their areas, in addition to their existing responsibilities for public health and reducing health inequalities which apply to people in prison and ex-offenders as much as to other residents.

- the mortality rate for prisoners is 50 per cent higher than the rest of the population
- in 2012 36 per cent of prisoners in England and Wales had a disability and/or mental health problem⁷²
- forty-two per cent of men and women in prison and 17.3 per cent on probation suffered from depression, compared to just over 10 per cent of the rest of the population
- up to one in three prisoners have tested positive in drug tests and 13 per cent developed a drug problem while in prison⁷³
- alcohol use disorder is much higher in the offender population compared to the general population⁷⁴
- people in and out of the criminal justice system are four times more likely to be smokers
- it is broadly recognised that many prisoners have the biological characteristics of those who are 10 years older than them.

The wider determinants: criminal justice

The links between the wider determinants of health and factors affecting reoffending such as sustainable housing or employment create a potentially vicious circle. For example, offenders with addiction or mental health problems are more likely to need support with housing, education or employment to change their lives and prevent future victims, yet these offenders find it more difficult to get help than the general population. Increased health inequalities are therefore compounded by greater barriers to accessing services.⁷⁵ Many individuals leave prison with no fixed accommodation, no financial support and no prospect of finding work. The importance of secure accommodation for prisoners to go to on release has been recognised as key to reducing offending. For this group, as for others, employment and settled accommodation often go hand-in-hand.

Offending and educational attainment

Forty seven per cent of prisoners are estimated to have no school qualifications, including GCSEs.⁷⁶

Offending and employment

Employment can significantly reduce the chances of reoffending, but only 26.5 per cent of prisoners enter employment on release from prison.

Offending and homelessness

Fifteen per cent of prisoners are homeless immediately prior to custody, compared to a lifetime experience of homelessness of 3.5 per cent in the wider population.

The figures outlined above are of particular relevance to local authorities in relation to their public health role in commissioning drugs and alcohol services, smoking cessation and their roles in relation to mental health support, social care, community safety and housing strategy.

Inequalities and criminal justice: what councillors need to know

1. Do you know the number of ex-offenders and what support is in place for ex-offenders living in your area?
2. Does your Joint Strategic Needs Assessment (JSNA) capture the needs of offenders both in detention and in the community?
3. If there is a prison in your authority's area, do you know what kind of prison it is, how many people pass through its doors, what kind of social care and public health support they and their families are receiving from your authority and what happens to them when they leave prison?
4. Is your council working with appropriate partners such as the National Offender Management Service, local prison authorities, relevant voluntary organisations, housing associations and local employers to provide 'through the gate' support for people leaving prison so as to assist their rehabilitation and help reduce reoffending?
5. Can you work with local employers and voluntary organisations to encourage more employment of ex-offenders – for example, by signing up to the 'Ban the Box' campaign to postpone ticking the criminal record disclosure section on job applications to a later stage in the application process (the Government has removed this section from the majority of civil service roles).

Essex County Council

Support for people in the criminal justice system

Essex County Council has procured an 'all vulnerabilities' criminal justice care management and navigation service for people with complex and additional needs who are in contact with criminal justice services. The service, Full Circle, is provided by Phoenix Futures Group¹⁰ and North Essex Partnership University NHS Trust. It works with local liaison and diversion services, the community rehabilitation company, probation and prison services to actively identify individuals at risk, and to provide them with a named support worker.

The support worker helps to address underlying difficulties such as debt, housing and employment, and refers individuals into specialist provision, as needed. Full Circle will support the development of pathways for groups that have historically been underserved within criminal justice, such as people with learning disabilities or difficulties and women. This is the first step in a wider piece of work to develop an integrated system of support for people in contact with criminal justice services, to improve their health and wellbeing, and reduce offending.

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3. The strategic role of local government

Taking a corporate approach

Any council that wants to make a real transformation in the health of its population and, in particular, to reduce health inequalities within its population needs to make some commitments at a strategic level. As Public Health England points out, there are many ways of intervening to reduce health inequalities, but to have real impact at population level, interventions need to be:

- sustainable
- systematically delivered
- delivered at a scale that will impact on large sections of the population.⁷⁷

To bring about this kind of change, a corporate, council-wide approach to embedding health objectives is necessary.

The following suggested areas for high level commitments by councils may help in developing a systematic understanding of and effective approach to reducing health inequalities, drawing on all the council's resources and partnerships.

- A declaration by the council that recognises the links between health inequalities and deprivation, acknowledges that reducing health inequalities is a matter of social justice and makes a commitment to mitigating health inequalities in everything the council does.
- A commitment to and appropriate resources for data collection, monitoring of trends and intelligence gathering on the extent and nature of health inequalities in the authority's area.
- Intelligence that incorporates non-monetary forms of poverty, such as environmental poverty (traffic and pollution, unsafe neighbourhoods, lack of access to green spaces and the natural world etc).⁷⁸
- Development of a credible 'story of place' understandable to partner organisations and the public. Use of population intelligence to inform the Joint Strategic Needs Assessment.
- Leadership and engagement across the whole system with a commitment of innovation, resources and financing by all relevant partners – substantial impact on inequalities cannot be managed through small, 'add-on' projects.
- An integrated poverty-reduction strategy, like that of the Plymouth Plan outlined above, tailored to your particular place and community that is cross-sectoral and addresses deprivation and inequality through authority-wide partnership. Recognition of the importance of poverty reduction in reducing health inequalities within local plans. Programmes for poverty reduction that do not focus only on housing provision or estate regeneration, but instead include improved transport links, access to local services and amenities, and safer communities, all of which are important to creating better environments and reducing health inequalities.
- A Health in All Policies strategy focused on concrete objectives, which includes specific measures to tackle health inequalities across the full range of the council's activities.⁷⁹ Health inequalities addressed as part of mainstream agendas, using mainstream budgets and tackled systematically, at sufficient scale and sustainably.

- A commissioning strategy that explicitly recognises the impact of the social determinants of health and commissions services designed to meet the needs of specific groups experiencing the detrimental effects of health inequalities.
- A place-based approach to reducing health inequalities, as well as a people-based approach. A place-based approach requires partnerships of organisations that provide services, education and employment in an area and co-ordinated neighbourhood-wide strategies for mitigating deprivation and the resulting health inequalities. A people-based approach requires partnerships with those belonging to and representing the interests of the diversity of groups who are at and near the bottom of the scale of inequality.
- Systematic community engagement, especially with the most disadvantaged communities, as a critical element in developing strategies which address health inequalities.
- Recognition of the council's potential as a large employer to address some of the determinants of health and inequalities and an appropriate health inequalities employment strategy. Acting as a role model for other employers and a convenor of an employment forum with the objective of addressing health inequalities and creating workplaces supportive of health and mental and emotional wellbeing.
- A systematic training programme for councillors, chief officers, middle managers and frontline staff on health inequalities in the area, the social determinants of health and how the specialist functions of the council impact on the health of residents.

4. Maximising the health impact of councils' functions

The relevance of local government's functions

As well as strategic commitments, councils need to make the most of all of their functions in reducing health inequalities. The Marmot review stresses the importance of taking a lifecourse perspective and recognising that disadvantage accumulates throughout life. It emphasises that the close links between early disadvantage and poor outcomes can only be broken by taking action to reduce health inequalities before birth and continuing this throughout life. Marmot also emphasises the gradient in health inequalities – where people are on the socioeconomic ladder – and the need to take action across the whole social gradient.

Most councils have taken on board this message and are taking a lifecourse approach to health inequalities. Marmot said that addressing the social determinants of health and reducing health inequalities will require action on six policy objectives – these objectives have been adopted widely across government, local government and public health:

- 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.

Looking at this list, it is clear that local authorities, not only unitary and county councils, but also district, town and parish councils have a central role to play, for example, through their work on early years, health visiting, schools, teenage pregnancy, employment and the local economy, healthy workplaces, leisure and environmental services, housing and services for older and disabled people.

Note that this list extends far beyond public health and social care: it could include almost every local government function. It is also important to note that no one agency could implement any of these objectives on its own. They require collaboration, partnership and collective action in many different spheres of activity. This makes it all the more important that everyone in the council understands not only the impact of their work on health, but also where inequalities in health are to be found between the communities and populations they serve.

Targeted and universalist approaches

Local government has a duty to improve the overall health of its communities while reducing inequalities between groups. This means that in some spheres of activity councils will need and want to take a universalist approach, ie measures which apply to an entire population, eg 'all residents' 'all children under the age of six', 'all women', 'all people living in a particular geographical area'.

For other purposes, a targeted approach will be most effective, addressing barriers and disadvantage experienced by a particular group in a wider population, eg 'teenage mothers', 'children in receipt of free school meals', 'seasonal workers', 'members of a particular ethnic group'.

In addressing health inequalities, the Marmot review recommended an approach of 'proportionate universalism'.

This approach is intended to recognise that to close the inequality gap between those with the best and the worst health programmes and policies must include a range of responses for different levels of disadvantage experienced within the population, ie strategies and interventions must recognise the social gradient in health. Marmot said that "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."⁸⁰

Councils are required to provide certain services universally, such as access to school places or information on residential and home care to older and disabled people and their families. But it is recognised that while some services may be universal in principle, in practice they may not be so. For example, while all members of the public may be entitled to use councils' parks and recreation facilities, it may be easier for some residents to do so.

This means that special efforts need to be made and interventions targeted to ensure that others can use services that are theoretically open to all. Another example is that while in theory anyone can go to any supermarket, in practice targeted actions are needed to ensure that people have access to sufficient healthy food, for example through local markets, community gardens and food banks in deprived areas, including distributing food through community organisations, churches and mosques.

Making effective use of local government functions

Since transferring to local government from the NHS, public health teams have increasingly been taking a 'whole council' approach to their role, aiming to embed an understanding of the social determinants of health and health inequalities across councils and to work with council departments in developing a mutual understanding of where they can make the most impact on reducing health inequalities and improving health.

There is also a developing body of research to which local authorities are contributing, on the interventions by local government that can be most effective in reducing health inequalities.⁸¹ In the current financial climate, policies and practice that are evidence-based are vitally important in ensuring that resources are directed where they will be most needed. This may seem obvious, but reducing health inequalities is an area in which there are many misperceptions, such as the issues of choice, the role of education and the role of the NHS discussed above.

The examples below are only a small number of the many approaches local authorities have developed with the support of their public health teams. They are chosen to illustrate the very wide range of local government functions, the need for partnership and a corporate approach and the different tiers at which councils can act to address health inequalities.

These examples refer, by and large, to specific issues relating to health inequalities. It is important to emphasise that the actions described in the examples will be only part of a range of interlinked issues a local authority will need to address to achieve real change.

Directors of public health (DsPH) and their teams are appointed to local authorities with social services functions, ie unitary authorities and county councils. Much of their strategic developmental work will be at this level, not least because public health is about improving the health of populations at

sufficient scale to impact on big long-term issues like life expectancy rates that can take generations to change. The functions of unitary and upper tier authorities lend themselves well to a health in all policies approach.

Some of the major local government functions are discussed below. However, in relation to the ill health and lower life expectancy experienced by particular disadvantaged groups, interventions aimed at reducing detrimental health inequalities sometimes need to be targeted at segments of the population. This is one reason why councillors need to have a detailed understanding of the make-up of their population and the groups that are at most disadvantage.

They also need to have a good relationship with the different communities of place and of identity that their residents constitute so that they can engage in dialogue about the kind of interventions that are likely to be most effective in relation to a particular group.

Many of the functions of district councils place them also in a good position to influence the factors that determine health and health inequalities. They also have a key role in supporting communities and influencing other bodies to address these issues.⁸² Among their core functions planning and economic development, housing, leisure and green spaces, air quality and environmental health are key areas that impact on health inequalities. In two-tier areas, district councils are working with DsPH in county councils to develop strategies to tackle health inequalities. In some areas, a lead public health specialist is assigned to each district council, in others public health staff work with district councils on specific projects.

In addition to contributing to the county council's health inequalities strategic planning on, many district councils have developed their own action plans to tackle health inequalities. Some county councils, such as Kent and Gloucestershire, have allocated resources to each district council to assist it in improved targeting and effective management

of health inequalities programmes. Other counties such as Hertfordshire have made a sum of money available for which district councils can bid for specific projects to tackle health inequalities.

District councils have an important role in identifying and helping develop strategies to tackle health inequalities in rural areas where many two-tier areas remain and where overall affluence can mask pockets of deprivation.⁸³ For example, fuel poverty is a significant issue in contributing to health inequalities in rural areas and district councils have a key role in reducing this through schemes to improve insulation and reduce heating costs and excess cold.

In many rural areas, public health teams work closely with district councils but these relationships are still being explored in some areas. There is further work to be done in developing the understanding of public health teams of rural health inequalities and the role of district councils and the understanding of district councils of how they can contribute to reducing health inequalities.

The best start in life: the early years

The early years are a key determinant of health.⁸⁴ The Marmot Review recognised this in its priority policy objective, 'Give every child the best start in life' which is crucial to reducing health inequalities across the life course, and other social and economic inequalities throughout life. What happens in the early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status. Local authorities have specific responsibility for the health of children aged 0-5 as well as 5-19 and are responsible in particular for health visiting and school nursing.

In 2014, the UK was second only to Estonia in income inequality among EU countries:⁸⁵

- the UK has a higher infant mortality rate than nearly all comparable Western European countries⁸⁶
- rates of smoking during pregnancy – an important factor in the health of babies – are higher in the UK than in many European countries and highest in deprived populations and in mothers under 20.

Inequalities in the early years: what councillors can do

1. Have measures in place to reduce inequalities through services such as specialist pre and postnatal home visiting for vulnerable children and their families.
2. Have a council-wide strategy for promoting breastfeeding. Work with schools, local businesses and employers, particularly in the most disadvantaged areas to make your area 'breast-feeding friendly'.
3. Ensure you and partner organisations are providing educational and other support for teenage parents.
4. Commission good quality parenting programmes and make these accessible to all. Monitor the take-up of programmes and take action to improve take-up by parents from the most disadvantaged communities.
5. Protect children's centres from spending cuts, so as to reach out to the most vulnerable and disadvantaged parents and children.

Maximising capabilities: education and attainment

Of the various social determinants of health that explain health disparities by geography or demographic characteristics (eg age, gender, race-ethnicity), the literature has always pointed prominently to education.

Research based on decades of experience in the developing world has identified educational status (especially of the mother) as a major predictor of health outcomes, and economic trends in the industrialised world have intensified the relationship between education and health.

Educational attainment impacts on people's health. Inequalities in education and skills affect physical and mental health, as well as income, employment and quality of life. But health and wellbeing impact on educational attainment.⁸⁷

In reducing health inequalities, what is needed is a sustained commitment to children and young people through continued family support, education, training and employment. Local authorities have responsibility for the health of children aged 5-19 and are responsible in particular for the National Child Measurement Programme (NCMP).

More than one in five children starting primary school in England, Wales and Scotland are overweight or obese, the highest rates are in the most deprived communities and there has been little improvement in these figures over the past 10 years.

- The rates of children on child protection plans (CPP) or who are looked after by local authorities (LAC) are strongly statistically associated with measures of deprivation.⁸⁸ In general, the more affluent the neighbourhood a child lives in, the lower their chance of being LAC or on a CPP.
- Children's life chances are not just affected by poverty but by inequality itself. The UNICEF Index of Child Well-being in rich countries has been shown repeatedly to be significantly higher in more equal societies. Educational attainment is higher, fewer young people drop out of education and fewer teenage girls become mothers in more equal societies.⁸⁹

Inequalities in education and attainment: what councillors can do

1. Work with your Lead Member for Children's Services/Education to understand the statistics on educational attainment in your area and in particular inequalities in attainment between different groups.
2. Ensure there is good support for the home-school transition, making children 'education ready', especially those groups where you know later educational attainment is lower.
3. Ensure there is good quality childcare and support for working parents. Ensure there is provision where need is greatest.
4. Monitor the support and attainment of children with special educational needs.
5. Ensure your public health team is providing advice and support for schools in developing a whole school educational environment which fosters physical and mental health.

A healthy standard of living

Work and worklessness

Unemployed people, particularly long-term unemployed people have a higher risk of poor physical and mental health compared with those in employment:

- Unemployment is associated with unhealthy behaviours such as increased smoking and alcohol consumption and decreased physical exercise.
- The health and social effects of a long period of unemployment can last for years.⁹⁰
- There are particular risks associated with being unemployed at a young age. By the age of 21, those who are 'NEET' (not in employment, education or training) for longer than six months are more likely to be unemployed, low paid, have no training, a criminal record, and suffer from poor health and depression.⁹¹

For those who are in employment, the nature of work can also adversely affect health through adverse physical or psychosocial conditions of work, poor pay or insufficient work or insecurity and the risk of redundancy or job loss.

- in 2014, an estimated 1.2 million working people in Great Britain had an illness or health condition believed to be caused, or exacerbated by their current or previous work placement
- musculoskeletal disorders and work-related stress, depression and anxiety were the most common work-related illnesses in 2013/14.⁹²

Although national economic and welfare policy and outcomes will have the greatest impact overall on health inequalities associated with work and worklessness, there is still a wide range of opportunities for local authorities to support those in and out of work. These opportunities range from advice to skills retention, training and re-training to proactive action to create jobs and to the council's own role as an employer: often one of the largest in the area.

Current financial constraints make direct job creation extremely difficult if not impossible for local government. However, councils can still work through partnerships, including local enterprise partnerships, employment services providers and third sector organisations to devise job creation strategies that could reduce health inequalities. Working to improve the skills base of people in local and regional labour markets may help to attract more skilled employment to the area, and contribute to improving the quality of work. This is particularly important in more economically deprived regions such as the north of England, where a skills deficit already exists and sits side by side with greater health inequalities.

The devolution of budgets to several cities and regions has raised the level of the interconnections between economic development and health. The Due North report on health inequalities in the north of England says that 'local strategies for economic growth need to have clear social

objectives to promote health and wellbeing and reduce inequalities, backed by locally integrated public services aimed at supporting people into employment'.⁹³

The Public Services (Social Value) Act 2012 also provides opportunities for local authorities to improve employment through their procurement activities.⁹⁴ For example a council could contract with a social enterprise which employs local unemployed young people, trains them, and offers them a 'living wage', thereby achieving a 'social value' beyond the value of the service being delivered.

Welfare benefits support

Financial insecurity has been shown to have a negative impact on people's health and wellbeing as well as reducing the effectiveness of clinical interventions such as psychological therapies.⁹⁵ People with mental health problems are three times as likely to be in problem debt and the number of people at risk of problem debt is rising. One of the ways in which local authorities can support people in financial difficulty is to help them get the welfare benefits they are entitled to. Of course, local authorities want to maximise people's chances of finding and keeping fair employment and good work. But there are still many people in low paid jobs and many others who are unable to work for various reasons, including disability and caring responsibilities for whom welfare benefits are a lifeline.

Leeds City Council

Retaining jobs as well as finding them

Workplace Leeds Run by Leeds Mind in partnership with local mental health, social care and housing services.

Workplace Leeds offers a range of services and support to help people experiencing mental health problems stay in work or find new employment. It has been offering

employment support for the past 20 years, but since 2011 has dramatically expanded its services. Four years ago it had just six staff.

Now there are 34 and nearly 500 people get help each year. The range of help available includes: peer support, workshops, CV and interview skills.

Service Manager Vanessa Lendzionowski says: "We encourage people to find work which is meaningful, sustainable and fulfilling. Often they have been struggling to get work and their confidence and self-esteem may be low. The first task is to help them with these issues before moving on to give them support finding employment. We can work with people for up to a year, but for some it happens much quicker."

The second main service by Workplace Leeds is a job retention service for people who are experiencing difficulties at work. "They may be off sick or at risk of losing their job," Ms Lendzionowski explains. "Often we only get involved at quite a late stage – it would perhaps be better to work with them at an earlier stage. But we still find there is lots we can do."

Last year over nine in 10 people who were helped through the job retention service managed to stay in their jobs, including nurses, teachers and IT professionals.

Sinead Cregan, Leeds City Council's Adult Social Care Commissioning Manager, says she is "really pleased" with the service. "The joint work in our day centres is going really well with many good outcomes for our clients and the IT training is getting excellent results."

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www.leedsmind.org.uk/employment/

Other examples on work and worklessness: LGA and PHE, Health, work and health-related worklessness: A guide for local authorities
www.local.gov.uk/sites/default/files/

Durham County Council

Helping people maximise their standard of living

Durham's Welfare Rights Service (WRS) is a partnership between Durham County Council and Macmillan Cancer Support, supported by NHS primary and acute trusts within County Durham and linked to a network of voluntary and community sector organisations. The WRS sits with Durham County Council's Social Inclusion Service and aims 'to provide those affected by cancer with comprehensive, free, confidential and impartial advice and information on their entitlement to social security and housing benefits, tax credits and grants at appropriate points in the patient pathway'.

An evaluation report of the service found that every £1 spent on the service generated £20.58 of benefits and, in addition, users and stakeholders reported that the WRS had a considerable positive impact on outcomes.⁹⁶ For example, it had:

- enabled users 'to afford necessities and additional items that were required as a result of a diagnosis of cancer'
- 'eased feelings of stress over financial issues at a time when participants were concerned about dealing with the impact of cancer'.

Further analysis indicated that the service also frees up the clinical capacity of specialist staff to perform their core functions.

Inequalities and employment: what councillors can do.

1. Understand the patterns of employment and unemployment in your area and how they affect the different groups discussed in chapter 2.
2. Ensure your council's and local partnerships' strategies for economic regeneration, tackle low pay and worklessness designed to address the inequalities highlighted here.
3. Encourage the creation of jobs where workers are valued, have opportunities for promotion and are protected from adverse conditions, like shift work, where possible.
4. Develop employment strategies to mitigate the underemployment of seasonal workers off-season.
5. Consider a commitment to a 'living wage' for your employees and as part of procurement. Take the lead in introducing discussions of this idea among local employers.
6. Ensure the council is contributing to improving the skills base in your area through training and re-training.
7. Set an example in supporting and improving the health of the council's own workforce, including manual workers and those in outlying workplace settings.
8. Monitor and evaluate your and local employers' provision of employment opportunities among groups experiencing worse inequalities.
9. Make the most of your procurement and commissioning contracts to ensure that employers you contract with provide good quality employment, social value and contribute to reducing inequalities.
10. Support welfare benefits advice services in your area. Ensure that advice is available to and accessed by people with mental problems, disabled people, carers and other disadvantaged groups.

A healthy and sustainable environment

Where you live matters as well as who you are. Lack of essential amenities such as banks and post offices and supermarkets can reinforce poverty, inequality and ill health. The Marmot Review defined 'environmental inequalities' as the unequal impact of environmental factors on health and wellbeing:

- each year, more than 1.4 million people miss, turn down or choose not to seek medical help because of transport problems⁹⁷
- since 2010, £78 million has been withdrawn from local authority bus funding in England and Wales resulting in over 2,400 bus services being reduced, altered or withdrawn from service while petrol prices have risen by 70 per cent
- food poverty (defined as the inability to obtain healthy affordable food) is significantly affected by whether people lack shops in their area or have trouble reaching them
- people living in rural areas typically need to spend 10 to 20 per cent more than people in urban areas to reach a minimum acceptable standard of living.

In addition to obvious health factors such as poor air quality, pollution and higher rates of road traffic injuries and death which are linked to deprived geographical areas⁹⁸, there is significant and growing evidence on the health benefits of access to green spaces.⁹⁹

- people living in deprived areas are less likely to live near green spaces
- the benefits of green spaces include improved air and water quality, noise absorption and reduced 'urban heat island' effects
- research shows higher levels of physical activity in areas with more green space – physical inactivity costs the NHS up to £1.8 billion a year

- increasing the use of good quality green space for all social groups is likely to improve health outcomes and reduce health inequalities
- greater use of green spaces can also increase community cohesion and reduce social isolation.

Environmental inequalities: what councillors can do

1. Use local data to map public transport access to healthcare facilities in your area against levels of deprivation.
2. Map access to green spaces against levels of deprivation in your area.
3. Be aware of levels of air pollution and how they correlate with areas of deprivation.
4. Work with your fellow councillors with a planning role and your public health team to ensure your council's approach to planning and your local plan embed a 'healthy planning' approach, planning for green spaces, access to services and facilities, walking, cycling and 'liveability'.
5. Improve access to healthcare settings for those who now have least access. (Can you influence transport routes and frequency? Can you bring healthcare settings closer to those in most need?)
6. Take action to make access to green spaces, parks and leisure facilities more equal. (Can you make better use of council land? Could you create 'pocket parks'?)
7. Take action to combat air pollution from traffic and other factors and to reduce people's need to travel through polluted areas (eg children walking to school).

Helping unemployed people into work through transport

Many areas have put together packages of measures to help unemployed people travel to work. Typically, these include combinations of travel advice and information, journey planning, free or discounted tickets for public transport, subsidised bikes and scooters with training to ensure safety. Authorities have also provided training to help unemployed people get jobs in the transport industry – Greater Manchester has a ‘train, learn, drive, earn’ programme to train people to become drivers for community transport services, while Surrey has funded a motor mechanics course for young unemployed people through its community funding initiative.

Many authorities have developed partnerships with Job Centre Plus to deliver these programmes – in Greater Manchester the transport authority has helped staff at Job Centre Plus and at Work Programme contractors to become ‘travel champions’. Many areas have also introduced ‘Wheels to Work’ projects, which lend scooters to unemployed people getting into work, to overcome the transport costs many face.

Bristol City Council

Accessible green space

In 2008 Bristol City Council developed an accessible green space standard, known as the distance standard, which sits alongside quality and quantity standards. The distance standard aims to safeguard and encourage an accessible network of green spaces. It is based on local research that identified the distance Bristol residents felt they could reasonably walk to access green space, which coincided with the layout of Bristol’s green spaces to ensure the standards were credible.

Tower Hamlets

Using planning legislation for health

Tower Hamlets is one of the 20 per cent most deprived council areas in England and about 34 per cent (18,300) of children live in low income families. Life expectancy for women is the lowest in the country and the fourth lowest for men.

In an imaginative use of Section 106 of the Town and Country Planning Act 1990, public health staff have worked with the planning department and the local NHS to develop more health-related provision, using the evidence base for healthy planning.

Section 106 agreements made between local authorities and developers can be attached to a planning permission to make acceptable development which would otherwise be unacceptable in planning. The public health team has not restricted the use of Section 106 monies to healthcare facilities, for which they are often used. Its analysis showed a detrimental relationship between aspects of the environment in the borough (eg limited open and green spaces) and health. This evidence provided the impetus for a £1.4 million investment in green infrastructure projects such as ‘pocket parks’ (small areas of inviting public space for everyone to enjoy, often created on a single vacant building plot or on small, irregular pieces of land).

Other initiatives include an outdoor gym and investing in Green Grid (linking green spaces across the borough). This approach has involved a move away from buildings infrastructure (eg health centres) and more towards making the environment in general a healthier one. The public health team has fully assimilated with the infrastructure planning team, ensuring health facility and health impacts are reflected in key documents such as the Infrastructure Delivery Plan and the Local Plan.

Health requirements were taken into account when the authority set its Community Infrastructure Levy (CIL) and this also highlighted them as potentially requiring CIL funding once the Section 106 contributions are exhausted. This work has provided a lasting legacy for future development in terms of securing resources.

Housing

The quality of people's homes is a significant social determinant of health and a contributor to health inequalities. Variations in housing costs between places have a substantial impact on the numbers of people defined as living in poverty. For example, once housing costs are taken into account, the number of Londoners living in poverty almost doubles from just over one million to just over two million and those in the South East of England are also affected.¹⁰⁰ Housing conditions which constitute a risk to health, primarily for those on low incomes, include homelessness, over-crowding and housing in a poor physical condition. High housing and energy costs and energy-inefficient properties detract from people's disposable income with resulting health implications.¹⁰¹

- living in cold damp homes increase the risk of cardiovascular and respiratory diseases and mental health problems as well as affecting children's educational attainment
- rates of respiratory disease, tuberculosis, meningitis and gastric conditions are higher in overcrowded households which can affect children's education, and physical, mental and emotional wellbeing
- homeless people have a higher risk of physical and mental health problems, including alcohol and substance misuse, smoking and tuberculosis. Their average age at death is 40 to 44 years.

There are many ways in which local government is addressing health inequalities through its role in housing. Much of this work is done under the remit of social care, for example working

with social housing providers to understand housing need and ensure a range of housing options for people with different needs and providing housing adaptations to enable older and disabled people to live more independently in their own homes.

But there is a whole range of other housing-related local authority functions that can impact on health inequalities, from homelessness strategies to administering housing benefit to reducing fuel poverty, overcrowding and poor housing conditions to carrying out the local government's environmental health regulatory role in relation to private letting. Because of the spread of these functions across council departments and even across councils in two-tier areas, a Health in All Policies approach is vital to ensure that councils have a coherent and strategic perspective to the myriad ways in which their work on housing can address health inequalities.

Inequalities and housing: questions for councillors to consider

1. How well integrated are your health, social care and planning strategies in a systematic approach to housing that meets people's needs at each of the life stages?
2. Is the council using its planning powers to maximise opportunities for genuinely affordable housing?
3. Is the council putting well-directed resources into reducing overcrowding and inadequate housing conditions in both the public and private sectors with advice from public health on health impacts?
4. Does your homelessness strategy address wider issues than simply ensuring that people have a roof over their heads – for example does it include working with homeless people on mental health issues such as drug and alcohol misuse?
5. What are you doing to tackle fuel poverty and ensure measures reach those in most need?

Addressing poor health outcomes and health inequalities at home

The Chartered Institute of Environmental Health has collected a number of case studies illustrating a wide range of interventions to tackle health inequalities related to housing.¹⁰² These include:

Newham Fair Lettings Project

Newham Council with the Metropolitan Police: project to ensure all residential letting agents' activities are fair, transparent and legal.

Dorset Healthy Home Project

Dorset County Council, Bournemouth Borough Council, Poole Borough Council and Dorset Energy Advice Centre: developing a robust evaluation framework to contribute to the evidence base on the health impact of improving warmth and reducing damp.

Derby Healthy Housing Hub

Derby City Council with a broad range of health, public health, social care, housing, voluntary and community sector partners: strategies aimed at reducing home accidents, falls and health risks, enabling independent living and facilitating hospital discharge and reducing demand on health, social care and emergency services.

Durham Keep Warm Stay Safe pilot project

Durham County Council with Durham Home Improvement Agency, Durham Community Action, Durham Police and Durham and Darlington Fire and Rescue Service: a package of measures for vulnerable people in the private rented or owner occupied sectors, focussing on poorly insulated and/or inefficiently heated properties.

5. The proximate causes of health inequalities

In this section, we look at three of the most significant ‘proximate causes’ of health inequalities. These are the ‘lifestyle’ issues that impact directly on health, life expectancy and years of healthy life and are significant contributors to health inequalities. However, this section comes with a big ‘health warning’ and a reminder of the discussion above about the social determinants of health and the extent to which individuals’ apparent ‘choices’ are constrained by their situation. Where the social determinants are the ‘causes of the causes’, these lifestyle factors are the direct causes of ill health and health inequalities. But we should not forget that the social determinants are just what their name implies: they determine to a very large extent the lifestyle behaviours discussed in this section. That is why the inequalities described below exist – different population groups live in different social and economic circumstances and these influence the choices they make.

Patterns of multiple lifestyle risks (smoking, excessive alcohol use, poor diet and low levels of physical activity) are unevenly spread across socioeconomic groups, with those in the most disadvantaged groups more likely to engage in more of these behaviours. Public health interventions which rely on individuals to change, such as public education campaigns, while they may work for populations as a whole, are likely to increase health inequalities. The overall message of this publication is that local government can make the biggest difference at the level of population by addressing the social determinants of health as well as lifestyle issues because the two are so closely related.

Inequalities in smoking

Smoking is still the single most preventable direct cause of health inequalities in the UK. Rates of smoking have declined in the UK in recent years, but the rate of decline has been significantly slower in more disadvantaged groups.

Therefore the gap in inequalities has not declined. Exposure to second-hand smoke (passive smoking) can lead to a range of diseases, many of which are fatal, with children and those in the most deprived groups especially vulnerable to the effects of passive smoking. For every indicator of disadvantage (gender, ethnicity, lone parenthood, mental health problems, youth offender, prisoners) there are greater rates of smoking:

- Over 200 deaths every day (79,000 deaths a year in England) are caused by smoking.¹⁰³
- In 2016, 15.5 per cent of adults smoked, down from 20.1 per cent in 2010.
- In 2015 across the UK, 19.3 per cent of men and 15.3 per cent of women smoked.
- Smoking accounts for approximately half the difference in life expectancy between the richest and poorest in society (and smoking rates closely follow the gradient of deprivation all the way to the top).
- From 2012 to 2015 there were around twice as many smoking-related deaths in the north-east compared to the south-west. But smoking affects poor communities across the country. The local authority with the highest rate of smoking is Hastings, with 26 per cent of people smoking.

- The prevalence of smoking in pregnancy is 10.5 per cent. Smoking in pregnancy carries risks of miscarriage, premature birth, still birth and neonatal complications.
- More than 40 per cent of people with a serious mental illness smoke.
- Around 80 per cent of the prison population is estimated to smoke.
- Smoking retail outlets and availability of illegal cigarettes are much more prevalent in deprived areas – this is an important finding both for planning authorities and for trading standards whose enforcement work can make a significant difference to the amount of smuggled tobacco available.
- Smoking costs the NHS in the UK around £2.5 billion a year.

Not only are smokers from disadvantaged groups more likely to smoke but they also find it more difficult to stop smoking even with the help of stop smoking services, than more affluent smokers. Difficulty in stopping smoking may be due to lack of social support, perhaps because people are living in a household with other smokers, higher nicotine dependence (less affluent smokers smoke each cigarette more completely and take deeper drags on the cigarette than less dependent smokers), challenging life circumstances and where and when stop smoking services are provided may not suit the life circumstances of more disadvantaged groups.

The evidence suggests that targeted support for disadvantaged groups which recognises the pressures people experience that undermine their attempts not to smoke is the most effective way of reducing the health inequalities due to smoking. Public Health England (PHE) has identified the following initiatives as being the most effective in reducing health inequalities due to smoking:

- mass media – TV rather than print and social networks if used to support change rather than reinforcing existing habits or ‘victim blaming’
- face to face support – targeted stop

smoking services, including targeting people with long term conditions, mental health problems, asthma and diabetes and pregnant women

- using primary and secondary healthcare contacts to provide ‘teachable moments’ about the desirability of stopping smoking
- very recent research suggests that a combination of tobacco control measures: tax increases; public information campaigns; on-pack pictorial health warnings; advertising bans; smoking cessation initiatives; and smoke free areas would benefit the most disadvantaged fifth of the population, reducing absolute inequality of deaths by coronary heart disease by about 4 per cent, a significant amount.¹⁰⁴

The All Party Parliamentary Group on smoking and health recently recommended that local authorities should have tobacco control plans, developed with National Institute for Clinical Excellence (NICE) guidance and advice from PHE.¹⁰⁵ Tobacco control alliances should be established and sustained to help ensure effective delivery of the plans.

Inequalities in smoking rates: questions for councillors to consider

1. Do you know how well your stop smoking initiatives are reaching all areas of the population, including those in the most deprived areas and in routine and manual occupation?
2. Are you aware of any differences in outcomes of smoking rates among different population groups?
3. What measures are you taking to address inequalities in smoking rates between groups?
4. Do you have ways to assess whether your stop smoking initiatives are reducing inequalities or not?
5. What specific measures are you taking to support pregnant women in different population groups to stop smoking (there are huge inequalities between different groups of pregnant women

and huge opportunities to reduce these inequalities)?

6. What specific measures are you taking to support people with mental health problems to stop smoking?
7. What specific measures are you taking to support prisoners and/or ex-offenders to stop smoking?
8. Is your public health team working with environmental health and trading standards on tobacco control enforcement?

Redcar and Cleveland

Bucking the trend in the North East

The latest smoking prevalence data released in July 2016, show that smoking prevalence in Redcar & Cleveland fell from 21.8 per cent of the adult population in 2013 to 17.3 per cent by 2015. The borough is now well below the North East average and only just above the England average. Forming a key part of local public health work, Tobacco Control has numerous initiatives that contribute to this continuing, downward trajectory in smoking prevalence. The borough is also one of the few areas nationally seeing an increase in referrals to smoking cessation services.

There is a strong partnership approach, both locally and across South Tees, with aligned delivery models achieving maximum value from resources. This is particularly well integrated in relation to smoking in pregnancy, with a successful multi-agency partnership in place. Achievements include significant increases in referrals of pregnant women (up 25 per cent in quarter 1 2016/17 on quarter 1 2015/16) and continued reductions, over four years, in 'Smoking At Time Of Delivery'. This follows work with the CCG and trusts to implement the North East BabyClear programme into midwifery provision. In addition, there is a nicotine replacement therapy (NRT) pilot for pregnant women who are smoking, and midwives use

pregnancy dolls with them to demonstrate the risks smoking poses to their baby.

In addition to work with pregnant women in the hospital setting, significant progress has been made in establishing discharge referral pathways from other wards into community stop smoking services. Close working with the mental health trust, to assist them in going, and remaining, smoke free across all their sites, is addressing significant health inequalities amongst individuals with long term conditions.

In the community, the adoption of a community asset/capacity development approach – across six identified priority place areas – addresses health inequalities in disadvantaged areas. Following community consultations each target ward has developed its own Smokefree Communities action plan.¹⁰⁶

Inequalities in obesity

Obesity is one of the biggest factors contributing to ill health and health inequalities in this country. Poor diet and physical inactivity are causal factors of obesity. Environments in this country tend to encourage over-consumption of food and physical inactivity. Obesity disproportionately affects the most deprived communities:

- in 2015, 58 per cent of women and 68 per cent of men were overweight or obese
- obesity prevalence increased from 15 per cent in 1993 to 27 per cent in 2015¹⁰⁷
- prevalence of obesity in the most deprived 10 per cent of areas in England is double that of the 10 per cent least deprived areas – and the gap is widening
- there is substantial variation in obesity prevalence between ethnic groups – it is higher among children of black and Asian ethnicities, compared to white children.
- the prevalence of obesity is higher in boys than in girls for both reception and Year 6.¹⁰⁸

Obesity can reduce overall quality of life and lead to premature death. Being overweight or obese significantly raises the risk of developing diseases and health problems like diabetes, heart disease and certain cancers. Excess weight can also make it more difficult for people to find and keep work, and it can affect self-esteem and mental health.¹⁰⁹

Given that the causes are deeply entrenched in the social, economic and environmental fabric, ie that we are living in an 'obesogenic environment', it is clear that no single action to tackle the causes of obesity will be effective on its own. Strategies need to be council-wide, place-based and partnership-focused. They need to draw on existing evidence but also use their work to produce further evidence to influence national government policy as well as their own activities. Councils are well placed to understand patterns of obesity in their own areas through their responsibility for the National Child Measurement Programme and other public health intelligence. Major components of strategies to tackle the causes of obesity and the health inequalities they lead to are action to facilitate and encourage physical activity and healthy eating. Each of these needs a multi-stranded approach, as the examples below illustrate. Councils are making use of their procurement, education, leisure, planning, employment and regulatory functions and their relationships with other employers and the voluntary and community sectors to develop wide-ranging healthy weight strategies.

Inequalities in obesity: questions for councillors to consider

1. Do you have statistics on the proportions of both children and adults in your area who are obese and overweight? Are you able to identify inequalities between different population groups and between different age ranges in rates of obesity?
2. Is there a council-wide weight management strategy for reducing obesity and inequalities in obesity, involving a number of departments and the community and voluntary sectors?

3. What is your authority doing to reduce the proportion of children leaving primary school overweight or obese, particularly among children from the most deprived areas and among black and Asian communities?
4. What is your authority doing to reduce the numbers of overweight or obese adults, particularly among those groups where obesity is greatest?
5. What measures are you taking across the council to improve the food environment and access to healthy food in your communities, particularly among groups where obesity is greatest?
6. What measures are you taking across the council to encourage and make it easier to access physical activities particularly among those groups that have the least access and the greatest levels of obesity?
7. Is the council setting a good example in relation to reducing inequalities in obesity as an employer and in settings where services are delivered?
8. How are you monitoring, evaluating and assessing outcomes from your council-wide weight management strategy and its impact on inequalities in obesity?
9. How well are you working with partners to combat obesity?

Blackburn with Darwen Council

Free access to leisure activities

Levels of health in Blackburn with Darwen are much worse than most other areas in the North West and there are wide variations within the borough, particularly linked to deprivation and poverty. Over 60 per cent of local children and young people live in the most deprived 20 per cent of areas nationally.

As part of re:refresh, it's comprehensive wellbeing service, Blackburn with Darwen

Council and the local NHS made all leisure activities free – everything from gyms and squash courts to swimming. Free leisure is not restricted to leisure centres but includes community venues, green spaces and parks. Physical activity rates have risen by more than 50 per cent. Over half of the wellbeing service's clients have come from the top 20 per cent of the most deprived wards.

Blackpool Council

Promoting physical activity through cycling

Blackpool is the twelfth most deprived local authority area in England. It also has comparatively low levels of physical activity and bike ownership. Cycle Blackpool was set up by Blackpool Council to increase the number of people that use and own bikes. This is a way of increasing levels of physical activity and reducing health inequalities. It has started a number of projects that focus specifically on people exposed to health inequalities or already living with chronic conditions. The projects include:

Boathouse cycling project – working with young people who live in the most deprived areas, providing training, cycling trips and bike maintenance courses.

Wheels for all – 12 tricycles and 4-wheeled bikes that are adapted for use by people special needs or disabilities. Take-up has exceeded the expectations of the project team and revealed how many people stop doing exercise once they become inactive through injury or illness.

Low-cost bikes – a cycle hire scheme at low cost. People referred by GPs can choose to have 12 weeks of free membership.

Dr Bike – refurbishing and selling bikes very cheap to residents (£5 to £25 each), with two bicycle mechanics funded by the Future Jobs Fund to train as professional mechanics and run regular Dr Bike sessions repairing bikes for free.

Planning for healthier eating

For some years, a number of local authorities have been using their planning powers, as part of an overall healthy weight strategy, to try to restrict the growth of hot food takeaways near schools and in town centres. There is evidence that there are elevated levels of obesity in communities with high concentrations of fast food outlets and further evidence that such concentrations are highest in areas of greatest deprivation.¹¹⁰

Medway Council has developed guidance which states that it will:

- restrict the hours of operation of hot food takeaways within 400m of schools
- restrict A5 uses to 10 per cent in town centres and 15 per cent in neighbourhood and local centres.¹¹¹

Gateshead Council developed a supplementary planning document that sets out the council's priorities in relation to planning control of hot food takeaways. As a result a number of outlets have been refused planning permission.

The council has been assisted by the Cambridge University Centre for Diet and Activity Research (CEDAR) in research indicating that year 6 students living in areas with the highest density of fast food outlets had a higher BMI than those living in areas with none.

Salford's policy of restricting takeaways close to secondary schools has raised the profile of childhood obesity locally. A number of hot food takeaways have been recognised as part of the Greater Manchester Healthy Catering Award Scheme for their efforts in improving the nutritional content of their meals. The first to be recognised was 'Naji's Kitchen' in Walkden, Salford just six months after the council adopted its Hot Food Takeaways Supplementary Planning Document.

Inequalities in alcohol misuse

There is a significant body of research identifying a key link between alcohol and health inequalities. Most importantly for this publication, lower socioeconomic status is associated with higher mortality for alcohol-attributable causes – despite lower socioeconomic groups often reporting lower average levels of alcohol consumption. Possible explanations for this include differing patterns of consumption, inaccurate consumption reporting and alcohol's interaction with other unhealthy behaviours and/or socio-economic determinants of health.

Alcohol is involved in a wide range of health and social issues, from dangerous driving to crime and domestic abuse, cancer, heart and liver disease, to accidents at work. Given this, and the fact that the most deprived communities are disproportionately affected by these issues, addressing problems associated with alcohol can be seen as central to efforts to reduce health inequalities across society, whilst reducing harm from the 'upstream' social, economic and environmental determinants of health inequalities is likely to support efforts to reduce alcohol-related harm.

The evidence suggests that minimum unit pricing and targeted restrictions on the availability of alcohol are more likely to be effective in reducing health inequalities than education campaigns. These kinds of 'upstream' interventions more effectively target heavy drinkers from low socioeconomic status backgrounds.¹¹²

- in 2015, there were 8,758 alcohol related deaths in the UK.
- alcohol-related death rates have not changed in recent years, but the rate in 2015 is still higher than that observed in 1994.
- the majority of alcohol-related deaths (65 per cent) in the UK in 2015 were among males.

- for both males and females, rates of alcohol-related death were highest in those aged 55 to 64 years in 2015.
- there are significant regional differences in alcohol-related mortality rates.
- people with severe and enduring mental illness are three times more likely to be alcohol dependent than the general population.

Inequalities in alcohol misuse: questions for councillors to consider

1. Do you know the patterns of harmful alcohol consumption in your area? Are you able to identify inequalities between different population groups and between different age ranges in rates of alcohol harm?
2. Can you work with your public health team to understand why alcohol-related harm is greater among certain groups and therefore how best to approach reducing harm among those groups?
3. Is there a council-wide strategy to reduce harm from alcohol use and to reduce inequalities in alcohol-related harm?
4. Are you working with appropriate partners including the voluntary and community sector, local businesses and the police in developing and implementing alcohol-harm reduction measures?
5. Does your alcohol harm reduction strategy include specific measures to reduce harm among people with mental illness?

Local authorities with the highest and lowest alcohol-related mortality rates 2012

Males		Females	
Highest		Highest	
Manchester	108	Corby	47
Blackpool	108	Liverpool	44
Liverpool	99	Burnley	44
Preston	95	Wyre Forest	42
Weymouth and Portland	95	Newcastle-under-lyme	42
Lowest		Lowest	
Babergh	34	Rutland	13
St Edmundsbury	35	Purbeck	14
Suffolk Coastal	38	Mid Suffolk	16
South Cambridgeshire	38	Chiltern	17
Ryedale	40	Craven	18

Rate per 100,000 population

Source: Institute of Alcohol Studies

Brighton & Hove City Council

A multi-faceted approach to alcohol misuse

Over a number of years, over-consumption of alcohol has been an increasing problem in Brighton and Hove. Brighton & Hove City Council leads a local partnership and programme board which brings together health, police, licensing, elected members, local universities, the voluntary sector and a leading supermarket and local public and bars. Its jointly agreed work tackles four areas: the drinking culture, the night-time economy, alcohol availability and early identification, treatment and aftercare of alcohol disorders.

The costs to Brighton and Hove of alcohol misuse were estimated at £107 million per year: £10.7 million due to the health impact, £24.5 million as a result of crime. The partnership recognised the paradox that households in more deprived areas are less likely to drink at increasing risk levels, but more likely to experience alcohol-related mortality. Alcohol-related attendances at A&E are 50 per cent higher in city residents from the most deprived fifth compared with those in the most affluent fifth of the population. LGBT people living in the St James Street and Kemp Town areas of the city are more likely to drink alcohol than those in other areas. Alcohol also plays a part in tenancy breakdown and evictions within hostel accommodation, leading to a cohort of revolving door clients with complex needs. Given these findings and the fact that people with mental illness are much more likely to be alcohol dependent, investing in a multi-faceted approach to tackling alcohol misuse is a direct way of reducing health inequalities.

Within the council, there are a number of inter-departmental initiatives that cut across the traditional local government 'silos', including the following:

- The 'Equinox' service which works with street drinkers is jointly commissioned by public health and the housing department and some public health staff are co-located with housing staff.
- In a pioneering approach to the council's licensing function, public health analysis mapped the presence, use and impact of alcohol around the city in a public health licensing framework which is used by the director of public health together with environmental health, where licensing is managed, to assess risk as a contribution to licensing decisions. The council has launched a campaign, 'Sensible on Strength' to reduce the number of off-sales outlets selling and super strength alcohol.
- The public health team commissions six health trainers who are managed by Environmental Health, including a 'recovering health' trainer to support people coming out of drug and alcohol treatment.
- The community safety team is now located within the public health directorate.
- The public health team has commissioned a full-time service-user representative who is based at MIND.
- The public health team with the support of local authority schools piloted a parental alcohol contract based on the Swedish 'Effekt' model, under which parents promise not to give alcohol to children under 18.

Alcohol-related hospital admissions fell steadily in Brighton & Hove over a number of years, then remained stable for several years. Although they remain higher in Brighton & Hove than in England, there has been a convergence in the figures.

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