The Health Foundation

NPC
New Philanthropy Capital

INSTITUTE *of*
HEALTH EQUITY

1

EXECUTIVE SUMMARY AND INTRODUCTION

VOLUNTARY SECTOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

CONTENTS

NAVIGATING THIS DOCUMENT

Throughout this document boxes are used to highlight specific information.

Key messages:

In the Executive Summary and at the beginning of each section on the social determinants of health these boxes are used to highlight key points from the research.

Strength of evidence:

At the beginning of Sections 2–9 these boxes are used to highlight the most recent research that examines the strength of evidence relating to links between the specific social determinants and health outcomes.

Example interventions:

A variety of case studies demonstrating action on the social determinants of health are presented in these boxes at the end of each section.

Key terms are identified and explained in these boxes throughout the document

Each section is followed by a number of evaluations and evidence reviews of interventions that address specific determinants of health.

EXECUTIVE SUMMARY

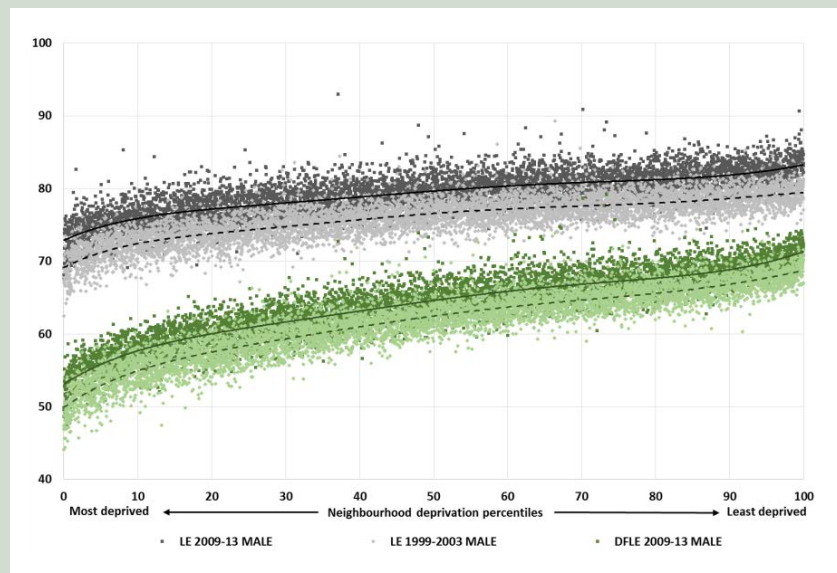## 1.1 The role of social determinants in the nation's health

Good health and wellbeing is an asset. It is one of the main factors that shapes our quality of life and can promote the health and wellbeing of the wider community.

However there are clear and persistent health inequalities across England. People who have lower socioeconomic status have worse health and live shorter lives in comparison with those who have higher socioeconomic status. This social gradient in health (shown in Figure S1 and Figure S2 on the right) affects everyone; inequalities in life expectancy and healthy life expectancy impact on everyone below the very highest socioeconomic status, not just the most deprived.

Health inequalities are a result of the social, economic, political, cultural and environmental conditions in which people are born, grow, live, work and age. This means that the majority of health inequalities are avoidable and that the social gradient in health is unfair and unjust. People are living shorter lives with longer periods of ill health unnecessarily, as a result of socioeconomic factors.

Action taken to address the social determinants of health is possible and effective and results in people living longer, healthier, lives.

Figure S1. Life expectancy and disability-free life expectancy (DFLE) at birth, males by neighborhood deprivation, England, 1999–2003 and 2009-2013

Figure S2. Life expectancy and disability-free life expectancy (DFLE) at birth, females by neighborhood deprivation, England, 1999–2003 and 2009-2013
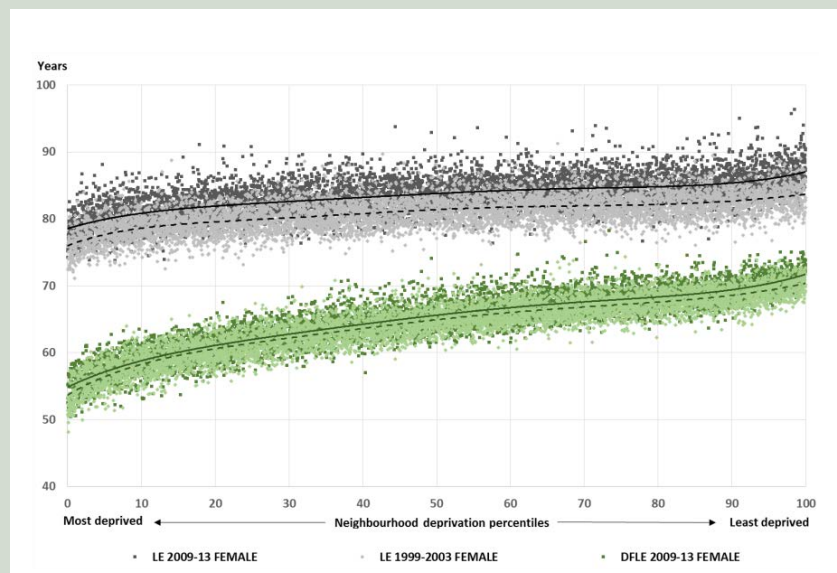
1.2 The role of charities in taking action on social determinants of health

Many charities take action on the social determinants of health which directly and indirectly impact on health outcomes, but relatively few articulate their work in terms of its relevance to health and health inequalities. This includes charities that already work in areas that directly influence health, but do not recognise their work as relevant to health. Meanwhile, charities that address specific health conditions and needs do not work to address the social determinants of those conditions. Their work could become more effective by influencing social determinants, fostering prevention of ill health and disease, as well as influencing and offering treatment and care. These charities may want to consider what role they could have in highlighting the impact of social determinants on their specific health condition.

Charities are often well situated to influence social determinants because of the kind of services they deliver and the proximity to the communities they engage with. Excluded communities that have a history of non-engagement with statutory or mainstream services and that often have poor health outcomes may choose to engage with charities. National policies will have only limited effectiveness in health improvement without local delivery systems that are focused on health equity and that can work effectively within communities. Charities are well placed to support this work.

Of course, charities are not homogenous – their activities span a range of actions, including:

- **Service delivery:** Charities deliver direct services to communities, including information, advice, emotional/psychological support, including social or clinical services such as nursing, social care, and specialist health workers.

- **Influencing policy, and lobbying:** Charities' policy and campaigning teams may aim to improve services to the people they serve, or to improve policies affecting people. The services/policies charities want to improve are often provided by government, although increasingly the commercial sector is an object of influence. For instance, charities have successfully campaigned for increases to basic wages through the Living Wage campaign, which was directed at both government and employers. Many charities work closely with government at all levels to improve health and social services.

- **Public awareness and campaigns:** Charities regularly raise public awareness of issues; for example, the recent high-profile Heads Together campaign about mental health stigma, spearheaded by the young Royals, was conceived and implemented by a group of charities.

- **Research:** The medical research area of the voluntary sector commands a high proportion of voluntary donations. Non-medical research by charities is also valued.

Any of these activities could be relevant to addressing social determinants of health. A housing charity may well provide people with temporary accommodation, or direct and support them into permanent accommodation, while campaigning for improvements in housing policy. They may also be active in raising public awareness of housing issues through media campaigns.

1.3 Why this report?

Many actors – funders, charities, academics, health professionals, government – are concerned with the UK's health and especially the relatively poor health of the most disadvantaged. The amount of expert and local authority attention given to the role of social determinants and inequality in causing poor health is also increasing. Groups of concerned organisations and individuals are keen to develop a social movement to address the problem and to engage further with a wider group of stakeholders and the public. There are many national and local actions, from a range of stakeholders, which can reduce inequalities. The important next step is ensuring that the most appropriate actors prioritise the issue and take effective action.

Three organisations – Health Foundation, NPC, and Institute of Health Equity – have formed a partnership to address part of the jigsaw: evidence.

This report is an initial step in supporting greater work and emphasis on social determinants of health by identifying the evidence of links between inequalities in health and social determinants of health and exploring relevance for the charity sector. This will help to make the case for the movement, and we hope will be a resource to draw upon. The report has

been developed with small- to medium-sized charities in mind, who may only just be starting to engage with the issue. A range of such organisations input into the report, and we also sought the views of some larger organisations.

The report will:

- Raise awareness among non-health charities that their work on the determinants of health influences health outcomes.

- Provide easily accessible evidence that demonstrates the likely health outcomes achieved by charities taking action on the social determinants of health.

- Provide evidence to shape strategy and service design in order to promote improved health.

- Enable charities to engage with policy-makers and the public about the impact of the social determinants of health in order to further build the movement around the social determinants agenda.

- Demonstrate charities' wider impact to their funders and supporters and potentially leverage a more diverse range of funding for their activities.

- Enable charities to communicate the health benefits of their work to beneficiaries.

- Enable charities to contribute to the body of evidence by identifying and measuring their own impact on health, if appropriate.

1.4 Explaining the issue of health inequity

Current healthcare systems focus almost exclusively on healthcare and treatment and most preventive action is focused on screening, immunisations and changing the behaviours of individuals and communities. Access to healthcare, although important, has a limited influence on health outcomes in England, and in particular a limited impact on the drivers of ill health across the social gradient. Social, political, environmental, cultural and economic determinants, however, are significant influencing factors on the patterns and prevalence of ill health in populations. People's health is worse as a result of disadvantage not only in absolute terms, but it also seems that poor health is exacerbated by being towards the bottom of the social scale.

Social determinants can have both direct and indirect impacts on health through three main pathways:

1. Material deprivation, linked to poor living standards has a direct effect on physical health: cold, damp housing, or poor nutrition as a result of poverty, for instance.

2. Material factors also act through the mind (the psychosocial pathway): poor living conditions can be associated with feelings such as stress, lack of control, misery, despair and hopelessness that inhibit self-efficacy and reduce wellbeing and directly impact physical and mental health.

3. Health behaviours (behaviour that has an impact on physical or mental health) are significantly influenced by social determinants: levels of physical exercise are influenced by the quality of the local environment, such as levels of crime, crossings of busy roads, and available green space. Quitting smoking is more difficult in adverse financial circumstances, stressful situations, poor-quality housing and unemployment.

1.5 The response

To address inequalities in health a greater focus is needed on social, political, cultural, economic and environmental circumstances, as these are the 'causes of the causes' that drive ill health. For example, although it is well known that a lack of physical exercise can cause obesity and related health conditions, there are multiple reasons why people are physically inactive. Local levels of crime and fear of crime, poorly maintained and busy roads and walkways, a lack of access to good quality green space – factors common to deprived areas – can significantly inhibit physical activity.

People who are lower down the socioeconomic scale live shorter lives and spend more time in poor health than those who are higher up the socioeconomic scale. To address the social class gradient in health, universal action across the whole social gradient is needed, but with a scale and intensity proportionate to need, so that those in greater need with higher risk of ill health and premature mortality receive proportionately greater intensity of action and support. This approach is called 'proportionate universalism'.

1.6 The evidence

The evidence relating to the impact of social determinants on health across the life course is strong, meaning that there is a wide range of evidence demonstrating either robust associations, correlations, causal links, or significant relationships between social determinants and health outcomes. Most of the evidence is centred on negative links – for instance poor housing is clearly linked to poor health.

Evidence relating to the efficacy of interventions that address the social determinants of health and the social gradient in health is less prevalent, and often considered less strong. This is partly because public health evaluations of interventions are based on a medical model of research. This medical model assumes, or hypothesises and assesses, that the relationship between an intervention and health outcome is linear. In other words, public health evaluations try to assess whether an intervention has worked, or not, related to whether it has caused a specific outcome. However, this approach is problematic. Social inequalities in health are shaped by multiple factors within complex systems and any evaluation that seeks to identify a causal relationship between a specific, isolated intervention and a specific health outcome will not take account of the dynamic, inter-related contexts of the drivers of poor health. There is now a growing acknowledgement of the need for a new approach to assessing interventions on the social determinants of health and building a stronger evidence base in this area.

1.7 Key messages

Inequalities in the social, political, environmental, cultural and economic conditions in which people are born, grow, live, work and age impact on health across the life course and result in differences in health status between different groups. These social determinants of health operate through the following pathways:

Material pathways link social conditions to health outcomes: for example, cold housing has a direct effect on physical health.

Psychosocial pathways connect the social and physical environment to psychological states, including feelings of stress, lack of control and anxiety and depression that can inhibit self-efficacy and reduce wellbeing.

Health behaviours – any behaviour that has an impact on physical or mental health – are significantly influenced by social determinants and improving local environments and reducing day-to-day stress can increase the likelihood of improved health behaviours.

This report examines a number of areas that can impact on health across the life course and that influence the social gradient in health. These include:

- Family
- Friends and communities
- Education and skills
- Good work
- Money and resources
- Housing
- Our surroundings

Family – key messages:

Family life is important for health. The wellbeing of mothers can positively impact on the health of foetuses and infants, on children's physical and mental health, and a range of other outcomes, such as education. Families can provide support throughout life, particularly during adverse experiences.

Social and economic inequalities impact on the level of resources available to support family life and increase the risk of poor health and developmental outcomes for children, and educational and employment outcomes.

For example, higher infant mortality rates are associated with lower socioeconomic status and there is also an increased risk of adverse childhood experiences (ACEs) for children who experience disadvantage and deprivation. Experience of ACEs can have long-term negative impacts on health and a range of other desirable outcomes: ACEs are associated with ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease, stroke, cancer, hypertension, diabetes, asthma, arthritis, angina pectoris and osteoporosis.

Adult family life can also be a determinant of health and factors such as caring responsibilities, family debt and marital conflict can have a detrimental effect on health, often mediated through poorer health behaviours and poor mental health.

Marital strain can cause chronic social stress with negative long-term consequences for health. Conversely, good quality relationships have been shown to lower levels of depression, stress and blood pressure.

Friends and communities – key messages:

Strong friendship networks and participation in community, political, religious and social groups have a positive impact on physical and mental health.

A lack of good quality social relationships and resulting social isolation affect physiological and psychological functioning, health behaviours, and the risk of ill health and mortality.[2]

Stress is the main mechanism through which social isolation impacts on health. Prolonged exposure to stress damages the biological systems of the body and has a clear impact on life expectancy and physical and mental health.

Social isolation and loneliness also increase the risk of poor health outcomes, mediated through poorer health behaviours.

A range of factors increase the risk of social isolation and loneliness including low income, poor-quality built and natural environments, cold housing and inadequate transport links, which can prevent people from developing and maintaining social ties.

Older people, people with disabilities, parents with young children and carers are more likely to encounter barriers to developing and maintaining social networks and relationships and as such have a higher risk than others of associated health outcomes.

Research has found that a sense of community can boost immune systems, lower blood pressure and guard against cognitive decline, while joining a community group can reduce the risk of dying.

Conversely, links have been found between civic distrust and poor social support and coronary heart disease and mortality.

Education and skills – key messages:

Education and skills are important for health. Participation in higher levels of education and higher education attainment are associated with healthier lifestyles, better mental health, greater levels of health literacy, and a reduced risk of a range of conditions, including cognitive decline and dementia.

Children from disadvantaged backgrounds are more likely to start school with lower levels of social, emotional, language and literacy development than their better-off peers.

Poor housing, adverse childhood experiences, poor living standards and nutrition, inadequate parental support, family conflict and poor interactions with children can negatively influence childhood educational outcomes.

These issues can impact on future life chances, including increasing the risk of a young person becoming NEET (not in education, employment or training), affecting future employment opportunities and future income.

Poorer educational attainment is linked to multiple adverse health outcomes, including an increased risk of obesity and dementia, decreased levels of health literacy, poor mental health, and poorer health behaviours.

Good work – key messages:

There are strong relationships between good quality employment and health. Good work enables enough economic resources for material wellbeing and participating in community life and contributes to psychosocial needs, including individual identity, social role and status.

Unemployment and poor-quality employment are strongly linked to poor physical and mental health outcomes.

Poor-quality work can lead to ill health including poor mental health and musculoskeletal problems and can increase the risk of prolonged absenteeism and future unemployment.

Unemployment increases the risk of limiting long-term illness, poor mental health and cardiovascular disease and is associated with an increased risk of mortality and suicide.

Unemployment also lowers living standards, increases psychosocial stressors and increases the likelihood of poorer heath behaviours including excessive alcohol consumption, smoking and decreased physical exercise.

Money and resources – key messages:

People on higher incomes live longer, healthier lives than those on lower incomes.

Low income and deprivation impact on health across the life course through various mechanisms, including material deprivation, psychosocial pathways, and health behaviours.

Research has demonstrated an increased likelihood of smoking during pregnancy, poorer foetal development, low birthweight, feelings of stress and lack of control, and an increased risk of cardiovascular disease and all-cause mortality, all linked to low income.

Particular groups are more at risk of low income and these include people with mental health illness, people with disabilities, young people, carers and lone parents and some ethnic minorities.

The relationship between low income and poor health is cyclical: low income causes poor physical and mental health outcomes, and poor health increases the likelihood of low income.

There are multiple social determinants that influence the amount and adequacy of people's money and resources. These include inadequate levels of benefits to meet the minimum income for healthy living (MIHL), in-work poverty due to high costs of living and low wages, and high levels of debt. These issues are influenced by the unequal distribution of taxes, and the clustering of payday loan and gambling outlets in areas of deprivation.

Payday lenders and betting shops, which can cluster in areas of deprivation, increase the risks of financial difficulties and debt and associated poor health outcomes, including intimate partner violence, emotional and psychological distress, and feelings of lack of control, insecurity, lack of safety, shame and stigma.

Income deprivation increases the risk of debt with at least a quarter of UK households experiencing income deprivation unable to pay specific bills, including mortgage and rent bills.

Strong relationships have been found between debt and: depression and anxiety; poor self-rated physical health, including obesity; suicide; and drug and alcohol abuse.

Housing – key messages:

Good quality, secure homes are beneficial to their occupiers, the wider community and to society. They can reduce the risk of poor physical and mental health and mortality, reduce the number of trips and falls, reduce lost school days and improve educational attainment, and reduce visits to the GP and other health and social care services.

There are clear inequalities in exposure to poor housing. Approximately three in 10 people in England live in poor-quality housing. This includes 3.6 million children, 9.2 million working-age adults and 2 million pensioners.

Poor housing and homelessness pose significant risks to health, including poor mental health, respiratory disease, long-term health and disability and the delayed physical and cognitive development of children.

Cold housing is particularly damaging for health and caused an estimated 20 per cent of the 24,300 extra winter deaths that happen during the cold winter months in 2015/16.

Poor-quality housing such as damp, cold, overcrowded, insecure and short-term tenure housing, is damaging for physical and mental health. Most of the poor-quality housing in England is in the private rental sector.

Emerging evidence shows that exposure to multiple poor housing conditions is particularly damaging, comparable to the health risks posed by smoking, and greater than the health risk posed by excessive alcohol consumption.

Our surroundings – key messages:

Our surroundings operate through a number of pathways and impact on health. Economic, geographical and social factors influence these pathways and the health outcomes of local populations.

Health-promoting surroundings are important for retaining people, place attachment, encouraging community engagement, and for thriving communities with improved health outcomes.

People who have inadequate economic resources are more likely to live in areas that have health-damaging characteristics. This can include poor-quality housing, obesogenic environments (encouraging people to eat unhealthily and do insufficient exercise), lack of good quality green and natural spaces, poor air quality and affordable transport availability, high levels of crime, or fear of crime and a lack of recreational and community facilities and opportunities for community participation. However, multiple interventions can be used to encourage good place-making and place attachment that promotes improved health outcomes, including:

Green infrastructure: Good quality green infrastructure (including parks, gardens and street planting) increases the likelihood of physical exercise, lowers the risk of obesity, and offers a restorative environment for mental fatigue. It can also create a sense of place and civic pride, and be used for social activities that promote social cohesion. It also combats climate change, which has associated health impacts.

Walkability and cycle-ability: Streets that are safe and easy to navigate increase the likelihood of using environmentally sustainable modes of transport, such as walking and cycling. This can also promote the spontaneous social interaction needed for social cohesion and improved mental health.

Community safety: Crime and fear of crime have direct and indirect impacts on health and can limit social behaviour and physical activity.

Feelings of safety are critical for community wellbeing and economic vibrancy. 'Crime prevention through environmental design' is an intervention that uses a number of approaches to reduce crime and fear of crime and focuses on territoriality, encouraging ownership and community cohesion and improving the physical fabric of communities, encouraging natural surveillance.

There is consistent and strong evidence demonstrating that the maintenance and upkeep of local areas decreases crime and the fear of crime (the broken window theory). Neglected spaces that have been repurposed have been shown to improve perceptions of safety and create economic and job opportunities.

Food outlets: Areas of high deprivation can experience a proliferation of fast food outlets, and this can have direct and indirect impacts on health.

'Food deserts' areas that have little access to healthy food, increase the risk of food poverty, obesity and malnutrition, in turn increasing the risk of cancer, diabetes and coronary heart disease.

Initiatives that promote independent food and other retail outlets, featuring locally-sourced food for example, and that limit the number of fast food, payday lender and gambling outlets, will support the local economy and promote improved health outcomes.

Accessible, affordable and sustainable public transport: This type of transport can provide access to education, employment and essential goods and services, including health and social care. Transport systems, including well maintained roads and pavements, encourage active travel and help reduce pollution and climate change.

INTRODUCTION

The social determinants of health – key messages:

Inequalities in the social, political, environmental, cultural and economic conditions in which people are born, grow, live, work and age impact on health across the life course and result in differences in health status between different groups.

Material pathways link social conditions to health outcomes: for example, cold housing has a direct effect on physical health.

Psychosocial pathways connect the social and physical environment to psychological states, including feelings of stress, lack of control, and anxiety and depression that can inhibit self-efficacy and reduce wellbeing. Chronic low-level stress impacts on physical health, including higher cholesterol levels, blood pressure and heart disease.

Health behaviours are significantly influenced by social determinants and poor or negative health behaviours cluster further down the social gradient. This clustering is increasing and means that health inequalities experienced between those at the bottom and the top of the social gradient will grow.

Improving local environments and reducing day-to-day stress can increase the likelihood of improved health behaviours, including increased physical activity, improved diet, and increased success with smoking cessation attempts.

1.8 Health inequalities in England

There are clear and persistent health inequalities across England, meaning that there are 'differences in health status or in the distribution of health determinants between different populations groups.'[2] Some health inequalities are caused by biological variations or lifestyle choices. However, there is now much wider recognition that the majority of health inequalities are caused by inequalities in the external environment and conditions in which people are born, grow, live, work and age. As such, health inequalities are unjust and unfair, and lead to inequity in health outcomes across populations.[2]

The Marmot Review, *Fair Society, Healthy Lives*, published in 2010, provided a review of health inequalities in England and made proposals and recommendations for action from government and other organisations. It clearly demonstrated that people in England who have lower socioeconomic status have worse health and shorter lives in comparison with those who are better off and have a higher socioeconomic status. The social gradient in health affects us all. Inequalities in life expectancy and healthy life expectancy impact on everyone below the very highest socioeconomic status, not just the most deprived. The social gradient in health is described in Figure 1 and Figure 2 on page 15.

Inequalities in health arise because of inequalities in the social, political, cultural, environmental and economic conditions in which people live. These social determinants, the conditions in which people are born, grow, work and age, affect life expectancy, and profoundly influence how long people live in good health (healthy life expectancy). The latest Marmot Indicators[A] (2015) demonstrate that there is a clear difference in both total life expectancy and also healthy life expectancy between men and women from the poorest and most well off areas.

[A]The Marmot Indicators provide information to local authorities annually about health inequalities and social determinants of health. There are a range of indicators at local authority level and at smaller area level within local authorities. The data is related to socioeconomic status and other social and economic domains to describe how health relates to area deprivation and social status.

Figure 1. Life expectancy and disability-free life expectancy (DFLE) at birth, males by neighborhood deprivation, England, 1999–2003 and 2009-2013
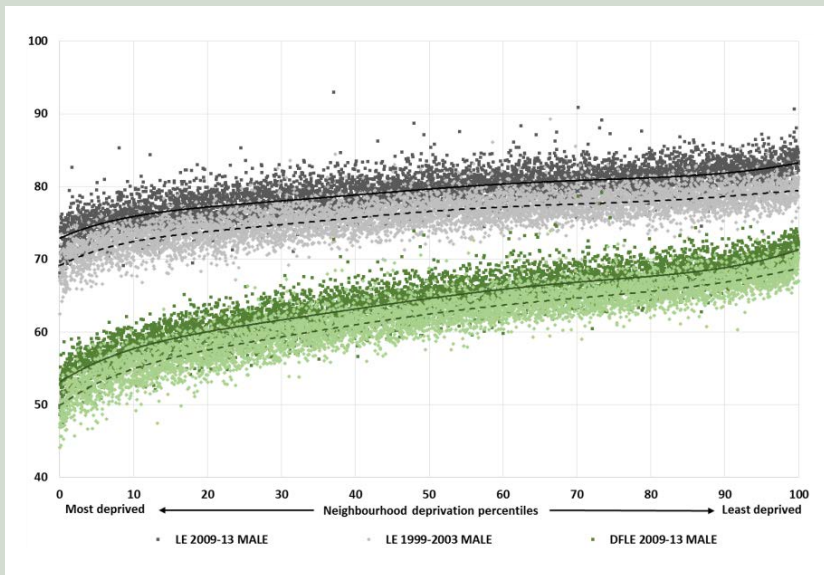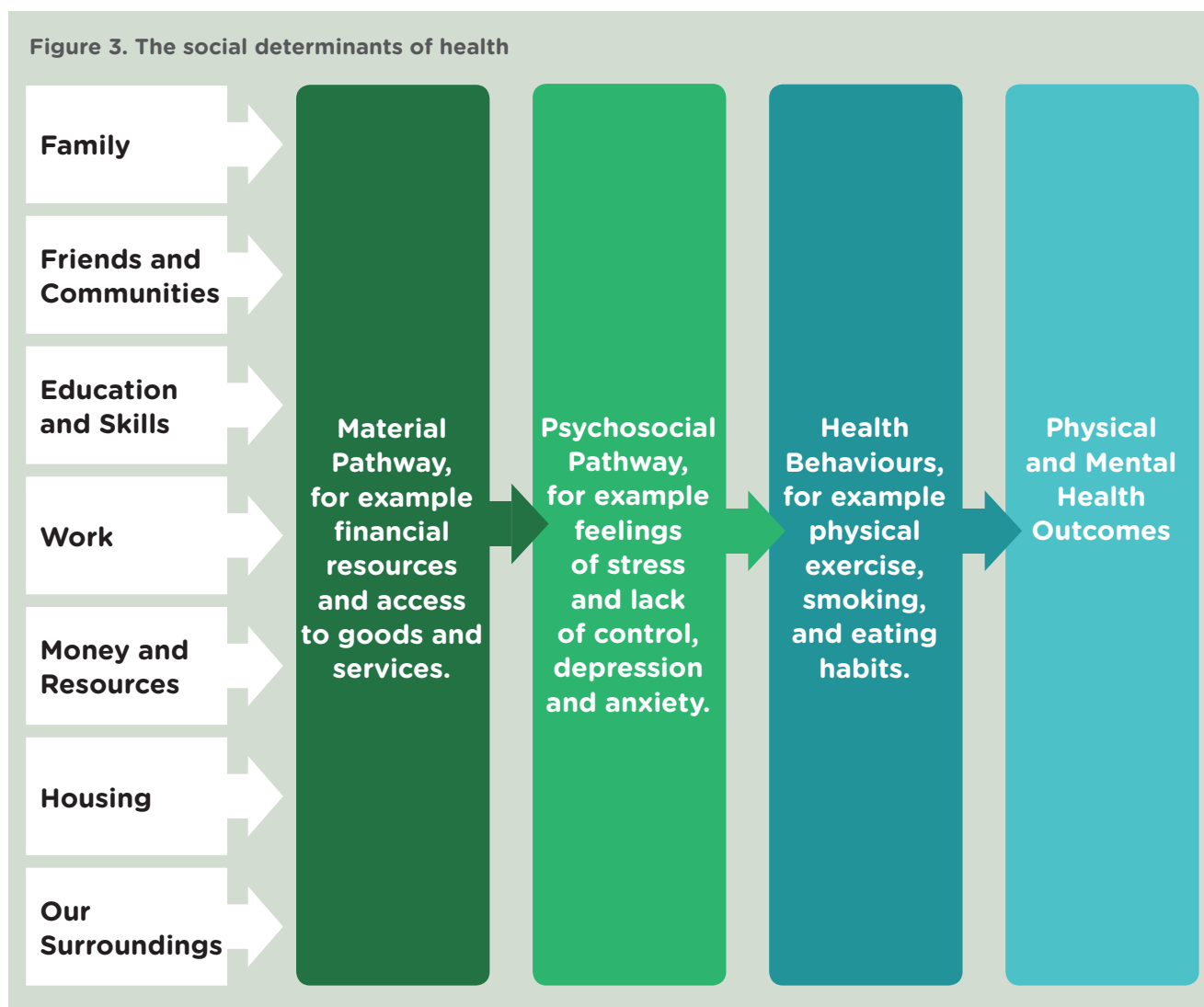

Figure 2. Life expectancy and disability-free life expectancy (DFLE) at birth, females by neighborhood deprivation, England, 1999–2003 and 2009-2013
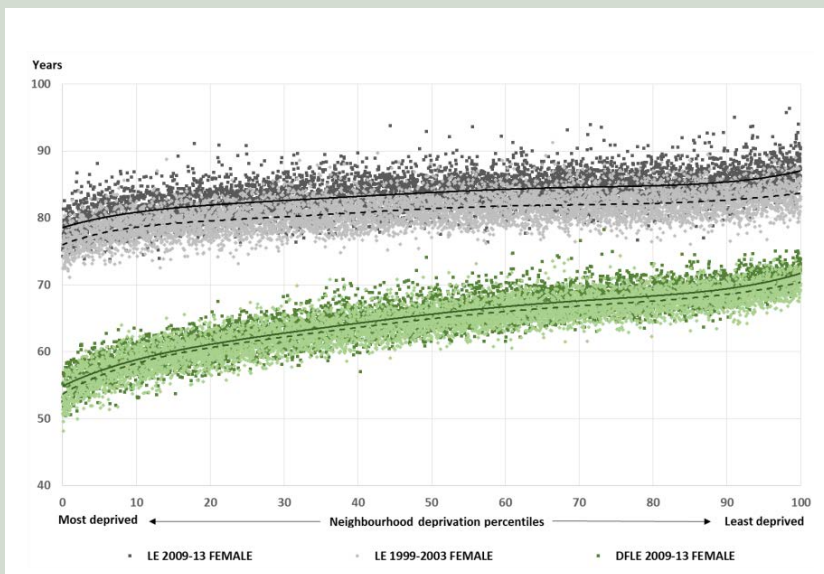
These differences are related to area deprivation. Men in Blackpool (in the Northwest) can expect to live around 74.3 years, while men in Wokingham (in the Southeast) can expect to live 81.7 years – a difference of 7.4 years in life expectancy. For women, the difference in life expectancy between the least and most deprived areas is 4.6 years. There are also clear differences in healthy life expectancy, or expected years lived without disability. In terms of living without a limiting long-term illness, men in Blackpool can expect to live to 54.9 in this condition while men in Wokingham can expect to live to 71.4, a 16.5 year difference. For women, the difference in healthy life expectancy is 11.6 years.

Figure 3 below provides a simplified model of how social determinants can impact on health through psychosocial or material pathways. How social determinants influence pathways to health and health behaviours is explained in more detail below.

Figure 3. The social determinants of health

Family				
Friends and Communities				
Education and Skills	**Material Pathway, for example financial resources and access to goods and services.**	**Psychosocial Pathway, for example feelings of stress and lack of control, depression and anxiety.**	**Health Behaviours, for example physical exercise, smoking, and eating habits.**	**Physical and Mental Health Outcomes**
Work				
Money and Resources				
Housing				
Our Surroundings				

The material pathway

Material pathways directly link social conditions to health outcomes. Material deprivation, linked to poor living standards (for example, cold housing) has a direct effect on physical health. Material factors also act through the mind (the psychosocial pathway): poor living conditions can be associated with feelings such as misery, despair and hopelessness, which inhibit self-efficacy and reduce wellbeing.

The psychosocial pathway

Social determinants can have both direct and indirect impacts on health. One way in which social determinants have an indirect impact is through psychosocial pathways.

Stress

Psychosocial pathways connect the social environment to psychological states, often inducing a state of stress, which can lead to anxiety or depression. The use of the term 'stress' incorporates both the feelings generated by stressors such as poor housing, poverty or discrimination, and the ability of a person to cope with both the stressors and the feelings generated. Lazarus emphasises when stress can arise when:

'a person appraises a situation as threatening or otherwise demanding, perceives that it is important to respond, and does not have an appropriate coping response immediately available.'[3] People under stress typically

experience 'negative emotions (e.g. anxiety, depression), changes in physiology, and changes in behaviour patterns that increase risk for disease and mortality.'[4]

Ongoing challenges experienced through living with deprivation can cause chronic low-level stress, which can also impact on physical health, including higher cholesterol levels, blood pressure and heart disease.[5]

Control

Feelings of control, or lack of control, are further important psychosocial factors that influence mental and physical health and are determined by both macro- and micro-level conditions. For example, the nature and extent of social stratification in a society, and a person's position within that stratification, has psychological effects. Hierarchical societies attribute status according to, among other things, gender, sexuality, ethnicity, education, employment and income. Occupying what is considered to be a low status position is associated with experience of subordination that causes a sense of lack of control and low authority in decision-making.[6,8] This can be played out in multiple micro arenas. For example, adverse psychosocial working conditions that are characterised by high demand and low control[7] can cause job strain, associated with increased risk of coronary heart disease, poor health behaviours and common mental health disorders.[8,9]

Health behaviours

Any individual or group behaviour that has an impact on physical or mental health is known as a health behaviour. Health behaviours can be categorised as positive, for example taking regular exercise, or as negative, poor, or risky, the latter including smoking, drinking excessively, and not taking regular exercise.[10]

Health behaviours are significantly influenced by social determinants. For example, levels of physical exercise are influenced by the quality of the local environment, including levels of crime and perceived safety, pavements, crossings and available green space. A healthy diet is influenced by the availability and affordability of healthy produce, knowledge of nutrition and healthy food preparation. Smoking, or the inability to stop smoking, is associated with seeking relief from stress,[11] often caused by the day-to-day difficulties faced when living with deprivation.[5]

Poor or negative health behaviours cluster further down the social gradient. The latest evidence demonstrates that the strongest predictor for engaging in multiple risky behaviours is socioeconomic status.[12] People with no educational or training qualifications are more than five times more likely to smoke, drink and have a poor diet as those with qualifications.[13]

This concentration of unhealthy or poor health behaviours further down the social gradient is deepening.[13] Although the overall proportion of people in England engaging in three or more unhealthy behaviours reduced by 8 per cent between 2003 and 2008, most of these reductions were experienced by higher socioeconomic and educational groups.[14]

This means that although the health of the population may improve overall due to a reduction in poor health behaviours, the health inequalities experienced between those at the bottom and top of the social gradient will increase. [14]

Figure 4. Clusters of lifestyles matter for health
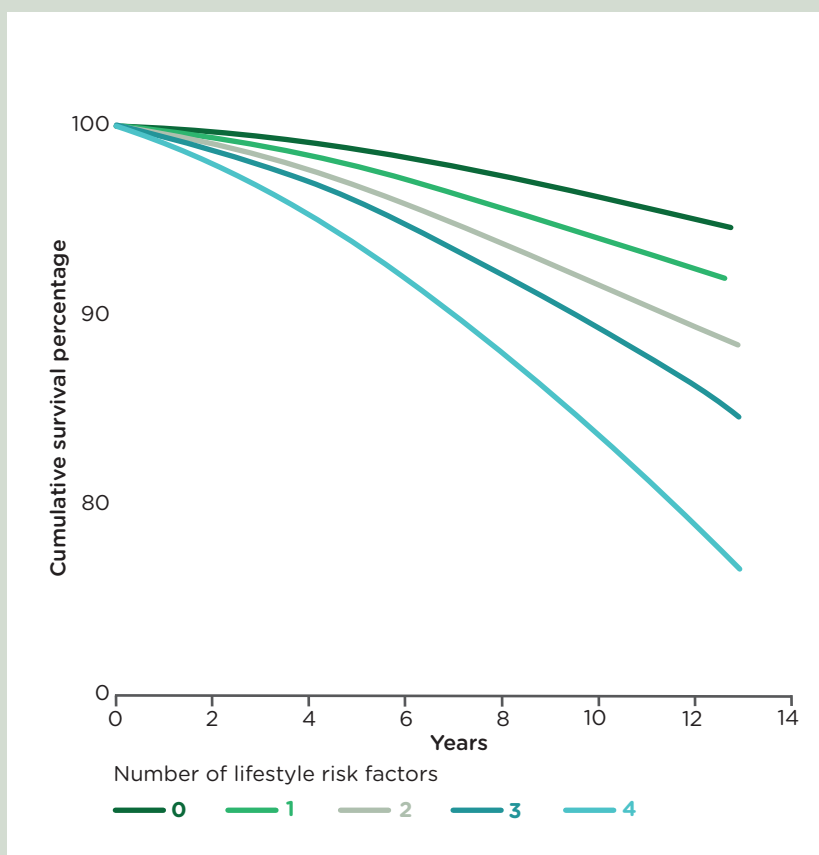
Reproduced from the Kings Fund: Clustering of unhealthy behaviours over time. Implications for policy and practice. 2012. Adapted from source: Khaw et al 2008.

Health as an asset

Approaches to health often focus on identifying problems and needs within populations and then targeting healthcare resources to address specific issues. These 'deficit models' are important for calculating level of need, and for prioritising services and care, but can result in high levels of dependence on hospital and welfare services.[15]

However, an asset-based approach to health focuses on positively activating assets and resources to promote health. This can be done at three levels:

- Macro, for example environments, institutions, organisations
- Meso, for example communities and neighbourhoods
- Micro, for example individual resilience, self esteem

An asset-based approach to health is helpful as it enables a focus on factors that promote health and enable communities and individuals to gain more control over their lives and circumstances.[16,17] It also enables a focus on health as an asset in itself, one that feeds back into the health and wellbeing of wider communities and reduces dependence on hospital and welfare services. Figure 5 below shows how an asset-based approach to health can help identify positive social determinants of health that contribute to ill health prevention, stronger communities and a reduction on reliance on healthcare and welfare services.

**Figure 5. An asset-based approach to health**
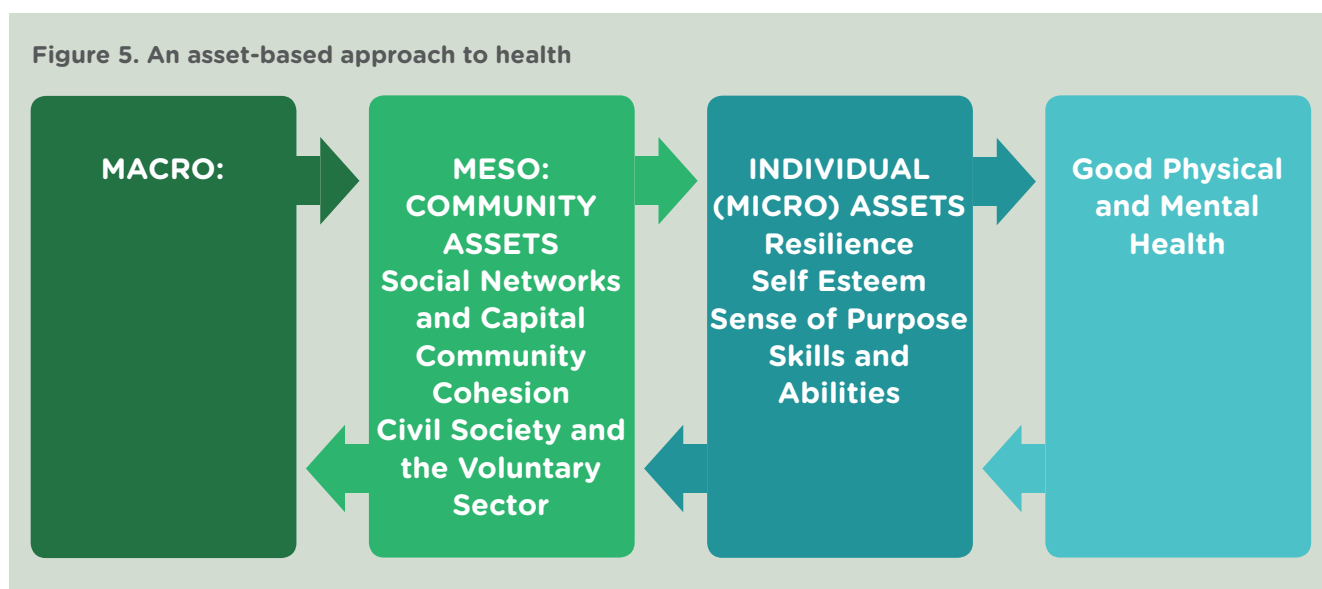
Given the social gradient in England, and the potential for health to enable communities and individuals to gain more control over their lives and circumstances, universal action across the whole social gradient is needed, but with a scale and intensity proportionate to need. The Marmot Review defined this approach as 'proportionate universalism' and, to reduce health inequalities, action was advocated across six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and the impact of ill health prevention

None of the areas prioritised for action on health inequalities related directly to the healthcare service. Indeed, it has been estimated that healthcare is only responsible for between 15 and 43 per cent of health outcomes, as detailed in Figure 6 below. Although there is much debate around the actual percentage, which is impossible to calculate definitively, it is clear that access to healthcare, although important, has a relatively limited influence on health outcomes, and in particular on what drives ill health across the social gradient. Social and economic determinants are the most significant influencing factors on the patterns and prevalence of ill health in populations.

Figure 6. Estimates of the contribution of the main drivers of health status.
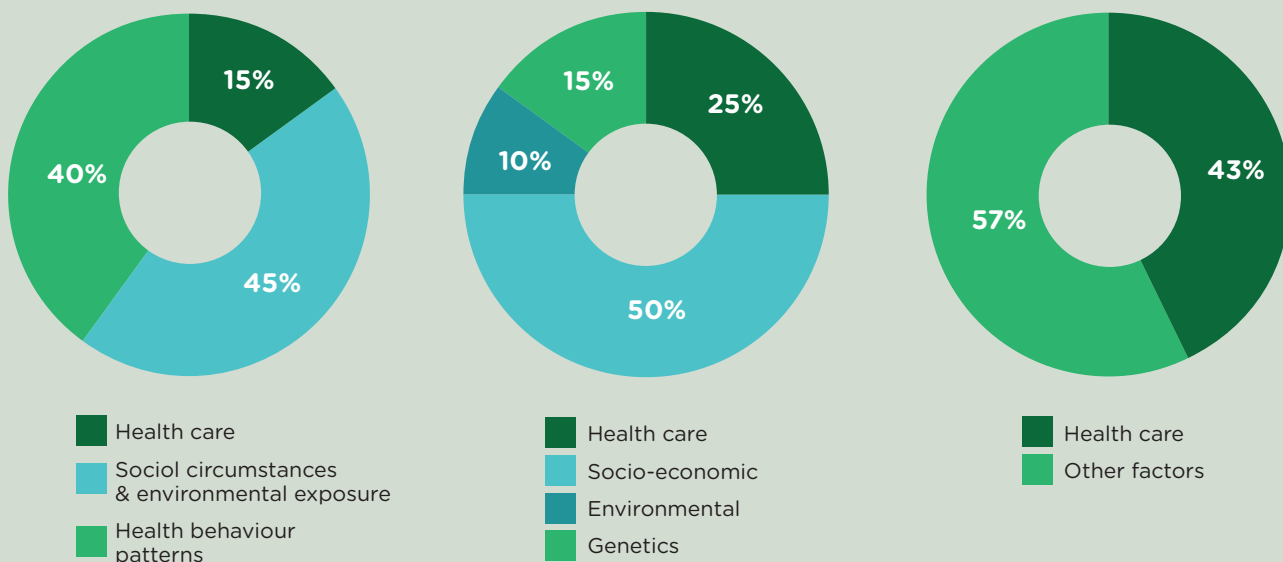
Source: [18]

However, current healthcare systems focus almost exclusively on healthcare and treatment and most preventive action is focused on screening, immunisations and changing the behaviours of individuals and communities. To address the social gradient in health a greater focus is needed on social, economic and environmental circumstances, the 'causes of the causes' that drive ill health. The underlying root causes of poor health, such as poor housing, unemployment and local area deprivation, need to be addressed if the gap between the least and most healthy is to narrow.

Delivering the policy objectives of the Marmot Review requires action across a variety of sectors and different types of organisations. These organisations include a wide range of local and national government departments, the community and voluntary sector, the NHS and other public services, and the private sector.

1.9 The role of charities in addressing the social determinants of health

The voluntary sector makes significant impacts on the social determinants of health, improving health and reducing health inequalities – even those charities whose primary purpose and remit may not be directly health-related.

Many charities pursue social outcomes that directly and indirectly impact on health outcomes but relatively few articulate their work in terms of relevance to health and health inequalities. This includes charities that already work on the social determinants of health, but do not recognise their work as relevant to health, and condition-specific charities that address health needs, but do not work to address the social determinants of those conditions. All the while, charities are often better situated, both in the services they deliver and proximity and engagement with communities, to work closely with communities, particularly those that have a history of non-engagement with statutory or mainstream services.

National policies will have limited effectiveness if local delivery systems that are focused on health equity are lacking. It is clear that charities are organisations that are close to some of the most deprived and excluded communities and play a role in advocating for communities and addressing gaps in statutory service provision; thus they have a significant and hitherto under-recognised role to play in relation to health. Charities frequently address the inequalities that result from the social determinants of health and also often have a direct role in influencing inequalities in the social determinants of health. Charities working in these areas are more likely to have a social rather than a health lens. Those that are focused on inequalities have developed services working with the most disadvantaged to address complex needs. Other charities offer activities that benefit people and society more generally, but may be interested in ensuring activities can be accessed by all, including those from disadvantaged backgrounds. We talk about these charities in more detail later in Table1.

Health charities could join the social determinants of health movement

Many charities also work to achieve better health outcomes for people who have specific health conditions, or are at risk of developing health conditions. These conditions range from mental distress, addiction issues and eating disorders to complex neurological conditions such as motor neurone disease, Parkinson's and multiple sclerosis. Other charities support people with chronic conditions such as asthma, Crohn's disease and arthritis. Some focus on conditions often associated with later life, such as

dementia and osteoporosis. Cancer and cardiovascular conditions, rare conditions and those affecting young children are also priority areas.

The work of health charities is usually focused on the following areas:

* Representing patient voice and advancing patient involvement, as well as involving families and carers

* Direct treatment and support, ranging from nursing to emotional/social support, and helping people with material aspects of their condition, e.g. employment, benefits, assistive technology

* Supported self-management: helping individuals to understand their condition, take control of its management, and navigate the system

* Engaging people in keeping healthy: prevention and early intervention are important here, as well as helping people to stay well once diagnosed

* Integrating and coordinating care

* System redesign: working with public services to improve the system and design of services delivered by others; may include lobbying and policy work

* Support for health and care professionals: specialist training as well as help with service design and implementation

* Raising awareness of conditions, to increase early identification and also improve awareness in others of the effect of conditions

* Medical and social research (adapted from Untapped Potential[19])

Health charities are increasingly connecting individuals' circumstances to recovery of health. For example, many mental health charities focus heavily on employment and its potential mental health benefits; cancer charities similarly support people to maintain or find employment. Many charities' helplines cover not only information about the condition, but also access to benefits, housing and other services. Some charities, especially those working in mental health, see the causes of distress as being rooted in unemployment, poor housing or debt.

Some health charities talk about inequality, and worry if they are or are not reaching the most disadvantaged individuals. Other health charities working in prevention talk about social determinants of health, although prevention strategies are usually based on changing behaviour, e.g. promoting healthy eating and exercise. But these are prone to failure unless underlying social determinants are addressed.

However, health charities have limited resources, many unequal to dealing with social determinants at scale – the problems appear too big to grapple with. Others may conclude that tackling social determinants is not the best use of their limited resources – and that they should be addressed by the state/government policy/organisations with the scale to make a difference.

Yet there is a strong case for health charities to become more involved in the debate, so that the level of impact that social determinants have on health is more widely recognised. In addition, charities are well placed to influence the social determinants for people

and communities they work with. Action at a local community and individual level can address multiple issues, such as debt or poor housing for instance.

1.10 Implications for charities

Recognising and raising awareness around the significant role that non-health charities already play in taking action on the social determinants of health and reducing health inequalities will:

- Raise awareness among non-health charities that their work on the determinants of health influences health outcomes.

- Provide easily accessible evidence that demonstrates the likely health outcomes achieved by charities taking action on the social determinants of health.

- Support non-health charities to use this evidence to engage with the health system, broadening the scope for identifying and securing new funding opportunities.

- Support non health charities to develop and use monitoring systems that capture impacts on health and wider determinants.

- Engage with condition-specific health charities to enable a greater focus on the wider determinants of health, and to develop and embed more preventive work that addresses the social determinants of specific health outcomes.

Therefore, this report aims to provide information to:

- Enable charities to recognise that their work has relevance to the social determinants of health and to health outcomes and to potentially expand their

work to better address the social determinants of health.

- Enable charities to access data that will help them to demonstrate that their work addresses the social determinants of health, or to identify and address the social determinants of their condition focus.

- Enable charities to measure and demonstrate the difference they make in a more systematic and convincing way, and to use this information to potentially expand their role to focus more on health outcomes and assist in advocacy at a local and national policy level.

- Enable charities to contribute to the body of evidence by measuring their own impact on health, if appropriate

Table 1 on page 22 provides an 'at a glance' view of the inequalities in social determinants of health and health outcomes, as evidenced in the Marmot and subsequent reviews. [20-27] Column 2 in table links to sections 2 to 9 of this report, which provide a wide range of evidence demonstrating the impact of social determinants on health and links to the latest evidence on effective interventions, many of which are already implemented by the voluntary sector. Column 3 provides examples of action that the voluntary sector either already does, or could do, to develop and expand its work, and to better identify charities' work as health related.

The following themes are applicable to all areas across the table:

Tailored services to meet the needs of the most vulnerable groups: Charities are generally alert to the needs of excluded people – this is a strength of the sector. The external environment constantly evolves, so charities may need to be vigilant in identifying groups.

Collaboration: We would encourage charities to share lessons, best practice and collaborate wherever they can – especially with organisations providing services to the same people, even if their services are different. It also makes sense to collaborate with similar service providers to avoid duplication and reduce costs. We see many opportunities for cross-referral with statutory services.

Evidence: We would urge charities to monitor, evaluate and assess their outcomes, and where appropriate and reasonable, to monitor any progress in health behaviours, or improvements in short-term health and wellbeing outcomes.

Table 1. Inequalities in social determinants of health and health outcomes, and where charities can respond

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
FAMILY Social, economic, and environmental inequalities impact on family life, including intimate and broader family relationships and the home environment, and these affect child health, life course health and life chances. Family disadvantage in early years leads to disadvantage in multiple domains throughout life and therefore interventions to improve the quality of family life are a priority. Adverse childhood experiences (e.g. bereavement, abuse, trauma) can have an adverse effect on future health.	**Section 2** provides evidence demonstrating the impact of social determinants on family life, and life course health outcomes, in addition to evidence relating to effective interventions and case studies.	Many charities support children and families, from pregnancy and infancy through childhood, adolescence and onto later life. Charities are well placed to: • Reach the most excluded and identify entry points for engagement • Develop trust and work holistically with excluded families • Pilot and share best practice in supporting families, children and young people, nurturing healthy relationships, developing skills, and promoting healthy routines/diets • 'Step in' when there is a crisis • Liaise with multiple agencies and services, ranging from GPs to nurseries and libraries • Support young people in the state care system • Monitor and evaluate the effectiveness of programmes A focus on the early years is especially valuable, although many would argue charities should not ignore the whole course of family life.
FRIENDS AND COMMUNITIES The quality and quantity of social networks affect health behaviours and physical and mental health. The social, economic and environmental determinants of poor-quality social networks and a lack of social connectedness are not distributed evenly and so particular individuals and groups will be disproportionately at risk of social isolation throughout the life course.	**Section 3** provides evidence demonstrating the social determinants of social networks, and the impact of social isolation on health behaviours, physical and mental health, in addition to evidence relating to effective interventions and case studies.	Many charities foster social networks and friendship for a range of disadvantaged and excluded groups, ranging from people with mental health issues to refugees. Activities include: • Community and social groups and activities • [befriending schemes] Social interactions and support • Identifying the most isolated and addressing their needs • Creating neighbourhoods, towns and cities that are 'friendly' towards, autism, dementia, disability and other disadvantage • Campaigns to promote neighbourly action

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
EDUCATION AND SKILLS Multiple determinants, including family and community-based factors and material inequalities, influence the educational outcomes of children, young people and adults. Lower educational achievement increases the risk of a range of poor health outcomes, including a clustering of unhealthy behaviours such as smoking, excessive alcohol consumption or substance misuse, and obesity, cognitive impairment and dementia, diabetes, heart disease, stroke and some cancers. It also increases the risk of poor health literacy. Inequalities in educational outcomes and experiences as a child and young person lead to inequalities in a range of domains throughout life. Addressing inequalities requires action in schools, work and in the community.	**Section 4** provides evidence demonstrating the determinants of poor educational outcomes and impact on health, evidence of effective interventions and case studies.	Many charities work within or outside the education system and can: • Work directly in schools to support staff and students • Work across school/home boundaries to provide support • Provide after-school and extra-curricular activities • Provide alternative learning environments for students with special needs, including social, emotional and behavioural difficulties. These may be provided within the school or outside • Support transition between schools • Support the transition from school into further education, employment and adulthood, e,g. by facilitating work experience • provide lifelong support, training and education to adults to address education/skills gaps • Life and employability skills • Basic educational attainment e.g. literacy and numeracy • Building social networks • Healthy lifestyles, including diet, nutrition, physical activity, mindfulness • Raising aspirations The avenues of work referred to above can address these themes: social and emotional skills, including confidence, resilience and so on. Charities are often able to link with, and gain the trust of, those who are most disadvantaged, and struggle most to engage with formal education. Charities benefit from being outside the formal education system as this enables much greater flexibility in developing and testing imaginative programmes. Charities can also, less directly, raise awareness and take action on the social determinants that impact on educational achievement such as poor housing, family stress, poor-quality housing and fuel poverty, access to green space and adequate green infrastructure.

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
GOOD WORK There is inequality in access to the labour market and good quality employment. Poor-quality work, such as temporary, inflexible, routine work that is badly paid, leads to ill health and psychosocial stress. Unemployment increases the risk of mental ill health, cardiovascular disease and overall mortality through a range of mechanisms including material deprivation and psychosocial stressors. Long periods of unemployment are particularly harmful to health and a range of other factors throughout life.	**Section 5** provides evidence demonstrating the links between unemployment and poor-quality employment and poor health outcomes, in addition to effective interventions and case studies.	Many charities work to improve employment: • Preparing people for work, including lifelong learning • Placing people in work/brokering work placements and supporting vulnerable people in placements • Supporting people to engage with active labour programmes • Working with employers to employ the vulnerable and disadvantaged, e.g. carers, lone parents, people with disabilities or health/mental health problems • Working with employers to support healthy lifestyles, e.g. diet, active travel • Campaigning for better working practices, e.g. living wage, flexible working, job security, inclusive recruitment • Supporting workers to negotiate
MONEY AND RESOURCES Income and debt significantly influence health through direct and indirect pathways. Low levels of income and debt can influence health directly by preventing access to health-promoting goods and services. Low income and debt can also increase the likelihood of social isolation and can impact on mental and physical health and health behaviours through psychosocial pathways, including feelings of stress and lack of control.	**Section 6** provides evidence demonstrating the impact of poverty and low standards of living on health, in addition to evidence relating to interventions and case studies.	There are many charities: • Offering debt advice and referrals to debt management and other support services • Offering information on money issues, such as changes in status resulting in economic hardship, benefits, guidance on pensions • Building the capacity of people to manage their money better and build financial resilience, including schemes promoting savings, insurance • Campaigning on issues that result in people being financially excluded. Charities are often able to reach the most excluded and disadvantaged, for instance mental health charities are very alert to the needs of people in mental distress, and recognise financial difficulties as the cause of distress. Collaborating with statutory services such as health, criminal justice, adult learning and housing services would be valuable in identifying those at risk and would help to serve those people from accessible venues.

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
HOUSING Living in poor-quality and insecure housing has as significant impact on physical and mental health. Poor housing conditions including damp, mould and cold homes, is linked to poor mental health and respiratory illness. Insanitary conditions can lead to the spread of infectious diseases and cold, energy-inefficient housing contributes to excess winter deaths every year. Poor housing also influences levels of social isolation and loneliness.	**Section 7** provides evidence demonstrating health inequalities resulting from poor housing, in addition to evidence relating to effective interventions.	Charities work at several levels on housing: dealing with individuals but also campaigning on issues that affect the housing of vulnerable people. Charities work to: • Provide individual advocacy and advice to people needing housing, enduring poor-quality housing • Provide individual support to those who need help maintaining tenancies or are housed in tailored accommodation • Provide specialist housing • Provide specific programmes addressing issues such as fuel poverty • Campaign on housing issues, such as private rental sector market regulation • Campaign on the severe shortage of affordable housing • Gather information on the housing status of clients and impact on health
OUR SURROUNDINGS The local built and retail environments and green and blue space are significant determinants for physical and mental health, influencing health behaviours including levels of physical exercise, diet and social connectedness. However, good quality local environments are not evenly distributed and contribute to health inequalities across the social gradient. Poor local environments also increasing pollution and energy consumption, contributing to climate change, which also has a detrimental effect on the	**Section 8** provides evidence demonstrating health inequalities resulting from poor-quality local environments and climate change.	There are many charities that: • Support communities to engage with the planning process regarding public space, transport and local neighbourhoods and high streets • Highlight and help to address accessibility for vulnerable groups in local regeneration plans • Provide support to influence local decision-making • Design and deliver interventions that promote, encourage and facilitate active travel and increase levels of walking and cycling, in particular walking groups for older people more vulnerable to busy roads and high levels of traffic • Highlight and support '20 is plenty' campaigns (to limit traffic speed to 20mph) • Improve and maintain local green areas in ways that engage local residents and promote ownership and social cohesion. This can include gardening groups, allotments, city farms, and green space interest groups • Advocate for an improved local food environment and provide interventions that promote cooking skills and healthy eating. • Campaign for improvements to the high street environment including the retail offer, and better, inclusive street design. • Promote and support volunteering and community engagement.

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