Better Health for All Londoners - My Fair London's response to the Mayor's consultation on his draft health inequalities

Summary

My Fair London strongly supports the Mayor's opening proposition that "cities that are more equal are happier, safer, and healthier." London is the most unequal city in the UK and making it more equal in terms of income and wealth would undoubtedly make its citizens more healthy. There is a huge body of knowledge that emphasizes the importance of the social determinants of health in creating health inequalities (such as pay rates, status hierarchies, poor working conditions, poor housing, degree of control, the distribution of social goods). This weight of evidence challenges simple 'lifestyle' explanations (poor diet, lack of exercise, lack of will power or good sense by the individuals affected), which dominate the media and much visible public health advice. In public health jargon this is the difference between focussing on the proximate (near) and distal (underlying) causes of health inequalities.

The draft strategy falls between these two perspectives. We believe it would be stronger and make more difference to the lives of all Londoners if it engaged more fully with the deep, structural social determinants of health.

Inequality and health

London is the most unequal city in the UK. Within the city there are wide differences in health outcomes according to levels of wealth and income. For example, in Kensington and Chelsea the life expectancy of the poorest section of the community is 14 years lower than the wealthiest. While people at the bottom of our harsh economic and social gradients are directly harmed by poverty and social exclusion, we are all harmed by the size of social and economic gaps between us. My Fair London proposes that the most important and impactful long-term measures to narrow health inequalities would be focussed on narrowing income and wealth gaps between rich and poor. Policies that had this effect would improve health across the social gradient, not just at the bottom. The Mayor's stated 'overall ambition' for the strategy could be clarified by a much sharper focus on raising people at the bottom of the gradient, while flattening its incline. To call for healthy life expectancy is not an ambition related to health inequalities, it is related simply to health.

We also recognise that such interventions will be the most politically challenging, and that the Mayor's powers to influence the structures of London's economy and wealth distribution are very limited. Nevertheless we would hope that the Mayor's Health Inequalities Strategy would make a clear statement of intent in this regard: economic inequalities overwhelm other factors in Londoner's lives that foster health inequalities and in every regard

make health inequalities worse. Narrowing income and wealth gaps should be the strategy's dominant priority.

Beneath this priority, and as the Mayor seeks to engage with the ‘causes of the causes’ of health inequalities, we suggest he should place a stronger emphasis on the psycho-social factors that are so implicated in variations in health status. To give one example, it is clear that people who feel that they have more control over their lives have a better chance of being more healthy, and one of the most empowering things in modern life is money. Lack of money in an unequal city with visible conspicuous consumption next door is psychologically harming.

Most determinants of ill health are socially created, not individually caused, and we urge that the strategy should shift the focus in this direction.

Social determinants of health

The draft strategy recognizes that health inequalities are caused by the social determinants of health, but we urge that this link should be much more strongly emphasized. The media and many members of the public and even staff in the health services tend to see ill health purely as an individual problem to be sorted out at an individual level. Too many people have the view that if only poor people would eat more healthily, take more exercise, generally live a better lifestyle, there would be no problem. Work related stress is to be dealt with by individual stress busting exercises rather than changing the work environment to reduce the features of the work situation that cause the stress in the first place. This is intrinsically unfair and contrary to much evidence of the causal factors that underpin health inequalities. It places responsibility for complex social problems on the shoulders of people who are largely not responsible for their circumstances, and people highly likely to have diminished personal and social resources to deal with the problems that face them.

We think the strategy might be further strengthened by adopting and endorsing a positive definition of health – for example ‘the freedom to live a life we have reason to value.’

The Joseph Rowntree Foundation finds that the number of people living in households below its definition of the minimum income necessary for healthy living has now risen to 30%, and the majority of Londoners living in poverty now live in households with members in work. JRF has no doubt as to the links between income and health. Nor, in common with most experts in this area, does it doubt that the causation usually runs from poverty to poor health, not the other way around. More people are unhealthy because they are poor than are poor because they are unhealthy.

However avoidable ill health is not just a problem for the worst off sections of the population, large though these groups may be. Those who are very well off are healthier than those who are only moderately well off and so on down the income scale - there is a social gradient.

This is a function of the degree of inequality in a given country. Even the richest in a very unequal country suffer worse health than the richest in more equal societies. Everyone is affected and would experience health gains from greater economic equality. We believe this is particularly the case for children and young people. Inequality makes us all more status conscious, more concerned about how others see us, and less trustful. Just as poor air quality is bad for everyone, but especially the young, so high inequality is creating a toxic social environment in which our young people have to grow up.

We have quoted life expectancy differences as a prime example of the result of large income and wealth differentials. There are many other health or health related problems that correlate closely to differences in wealth and income within different countries. A prime example is the length of healthy life expectancy – this varies greatly for those in different income bands in the UK, less in more equal countries. There is a similar link for many other health related issues, such as infant mortality rates. Although these have declined in developed nations over the years, the decline has been less marked in the UK, which fifty years ago led the world in low relative infant mortality and today ranks poorly in the comparative rankings.

The differences are not just correlations. Many studies have shown there is a causal link from income and status inequality to ill health, notably in Marmot's Whitehall Studies. There is a huge volume of work which brings together the international evidence of the health harms of inequity. A dramatic example are obesity rates, which are socially patterned and vary closely with inequality differences between countries. The causal chains that link higher rates of obesity to inequality are complex and multi-layered. We have allowed the food industry to create an unfortunate food environment but it is clear that Londoners would all be more resilient to the problem of weight gain if they were more equal.

The distribution of good health in a country bears little relation to expenditure on healthcare, it is related to the degree of equality. The US, top or near top of the league on most inequality measures, spends over 15% of its national income on healthcare, compared to a European average of about 10%. The US has one of the highest rates of ill health in the developed world and extreme health inequalities. And yet the Mayor's draft strategy seems to be drawn regularly back towards the actions of health services as being the primary response to health inequalities. While there are many important contributions health services can make to preventing ill health and to supporting people to live more healthy lives, one recent estimate suggests that healthcare mediated interventions can only influence around 15% of human health.

We welcome the sections in the strategy on children and young people, on housing and homelessness, and on employment and work. But in many cases the policy responses proposed default to individual level programmes, treating the symptoms and not the causes.

One final point – health inequalities do not exist in individuals, they describe health differences between people. The insight that a health equity perspective brings is that there are many understandable and avoidable variations in human health between different people. Statute asks the Mayor 'to identify inequalities between persons in Greater London' where there are 'major health issues.' We were surprised not to see a more comprehensive analysis of health inequalities in London as they exist by social class, by income and wealth, by age, by ethnic group, by gender, by LBBTQ+ status, by disability etc. Population health data could map different disease rates and disease markers for these populations. These variations could be mapped across the city. Such an analysis would allow the Mayor to understand better how these factors overlap, to highlight the intersections where health inequalities are most extreme, and where proportionately more action should therefore be targeted. For example the strategy talks about HIV and TB, but doesn't mention Hepatitis C. It doesn't give any suggestion of the relative health costs and or scale or severity of the two conditions or geographically where the diseases are more prevalent.

Responses to the consultation questions

Some of our responses are of a general nature and apply to most if not all subject areas listed. Where our comments refer to particular subject areas, we have identified them.

What can the Mayor do?

From our previous general comments and from a large body of similar evidence we want to stress that a successful health strategy should focus on a more equitable distribution of wealth, income and other fundamental health promoting resources, like good quality housing and access to green space. The Marmot network model, already taken up by cities such as Coventry, is a good example to follow. Here the health strategy is explicitly based on reducing inequalities and ensuring good economic growth that benefits everybody. It also encourages the private sector to adopt a more egalitarian ethos and gives a clearer public image of what the city is trying to achieve. It focuses attention upstream.

We think that there is danger in too piecemeal an approach. There is no reason not to treat the symptoms of health inequalities, but treating underlying causes too is likely to have a more powerful long-term effect. For example, the strategy usefully raises the potential role of businesses in helping staff with **mental health** problems but it should give more emphasis to prevention by structuring work to avoid practices that are known to be bad for employees. Good physical conditions are obviously important but so too are strategies to avoid unnecessary and unreasonable demands, unfair pay and reward structures, and overly hierarchical corporate structures. Further energetic promotion of advice on providing healthy **work places** would be useful. Trade unions can provide a good conduit for identifying and communicating problems and employers should be encouraged to recognize

them. As the strategy points out, suicide rates are much higher for unskilled workers and it is here that attention to conditions of work could be closely focussed. Efforts to reduce suicide in working class men are to be welcomed, but the strategy offers no insights into the likely causes. Perhaps an increasingly casualised labour market, the erosion of terms and conditions for low paid workers, the lack of secure and affordable housing, and the stigmatising of working class men has something to do with it? The Mayor could use the strategy to indicate that he will campaign strongly against casualization of work in the form of zero hours and short-term contracts. There is good international evidence that trades unions are very good for workers health. Perhaps the Mayor should support and encourage the unionisation of workers in these sectors?

Much mental and other ill health can be traced to dis-empowerment or lack of control, often as a result of bad **employment practices.** Encouragement of worker participation, avoidance of arbitrary management styles, are also an aspect of healthy workplaces.

The draft strategy rightly emphasises the importance of **economic fairness** as one of the best ways to reduce health inequalities and argues for reducing the number of Londoners on low pay by measures such as the Living Wage. However, if extremes of inequality are the problem, this in itself will not be adequate. People on excessively high incomes are part of the problem and give added weight to the importance of pushing for lower income ratios. It is the size of the gaps between people that are harmful and to narrow these gaps in wealth and status we need not only to raise pay at the bottom, but to reduce it at the top of the income distribution. We support all efforts to tackle poverty as a direct health harm but above a certain level there is no evidence that increased wealth makes people healthier or happier.

Encouraging firms to publish pay ratios as a mark of a fair and socially responsible business as part of the healthy workplace charter and employer voluntary accreditation process is to be welcomed. We also suggest greater emphasis on ways to discourage extreme high pay, such as making it a condition of GLA contracts to maintain reasonable remuneration levels for all staff, or encouraging worker representation on boards. Firms who do not pay the living wage and have extreme pay ratios should not be considered for public contracts.

Wealth inequality is also relevant. The richest 10% of Londoners own 500 times as much wealth as the poorest 20%, according to the latest London poverty profile from the Trust for London. Much of this wealth derives from ownership of property or other resources, rather than wealth creation. We understand that the Mayor and GLA have limited taxation powers, but urge that they should raise their voices in pressing for more equitable wealth taxes; for instance, additional council tax bands for the most expensive housing.

There are inequalities in access to non monetary resources, such as participation in **community life.** Participation rates vary strongly with income

and any moves to provide more and better public provision aimed at those in lower income groups are to be welcomed. However, as mentioned above, the most direct way to empower disadvantaged people in our society is to increase their control over their lives, and for low income groups increasing income is the most obvious way for people to have more control.

On the theme of empowerment we observe that the draft strategy contained little mention of crime and violence in London, both socially patterned phenomena with strong negative relationships to health, and with complex 'up stream' causes in which inequality is implicated. Some youth crime in London can be seen as the desperate response of fundamentally disempowered young people seeking to claim or assert power through violence and the proceeds of crime. Great unfairness, being stabbed and/or being fearful on the streets, is very bad for health. Similarly sexual and domestic violence are little referenced in the strategy, though their negative effects on mental and physical health can hardly be overstated.

How can others help?

Much of the Mayor's effect on health equity policy will be by influence, rather than direct control. As an organisation of Londoners My Fair London would welcome the chance to join in efforts to widen the understanding of the underlying social and structural causes of health inequalities and counter superficial scapegoating and victim blaming. We would like to help change the focus of the debate and to lay the foundations for a more upstream, radical approach, supporting Londoners suffering the consequences of inequality today (relatively poor health) while putting in place sustained long-term actions to address the ingrained, structural causes of inequality.

Measures of success

We agree with the consultation paper that responsibility for health is not just a matter for the NHS. The GLA is in a strong position to demonstrate the role that other organizations can play; for example, to encourage pilot schemes for developing better employment practices. Pilot schemes can used to refine and develop measures of success as well as demonstrating better ways of doing things

Most areas of public policy make an impact on health. GLA proposals in most public policy areas should include an estimate of potential impacts on the distribution of health – for example, it is clear that improvements in the availability, quality, and volume of social housing will do a great deal more for overall health levels than highly expensive luxury developments. The increasing physical segregation of Londoners by social class and wealth is a further negative consequence of inequality, and sets up further problematic vicious circles. As Londoners become less used to mixing with people from different backgrounds their attitudes towards each other become less generous and more distrustful, and inequality itself undermines trust in a society. Conversely higher levels of social contact between different groups can foster increased levels of trust between people and are likely to improve

community mental health. The Mayor should use his planning and housing powers to encourage as much mixing of people across social, economic and class divides as is possible. This would be a fundamental measure of success towards the strategy's aim of making Londoner's 'happier, healthier and safer.'

Impact assessments should also include proposals for how the success or otherwise of any particular initiative can be judged – has it worked in terms of better health? This will help develop a robust set of measures across appropriate policy areas.

Inequalities have a variety of clear, negative impacts on human health. We fully support the approach stated in the introduction to the consultative paper that "cities that are more equal are happier, safer, and healthier."

Note on My Fair London

My Fair London is a group of concerned Londoners. We campaign for action to reduce the wealth and income inequality that is damaging our city. We are affiliated to the Equality Trust, which educates and campaigns at the national level and which has contributed greatly to putting inequality at the forefront of the political agenda. We are motivated not only by the view that current levels of extreme inequality are wrong in themselves, but that the evidence is clear that they have a wide range of adverse social and economic consequences.

We copy below Michael Marmot's two lists of tips for a healthy life. We think the Mayor should focus most of his attention on the right hand list.

Two lists of top tips for a healthy life

1. Don't smoke. If you can, stop. If you can't, cut down
2. Follow a balanced diet with plenty of fruit and vegetables
3. Keep Physically active
4. Manage stress by, for example, talking things through and making time to relax
5. If you drink alcohol, do so in moderation
6. Cover up in the sun, and protect children from sunburn
7. Practise safer sex
8. Take up cancer-screening opportunities
9. Be safe on the roads: follow the Highway Code
10. Learn the First Aid ABC, airways, breathing, circulation

1. Don't be poor. If you can, stop. If you can't, try not to be poor for too long
2. Don't live in a deprived area. If you do, move
3. Don't be disabled or have a disabled child
4. Don't work in a stressful, low-paid manual job
5. Don't live in damp, low quality housing or be homeless
6. Be able to afford to pay for social activities and annual holidays
7. Don't be a lone parent
8. Claim all benefits to which you are entitled
9. Be able to afford to own a car
10. Use education to improve your socio-economic position

Quoted by M Marmot, 'The Health Gap', 2015, pp 50-51

Note:

This recent literature review offers a wealth of evidence exploring the psychological (and health) impacts of inequality. It also begins to elucidate some of the causal pathways through which inequality causes harm to us.

Wilkinson, R. G., and Pickett, K. E. (2017) The enemy between us: The psychological and social costs of inequality. Eur. J. Soc. Psychol., 47: 11–24. doi: 10.1002/ejsp.2275.