

Social Inclusion and Social Mobility: Task Group 9

Summary and Proposals

The full report of the task group can be found at

http://www.ucl.ac.uk/gheg/marmotreview/consultation/Social_inclusion_and_social_mobility_report

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The work of this group focused on the exclusionary processes that present obstacles to social mobility and to the creation of an inclusive society, thereby contributing to health inequalities. In most discussions of social mobility the concern is with everyone having chances to move up a ladder which is fixed in terms of the number of rungs and the gaps between them. This report is concerned with social and economic inequalities that contribute to health inequalities; with the number of rungs and the gaps. It is also concerned with the obstacles or exclusionary processes that prevent many getting even basic education and employment. It is this aspect of social mobility which is the focus here.

The roots of social exclusion lie in inequalities of power and wealth, and are caused and perpetuated by policies which buttress those inequalities. The report considers three critical dimensions of inclusion/exclusion:

- Participation in the labour market
- The nature of service provision
- Empowerment in every day life.

The report focuses on the exclusionary processes relating to five circumstances. These illustrate the multi-dimensional nature of exclusionary processes and the complex and multiple disadvantage these give rise to. The report considers:

- Disability
- Mental ill-health
- Minority ethnicity
- Asylum seeking and refugees status

¹ The authors also wish to thanks Dr Kitty Stewart, Claire Whyley, Mary Carter, Myung Ki, Professor Eric Emerson, Dr Craig Morgan and Chantelle Whelan

- Homelessness

Recent Policy Directions

An independent assessment of the current Government's approach to social exclusion concluded that "*a broad and ambitious social policy programme has attempted to tackle child and pensioner poverty, unemployment and worklessness, area and neighbourhood deprivation, inequalities in health and educational attainment and inequalities by ethnic background*". Yet the same review said that while there had been progress in some areas, it was slower than expected and in some areas had stalled. The same report argued that inequality per se had not been a major focus of Government policy.

The Labour Market

Unemployment is a critical dimension and particularly related to health in three key ways. Unemployment creates financial hardship, and therefore lower living standards, impacting on social integration and loss of self-esteem. Unemployment triggers an increase in general distress, anxiety, and depression and it is likely that job insecurity works as a chronic stressor. Furthermore unemployment may alter health behaviours increasing in smoking and alcohol consumption, and decreasing physical exercise. In this context, the recent growth in economic inactivity and in insecure employment is important and is likely to be of even greater importance as unemployment rises.

Inclusive Services

The services people receive are a major component of their standard of living. A key aspect of social exclusion, which profoundly affects daily life and, consequently, health, is *service exclusion*: a lack of access to quality services that enable people to live safe, healthy and satisfying lives. As Age Concern (2008) stated:

'... social exclusion means being unable to access the things in life that most people take for granted'.

However, as with approaches to social exclusion and inclusion in general, service inclusion is a continuum relating to the *availability, accessibility, useability and quality* of services.

At its simplest, service exclusion means services are not *available* to people who need them. This can be influenced by factors such as geography, pressures on suppliers and resource constraint. For example, the consequences of living in 'food deserts' without easy access to healthy food are widely noted with people living in deprived urban areas, rural areas and areas with high concentrations of

minority ethnic populations most affected². The evidence suggests that actions to improve service inclusion fall into four broad categories: securing availability; increasing availability; promoting access and improving useability and quality.

Empowerment

The differential control people – individually and collectively – have over the forces shaping their lives have important social, economic and health consequences. While much evidence focuses on individual control, there is also research that suggests that control over resources and decision making at the collective/community level can also have powerful positive impacts on health. There is also a considerable body of research reporting that the degree of control individuals and groups have over decisions that affect their lives also impacts on intermediate determinants of health inequalities including the effectiveness of interventions aiming to improve conditions of daily life for low income people and the quality, uptake and effectiveness of services (see for example, Narayan, 2002).

Disability: Disabled people experience significantly poorer health outcomes than their non-disabled peers in aspects of health that are unrelated to the *specific* health conditions associated with their disability. Poorer health outcomes are also experienced by the carers of disabled children and adults. Disabled children and adults are at risk of experiencing social exclusion and discrimination associated with their disability. Policies to reduce health inequalities and social exclusion and improve social mobility often pay scant regard to the specific situations faced by disabled people

Mental illness: Those with a history of mental illness are amongst the most socially excluded groups in society. Rates of mental illness are highest in the most disadvantaged and marginalised groups in society and efforts to promote social inclusion will be limited if they do not acknowledge and address the

² See for example, Policy Link *Healthy Food, Healthy Communities: improving access and opportunities through food retailing* Policy Link 2005; Larson N, Story M and Nelson M *Neighbourhood Environments: Disparities in Access to Healthy Foods in the US* American Journal of Preventative Medicine Vol 36, Issue 1, Pp 74-81, January 2009; Bolen E and Hecht K *New Access to Healthy Food in low-income communities* Californian Food Policy Advocates, 2003; Saltmarsh N, Smith J and Davison A *Improving Access to Healthy Food in the Rural Bedfordshire Heartlands* Bedfordshire Heartlands Rural Food Access, 2006; Guy, C and David G *Measuring physical access to 'healthy foods' in areas of social deprivation: a case study of Cardiff* International Journal of Consumer Studies, Vol 28, No. 3 pp. 222-234, June 2004

causal link between social exclusion and mental illness, particularly in groups with existing high levels of social exclusion.⁶⁰

Ethnic minorities: Differences in health across ethnic groups, in terms of both morbidity and mortality, have been repeatedly documented in the UK. The socioeconomic inequalities faced by ethnic minority groups in the UK, are a primary driver of ethnic inequalities in health. An additional dimension of social inequality faced by ethnic minority groups is racism and discrimination. There is limited evidence on the impact of this on the health of ethnic minority people in the UK, but the available evidence does suggest that both physical and mental health are adversely affected by: experiences of racial harassment; fear of experiencing racial harassment; experiences of discrimination; and the belief that people generally discriminate against ethnic minority people.

Homelessness: Homelessness is a major exclusionary and health impacting experience whether it is characterized by sleeping rough, in shelters and hostels, precariously avoiding absolute homelessness through the goodwill of friends and relatives, or among the 67,480 households living in temporary accommodation. People sleeping rough and those in hostels who have slept rough for long periods, also have very poor physical health – higher rates of TB and hepatitis than the general population, poor condition of feet and teeth, respiratory problems, skin diseases, injuries following violence, infections, digestive and dietary problems and rheumatism or arthritis (FEANTSA, 2006a). Mortality rates, particularly for those with mental ill health, are up to nearly five times higher than for the equivalent age group in the general population (Rees, 2009).

Asylum seekers: Whilst an asylum application is being processed, asylum seekers are either placed in detention or dispersed around the UK, not allowed to work and receive financial support at 70 per cent of the level of income support. Those whose claims are rejected have 'no recourse to public funds'. There are a number of health issues that are particular to refugees and asylum seekers many of which stem from their experience of flight and exile. There is increasing focus and concern, about the situation of people who receive no support. Access to treatment has become a fundamental issue. An increasing bank of evidence shows that the physical and mental health of destitute refused asylum seekers deteriorates rapidly.

Conclusion

This report begins by discussing social exclusion and inequality in general terms. It highlights the powerful exclusionary processes that are contributing to health inequalities in England and considers the experience of particular groups to illuminate the nature and impact of these processes. The pivotal role of authentic empowerment of individuals and communities – giving them real power over decisions that shape their lives – has been emphasised in the final chapter.

Proposals

The 'macro' matters for the 'micro': The overall degree of inequality in Britain affects the circumstances of those who are most vulnerable. Economic inequality is the principal driver of social exclusion, underpinning and compounding exclusionary processes operating along other dimensions - social, cultural and political. Together these processes drive health inequality: evidence suggests that health inequalities cannot be substantially reduced without reducing economic inequality..

Economic strategies to maintain full employment are fundamental to reducing health inequality: Unemployment damages health. Employment problems are exceptionally severe for some groups, either contributing to ill health or resulting from it. Inevitably if unemployment generally rises, as it is doing, then the most vulnerable – among whom those with health problems stand out – will suffer most, and health inequality will increase.

The 'micro' matters and diversified provisions that address micro problems faced by particular groups are critical: Some groups are more severely affected by exclusionary processes than others – notably, people who are disabled, those experiencing chronic illness (including mental illness), people from minority ethnic groups, those who are homeless or seeking refugee – and the impact of these processes exacerbates health inequalities. To take three examples from many in the preceding chapters:

- Reducing the stigma and discrimination towards those suffering mental illnesses can improve their employment, their income and their health.
- Preparing those leaving the armed forces and prison much better for life on release can reduce their homelessness and their health problems.

Empowering people – giving them real control over the decisions that affect their lives – is key to delivering a more just society and greater health equity: This will require

central and local government recognizing and acting the profound changes in organisational and professional culture and practices that authentic empowerment requires.

Disability (See chapter 5)

- 1.1 To promote disability relevant practice and information within health systems and to contribute to the collection and dissemination of information on the health of disabled people. The establishment of a Public Health Observatory (PHO) on Disability could make a significant contribution toward this aim
- 1.2 To establish a national framework of guaranteed outcomes, based upon human rights principles, for health and social care
- 1.3 To bring GPs directly within the scope of the Disability Equality Duty and review the Quality and Outcomes Framework to ensure that it reflects and orients general practice to better meet the health needs of people with disabilities and their families
- 1.4 To require the NHS to monitor key outcomes and the delivery of major health initiatives (e.g. screening) by disability and sub-groups of disability against population level indicators of need in order to be able to demonstrate compliance with the Disability Discrimination Act.

In order to address the experience of disability and thereby plausibly to affect health inequity there is a need:

- 1.5 For the Department of Health to fund a programme of work examining the nature and impact of disablism on health and, in conjunction with the Equalities and Human Rights Commission, to implement a sustained campaign of social marketing aimed at reducing disablist attitudes among the general public.
- 1.6 To improve the lives, services and outcomes for disabled children and their families by, for example, up rating the Disability Living Allowance, funding the development and evaluation of a national demonstration programme that delivers intensive early intervention for pre-school children at risk of significant disabilities and reviewing the situation of children providing unpaid care for disabled relatives.

- 1.7 Address the barriers to rewarding employment for disabled young people and adults by, for example, promoting and monitoring the entitlement to work experience for disabled children at school, reviewing the current interface between employment related support programmes and the benefits systems and the adequacy of employment support programmes for people with more severe or longer-term disabilities (Rangarajan, Wittenburg, Honeycutt, & Brucker, 2008).
- 1.8 Improve access to and quality in housing and supported accommodation for disabled children, adults and their families by, for example, undertaking a review of the housing needs of families with disabled children and undertaking a fundamental review of the rules and regulations that relate to residential care homes and their interface with charging policies and the benefits system.

Mental Health (See chapter 6)

- 2.1 In 2004, the Social Exclusion and Mental Health report of the Social Exclusion Unit (SEU 2004) identified a twenty-seven point action plan. This has since been the focus of a series of initiatives at all levels to promote social inclusion for those with a mental illness, conducted under the auspices of the National Social Inclusion Programme (NSIP). There is a clear need for a long-term coordinated programme through which actions can be commissioned, implemented, and evaluated, leading to an accumulation of evidence of what works and of good practice.
- 2.2 Employment policies can promote both recovery and social inclusion by providing routine, purpose, income, social interaction, and self-confidence
- 2.3 There needs to be a fundamental transformation in the orientation of mental health services towards promoting recovery and social inclusion.
- 2.4 A public health perspective is required towards mental illness that embraces the need to reduce social exclusion in the wider society as a basis for reducing inequalities in mental health. The causal link between social exclusion and mental illness, particularly in groups with existing high levels of social exclusion (e.g., Black and Minority Ethnic) (Morgan and Hutchinson 2009), must be acknowledged.

- 2.5 Stigma and discrimination against those with a mental illness can be reduced. There is strong evidence that contact with individuals with a mental illness can dispel myths and decrease stigma, and that use of service user testimonies in targeted training programmes with select groups (e.g., children, the police) is effective.

Ethnic Minority Groups (See Chapter 7)

- 3.1 There is a need to develop evidence-based policy options in the specific field of ethnic inequalities in health; this should lead to trials of policy options and the rolling out of successful policy, paying careful consideration to the specificities of ethnic groups, places, and contemporary context.
- 3.2 These processes should be linked to an 'ethnic proofing' of policies focussed on social and health inequality more generally, with particular attention paid to possible implications for a widening, or narrowing, of ethnic inequalities; evaluation of policies focussed on social and health inequality should be designed and implemented in a way that allows for an explicit consideration of issues relating to ethnicity.
- 3.3 As employers and trainers of staff, public service employers have the opportunity to provide a significant leadership role, at both a national and local level. They are able to set standards regarding good, equitable employment practices, and ensuring subcontractors meet these standards.
- 3.4 Overall, in the short-term, employment policies, welfare, tax and benefit changes targeted at reducing economic inequalities, with a particular focus on the adverse economic position of ethnic minority people, and in the long-term policies that promote equitable life chances (education) and that address racism and the marginalisation of people with different ethnic backgrounds.

Homelessness (See Chapter 8)

In order to address the health circumstances of homeless people there is a need:

- 4.1 To develop statistically rigorous longitudinal data on the health and support needs of all categories of homeless people

- 4.2 To undertake a structural review of health service delivery to all homeless people – including mechanisms and access - with a view to measuring long-term outcomes, exploring alternative models, improving access and, facilitating smoother cross-over with mainstream services where appropriate.
- 4.3 In the interim, to extend training on homelessness awareness to mainstream services used by homeless people.
- 4.4 To review the ‘fit’ between hostel residents and the level of health support attached to their accommodation, to ensure that help is provided where it is most needed.

In order to address homelessness and thereby plausibly to affect health inequity there is a need:

- 4.5 To increase, as a matter of urgency, the supply of decent housing to reduce the increasing length of stay in temporary accommodation being experienced by higher numbers of priority households in the pressure areas of London, the South East, South West and East of England.
- 4.5 To extend access (through rent deposit schemes, floating support, etc.) to decent private properties so that people with lower support needs can move-on from hostels more quickly.
- 4.6 To undertake longitudinal analysis to better understand the structural and social - rather than immediate - causes of homelessness, which can then be used to develop alternative housing models and tailor service delivery.
- 4.7 To strengthen the effective participation of homeless people to be able to contribute to policy-making structures at micro, local, regional and national levels.

Asylum Seekers and Refugees (See Chapter 9)

To address the health care disadvantage of refugees and asylum seekers there is a need to:

- 5.1 Roll out the Refugee Healthcare Professionals Programme across the NHS, particularly in areas with high numbers of asylum seekers, refused asylum seekers and refugees.
- 5.2 Improve access to primary care for all asylum seekers and refugees, in conjunction with additional measures to clarify entitlements, and improve access to specialist services.
- 5.3 Extend awareness and training of refugee and asylum seekers' health issues across the NHS, especially with regard to the effects of torture and experiences of violence.

To address the negative social and economic impacts of asylum seeking and refugee status there is a need to:

- 5.4 Overhaul policy and approaches towards refused asylum seekers to prevent destitution and alleviate its impacts.
- 5.5 Remove work restrictions on asylum seekers whilst their claim is being processed and reinstate free access to English language courses.
- 5.6 Include the skills of existing refugees within managed migration skills shortage assessments.
- 5.7 Review the treatment of children within the asylum process, in particular towards ending the use of detention for all children; introducing a model of independent guardians to support unaccompanied children; and reviewing age assessment procedure and practice.

Empowerment (See Chapter 10)

- 6.1 Across government there are different definitions of and approaches to empowerment/engagement. A more coherent approach is required across government departments and at local level.

- 6.2 From a health inequalities perspective initiatives are needed that explicitly aim to empower people (individually and collectively) who are the target of the intervention, rather than adopting engagement or empowerment strategies as a mechanism for delivering action.
- 6.3 Future policies must recognise the empowerment requires a long term commitment and must be given priority over short term policy objective
- 6.4 A review of reviews is needed and a more coherent approach to this research agenda within government. Few evaluative studies of engagement/empowerment initiatives identified for the recent review of evidence on community engagement and empowerment undertaken for NICE included health outcomes (however defined) – this is an important agenda for future research
- 6.5 There is some evidence that community development expertise is associated with better outcomes for empowerment/engagement interventions particularly in the housing field e.g. tenant management initiatives. Consideration should be given to public funding of community development approaches to health inequality reduction.
- 6.6 In the short term the NICE guidance on community engagement for health improvement should be implemented across the health system and monitoring of performance on community empowerment should be incorporated into mainstream governance systems. In the longer term common standards for community empowerment should be developed and implemented across the public sector.