Living Well in London
The Mayor’s Draft Health Inequalities Strategy for London

Draft for consultation with the London Assembly and functional bodies
January 2008
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Foreword

I am pleased to introduce this first consultation draft of my health inequalities strategy for London. This strategy describes the differences in health between different parts of London and between Londoners. It analyses the many factors that influence our health and sets out my priorities for action.

Londoners no longer die in cholera epidemics, and diseases such as scurvy and rickets are rare. But large health differences persist between different groups of Londoners.

Many of our existing policies are already helping to make London a healthier city. We have planning policies delivering more affordable housing, well designed, with play space for children and accessible for disabled people. We have made massive investment in walking and cycling, leading to an eighty percent increase in cycling over seven years. We have invested in community policing to make our streets safer. We have launched a major programme of affordable childcare, established the London Child Poverty Commission, and launched the London ‘living wage’, all to highlight the unacceptable levels of poverty, particularly child poverty in London. And poverty is one of the biggest causes of health inequalities in London.

But while we can lay the foundations for a healthier London, Londoners also need to take action on their own health. As we head toward 2012 my first commitment is to lead growing campaigns to get Londoners active, whether through playing more sport or just walking or cycling more often. I want to see employers investing in the health of their staff, and in the face of the obesity epidemic I will work with all sectors to get Londoners eating healthier food. The NHS must provide top quality health services when we are ill, but it must also increase investment in preventive services to help stop us falling sick in the first place. Over a third of Londoners on disability benefits have a mental health problem. London’s health services have a major part to play in helping thousands of Londoners improve their mental health, getting them back into work or education, and enabling them to take part in a healthy and happy life.

Preventable inequalities in health are unacceptable in a leading world city. Health inequalities have huge economic and social consequences for London. Thousands of Londoners who could be contributing to London’s economy are unable to work because of poor health. The evidence on health inequalities shows that we all have a part to play, and that even
small changes to our lifestyles will help; but local, regional, and national
government, the community and voluntary sector and business can and must
take action as well.

Many organisations and individuals have helped develop this document. I thank
them for their contributions and look forward to continuing to work with them all
to refine this strategy further, and most importantly to make a real difference to
Londoners’ health.

KEN LIVINGSTONE
Mayor of London
About this strategy

This is the Mayor’s draft health inequalities strategy for London, as required by the 2007 Greater London Authority (GLA) Act. As required by statute this draft is published for consultation with the London Assembly, the London Development Agency (LDA), Metropolitan Police Authority, London Fire and Emergency Planning Authority, and Transport for London (the GLA ‘Functional Bodies’). In addition, the Mayor is inviting NHS London to formally and publicly respond to this draft, despite not being a statutory consultee at this stage in the process. This draft is also being made widely available to those involved in the process so far and interested in contributing to further work on the strategy’s development and delivery.

The Mayor will consider the London Assembly and the other agencies’ responses to this strategy before publishing a public consultation draft health inequalities strategy. This draft strategy does not include a detailed action plan describing who will take forward particular policies and how. The Mayor intends to use responses to this phase of consultation to help him develop this strategy’s detailed action plan.

Preparatory work for the strategy:
Over the past year the GLA staff have worked with wide range of stakeholders to develop this draft, including the Regional Public Health Group (RPHG) and the London Health Commission (LHC). Work has included:

• collation of published evidence on health inequalities from a range of published data sources and research
• a call for evidence to 600 community and voluntary sector organisations, supported by a community outreach initiative to gain deeper insight into the factors that affect the health and well-being of London’s more excluded communities
• analysis of existing policies at national, regional and local level to summarise current and planned programmes relevant to health inequalities, and identify opportunities for further action to reduce health inequalities
• ongoing stakeholder engagement within and beyond the GLA.

These strands of work were drawn together in the discussion document Reducing health inequalities: issues for London and priorities for action, launched by the Mayor in August 2007. That document set out the Mayor’s initial thinking on health inequalities and was published alongside more detailed reports of the evidence, outreach initiative, and mapping exercise. All publications referred to above are available on the GLA’s website at http://www.london.gov.uk/mayor/health/strategy/index.jsp

Since August 2007, the GLA health team has received eighty-five written responses to the Mayor’s discussion paper and has coordinated a number of workshops to develop key policy areas. This draft includes a small selection of quotes from these responses and workshops to illustrate the strategy’s objectives and policies.
Preparatory work for the Mayor’s Health Inequalities Strategy has coincided with development of several other regional strategies including the Mayor’s Housing, Refugee Integration, and Climate Change Adaptation and Climate Change Mitigation and Energy strategies, NHS London’s Healthcare for London: A framework for action, and the London Skills and Employment Board’s Adult Skills strategy. There is ongoing work to ensure all of these regional strategies are developed in ways that will be mutually reinforcing, with evidence being shared and policy development coordinated wherever possible.

This document summarises information about health inequalities, how they affect Londoners, and different approaches to reducing them. It goes on to set out the case for action to address health inequalities through long-term, coordinated action and shows the need for emphasis on the broader social, economic and environmental factors that underlie health inequalities, as well the need to empower individuals and communities to take action on their own health now. The strategy explains how the Mayor is uniquely placed to lead a programme of action to tackle health inequalities in the capital, working together with the National Health Service (NHS), local authorities, voluntary and community sector organisations and the private sector.

Chapter six sets out how the Mayor aims to reduce health inequalities and proposes six strategic objectives for London. It describes at a high level how these objectives will be achieved through proposed policies and actions.

**Next steps**
The Mayor will continue to lead work with the LHC, NHS and public health partners, London boroughs, employers, community groups and the widest range of other agencies to develop the public consultation draft and to plan delivery of this strategy. This further development of policies will be informed by consultation responses and recommendations from an Integrated Impact Assessment being carried out on the strategy. A report of that Assessment will be published alongside the public consultation draft.

The next version of this strategy will be developed for publication in mid-2008. It will include a detailed delivery plan setting out short, medium and longer-term actions and plans developed with a range of equalities communities and excluded groups on those issues where targeted action is required to meet specific needs. It will also describe the roles and commitments of a range of organisations and sectors in tackling health inequalities in London.

The Mayor is committed to monitoring, evaluating and publicly reporting on progress towards the objectives set out in this strategy. This draft does not specify the indicators and targets against which progress will be measured. These will be determined over the coming months and will be guided by responses to this consultation process and the advice of the LHC.
Executive Summary

London is home to more than seven and a half million people. It has a thriving economy and offers its inhabitants the chance of the highest quality of life. It also has probably the most ethnically diverse population of any city in the world and is the fastest growing major city in Western Europe. With over 2000 years of history, it offers unrivalled employment, educational and cultural opportunities and a wealth of parks, open spaces, world-renowned museums, galleries and entertainment attractions. It is one of the best-connected cities in the world, sitting at the centre of one of the wealthiest regions. Many Londoners can anticipate living rewarding and active lives equal to the healthiest societies in the world.

However for many other Londoners the benefits of living in this cosmopolitan capital city are outweighed by poverty and disadvantage. For a variety of inter-related reasons some people are excluded from, or unable to take advantage of, the opportunities that exist. These inequalities are illustrated most dramatically by differential health outcomes. In a single London borough average life expectancy can vary by as much as ten years between people living in the most and least deprived neighbourhoods. Across the city average life expectancy declines as you move from richer to poorer neighbourhoods, and at an individual level, chances of good health decrease for those lower down the income and social gradient. Levels of obesity, mental illness and smoking are higher in poorer neighbourhoods. 600,000 children in London live in poor households, and in inner London boroughs over half of all children live in relative poverty. All the evidence suggests that these children’s poor start in life will damage their long-term chances of leading a healthy life.

The Mayor believes that this scale of inequalities is unacceptable in a leading world city like London. They represent a shocking burden of suffering and unhappiness all the more unacceptable because we know that it is possible to very significantly reduce these inequalities. This strategy describes health inequalities in London today and sets out the Mayor’s priorities for action to reduce them.

For hundreds of years London has been a centre of scientific and medical advances in our knowledge of diseases and the causes of ill-health. It has also long been a place of extreme health inequalities. Because statistics of deaths were collected we know that the great plague in 1665 did not affect people equally across the city. The residents of poorer neighbourhoods were much more likely to die than their wealthier neighbours. Infant mortality (the proportion of children who die in their first year of life) began to be measured systematically in the nineteenth century. As late as the 1890s half of all children living in the most deprived areas died before reaching the age of one.
Dr John Snow’s famous work in the 1840s to pinpoint the Broad Street pump as the source of one of London’s many cholera epidemics was an early example of the importance of public health interventions. Yet the improvements in Londoners health over the last two hundred years have come not only from doctors but from engineers building sewage and water treatment works; social activists, campaigners and municipal authorities clearing slums, building new housing and introducing free education; and governments establishing the welfare state, universal pensions, and the NHS.

‘Health inequalities’ is an academic term coined to describe the observable health differences between different groups in the population. There is a growing body of national and international research that explores the causes of these differences in health outcomes. Unsurprisingly it generally shows that a person’s chances of a good and long life are affected by access to adequate food, shelter and clean water and that poverty is therefore a major factor causing health inequalities worldwide. The research also shows that in developed countries, where societies are wealthy enough to meet basic human needs of food and shelter, stark health inequalities persist. This international research suggests that the choices societies make about how they are organised (politically, economically, socially) will make a very significant difference to the severity and extent of health (and many other) inequalities in countries and cities.

International studies indicate that generally everyone’s health is better in more equal societies. Being wealthier will usually secure you a longer healthier life than being poor, but living in a more equal society will bring health benefits to rich and poor alike. However the evidence also suggests that positive changes at any level, from individuals giving up smoking or eating a healthier diet, through to Governments investing in education or increasing income levels for the poorest households, will all have a positive impact for peoples’ health.

This strategy sets out the Mayor’s long-term vision for a healthier London.

The Mayor is committed to making London a leading world city in tackling health inequalities in a systematic and determined way. To meet this commitment he will lead a programme of action to address the fundamental causes of health inequalities in the city. The Mayor wants to see improvements in the health and well-being of all Londoners and a significant narrowing of the gap between those with the best and worst health. The Mayor will work with local communities, the voluntary and community sector, the private sector, boroughs, the NHS and Government to:

- raise awareness across London of health inequalities and their causes, why they matter to all of us, and what we can do to reduce them;
• tackle the barriers to opportunity and participation which affect mental health, physical and social well-being;
• act now to help those Londoners bearing the greatest burden of ill-health; and
• develop London as an exemplar healthy city where all individuals and communities can thrive and flourish.

This draft strategy is the result of extensive dialogue and consultation between the GLA and stakeholders across London. It has been shaped and enriched by the responses from the wide range of organisations that responded to the GLA’s Call for Evidence or Outreach initiative. These organisations described the experience and health priorities of minority ethnic and faith communities, lesbians and gay men, refugees and asylum seekers, disabled people, older people, homeless people, and those living with HIV, mental illness or other health problems. Their responses highlighted that there are many shared challenges and common priority areas for a range of equalities groups and excluded communities, and these are reflected in the Mayor’s proposed actions.

This draft sets out the Mayor’s policies to tackle health inequalities under six strategic objectives, as summarised below.

1. **Income and poverty**
   
   The level of poverty in London, particularly child poverty, is a major long-term cause of health inequalities across the city. Levels of poverty and deprivation correlate closely with levels of poor health. Action to tackle poverty and reduce income inequality is therefore a high priority for the Mayor. Many of the most important ways to reduce poverty, for example through changes to the tax and benefits system, are in control of national Government. The Mayor will continue to make tackling poverty a major priority for all his agencies and will work with Government to change national policy to have more impact in London.

   **Objective 1:** To reduce income inequalities and minimise the consequences of relative poverty by:

   • reducing barriers to work, focussing particularly on the needs of those currently excluded from the labour market
   • campaigning for all Londoners, including those on benefits, to receive a living income, and those in employment to receive the London Living Wage as a minimum
   • protecting those on low incomes from the associated negative health and social impacts, and improving access to timely advice and support for people at risk of poverty.
2. **Employment**

The potential health-related benefits of work extend well beyond income alone. People’s employment status and the nature of their work have a direct bearing on their physical and mental health, and even on their life expectancy. People’s satisfaction in work is related to a sense of making a valuable contribution and also to increased social contact and networks gained through employment. In addition, there is evidence that hierarchies within workplaces can influence risk of health problems. At just over 70 per cent, London has one of the lowest rates of employment among its working age population. Given that all the evidence suggests that a good job is good for health the Mayor has made employment and work a central objective for tackling health inequalities.

**Objective 2:** To increase opportunities for people to access the potential benefits of work and other forms of meaningful activity by:

- recognising the value of work in increasing individual health and well-being and supporting effective implementation of workplace well-being policies and anti-discrimination provisions
- improving access to, and recognition of, a range of unpaid opportunities that contribute to London’s social and economic fabric, including caring and volunteer work
- extending opportunities for skill development and progression within and beyond the workplace, particularly for groups most excluded from the labour market.

3. **Participation**

Having the tools and resources, whether at an individual or community level, to control or influence what is going on around you is good for your health. London is one of the most diverse cities in the world. It has a hugely important and extensive network of voluntary and community organisations and a rich and varied cultural life. These are the foundation on which the capacity and skills of Londoners to get involved and take control of their lives can be increased. Building social capital is therefore a priority for the Mayor. He aims to support individuals to improve their own health and become health promoters within their own communities, as well as promoting exemplar models of user involvement. The Mayor believes that this approach, empowering individuals, families and communities to take control of their own health, is the best way to tackle the biggest long-term health challenges, like rising levels of obesity.
Objective 3: To empower individuals and communities to take action to improve their health and well-being by:

- building the capacity and skills of individuals and communities to take control of their own health and play an active role in the health and well-being of others
- supporting cultural activities as a powerful route to health and social inclusion and an approach to tackling health and other inequalities
- supporting the Voluntary and Community Sector (VCS)
- building the capacity of public services to actively involve communities and individuals.

4. Accessible high quality public services

In London, unequal experiences of ill health are compounded by inequalities in access to services and the uneven quality of those services. Londoners who are most vulnerable, and most in need of health or social care services, are often least likely to know how to access services and what their rights to them are. The Mayor believes that London’s health services should be world class. Wherever you live and whatever your background, you should be able to access the health services you need. London’s public services must also reflect the rich diversity of the Capital in their workforce composition and the way services themselves are designed and delivered.

Objective 4: To improve the health of people living with illness or impairment by:

- equitable provision of world-class health, social care and other public services, with improved local access to responsive, appropriate and coordinated services planned around individual need
- supporting rights-based approaches to health and social care service provision, with better information and support to increase access to services and informed choice about options
- improvements in the commissioning of health and social care across London and improvements in the quality of services available to all Londoners
- increasing diversity in the health and social care workforce and further developing the ability of all providers to competently meet diverse community needs.
5. **Healthy places for all**

The physical environments in which people live have a strong bearing on their health. Poor quality housing, the way new neighbourhoods are designed, the availability of open space, local air quality, levels of noise, and access to services all affect health both directly and indirectly. Also important is people’s sense of safety in and ownership of their local area. Across London the quality of local environment varies greatly. The Mayor’s planning powers and policy, control of public transport and many other environmental responsibilities in London mean he is already leading activity in this area. This strategy will build on the Mayor’s existing programmes to further improve London’s physical environment bringing renewed focus to environmental improvements that can reduce health inequalities.

**Objective 5:** To develop and promote London as a healthy place for all – from neighbourhoods to the city as a whole by:

- increasing the supply of affordable housing and ensuring new developments are designed and constructed in ways that improve health and reduce health inequalities
- bringing physical improvements to areas of London that are deprived, physically run-down and not conducive to good health
- promoting places that are safe, accessible and promote social cohesion
- making more explicit links between planning and actions on the environment and those on health and well-being, prioritising climate change adaptation and mitigation.

6. **Creating knowledge and learning for health**

There is already a wide range of work taking place in London to reduce health inequalities. However, much of the learning from this work is not shared or properly valued when decisions that affect peoples’ health are being made. Further work is needed to identify the most effective approaches to reducing health inequalities. The Mayor wants the expertise within the Capital to be shared. He wants to support Londoners to continue to learn about what will make the biggest difference in terms of improving overall well-being and narrowing the gap between those with the best and worst health.
Objective 6: To develop London as a world leader in the creation of knowledge about health inequalities and the use of shared learning to achieve sustained change by:

- according proper value and taking into account in policy development and resource decisions all sources of learning, including informal and community knowledge about health inequalities
- increasing levels of investment into research on the most effective approaches to reducing health inequalities
- improving co-ordination of learning across London to enable a wide range of stakeholders to co-create and share learning for change.

Next steps
Over recent years public health debates and initiatives have become increasingly focussed on individuals and their lifestyles. For example the debate on obesity is often dominated by concerns about poor quality diets, and sedentary life styles. As the case study in section 4.4 illustrates, the causes of obesity are complex. Simply lecturing people about their diets, or exhorting them to exercise more stands little chance of success without understanding some of the underlying factors that contribute to the problem.

The new cross-Government strategy on tackling obesity sets targets for reducing obesity and the number of people who are overweight. It has a clear focus on children and proposes action on healthier food, increasing physical activity and much else. The Mayor looks forward to working with Government on developing their programme in London.

The six objectives set out above therefore seek to tackle both the underlying long-term causes of health inequalities, like poverty, but also the need for action to improve Londoner’s health now. In some areas it will take time for measurable health benefits to emerge. In others, for example improving access to NHS services, or using the 2012 Olympic and Paralympic Games to encourage Londoners to exercise more, immediate benefits should be achievable.

The Mayor is publishing this strategy for consultation with the London Assembly and the functional bodies of the GLA. It sets out some evidence on health inequalities in London and a series of proposed high-level actions. At this stage it does not include a detailed delivery plan. The Mayor intends to use this phase of consultation to discuss with key partners which agencies are best placed to lead on delivery of key elements of the strategy.
1. Introduction to health inequalities

**Definitions used in this draft strategy:**

**Health:** According to the World Health Organisation (WHO), “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This strategy uses the term health in this broad sense, and also uses the term ‘well-being’ to emphasise that health is a positive condition.

**Health inequalities:** The UK Government defines health inequalities as “inequalities in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants”.

**Health outcomes** are measured and reported in terms of how long we live (life expectancy and infant mortality figures) and how well or otherwise we are (demonstrated by rates of different diseases and levels of self-assessed health).

**Wider determinants of health** are the economic, social and enviromental conditions in which people live, which play some part in determining how well or otherwise they are, and how long they live. These determinants of health are described in a number of ways – for example the WHO uses the term “social determinants” while the GLA Act (2007) refers to “general determinants.” In this draft strategy we use the term “wider determinants”.

**Excluded groups:** In certain places this strategy refers to ‘excluded groups’. This goes beyond the GLA list of equalities groups (black and minority ethnic communities, women, disabled people, lesbians, gay men and bisexual people, trans people, older people, children and young people, faith groups) to include other groups facing inequality and exclusion such as homeless people and gypsies and travellers.

**Minority ethnic groups:** We have used this term, which incorporates white minority groups, such as the Irish, in addition to black, Asian and mixed ethnic groups, to ensure that we fully reflect the disproportionately high health inequalities experienced by London’s minority ethnic communities.

**The social model of disability** recognises disability as resulting from the exclusionary way in which society organises itself, and where a lack of practical access to the social world or prejudice against disabled people can be seen as disabling processes which create inequality. In keeping with this model, the strategy uses the term ‘disabled people’ which includes people living with a range of illnesses, including mental illness, and/or physical impairment and/or sensory impairment.
1.1 Introduction
Health inequalities are differences in individuals’ health and well-being or differences in their life expectancy. These inequalities are seen between different areas, for example deprived and affluent neighbourhoods, and between different groups of people described by income, ethnicity, disability or other characteristics.

Life expectancy is an important measure of health and demonstrates one aspect of the variations in health outcomes that exist between countries, regions, boroughs and wards. Life expectancy in the UK continues to improve and London is no exception, but not all parts of the city are seeing the same improvements. A boy born in the London borough of Kensington and Chelsea today could expect to live to the age of 82.2 years. Another boy born on the same day in the London borough of Islington could expect to live to be just 74.6 years old, over seven years less than his contemporary. Similarly a girl born in Barking and Dagenham could expect to live to be 79.4 years old, over six years less than her contemporary from Kensington and Chelsea, who could expect 86.2 years of life.

It is not just where a person lives that determines their chances of a long life. It is also their access to income, employment, opportunities and life chances. Chart 1 in section 2.2 illustrates this relationship - the lower a Londoner’s social class the shorter their life expectancy. Some vulnerable groups experience much worse health than the general population. For example, a 2006 study by St Mungo’s found that the death rate among rough sleepers in London aged between 45 and 62 was 25 times that of the general population for this age group. The Government’s Social Exclusion Unit reports that people with mental health problems live on average ten years less and are more likely to suffer from a range of physical health conditions, than the general population. Taking action to improve the health of the most marginalised groups of Londoners will be a particular priority for the Mayor.

Life expectancy and mortality do not tell the whole story of health inequalities. Some Londoners are more likely to become ill, suffer from chronic conditions and feel that their own health is poorer than others. When it comes to self-assessed health, vulnerable and excluded groups and people living in deprived areas often report poorer health and well-being than the population as a whole. Another measure of health outcomes is the prevalence of major diseases such as cardiovascular diseases and cancers. Again there is evidence of a gradient related to income with the highest prevalence rates among those with the lowest incomes and lower prevalence rates as incomes increase.

In addition, although the availability of data on mortality and morbidity rates for minority ethnic groups is variable, there is evidence that some minority
1.2 Causes of health inequalities

Some people live longer and experience better health than others because of their individual characteristics. Each person’s biological make up means that they are more or less susceptible to certain illnesses or conditions. There are genetic reasons why some diseases are particularly prevalent among certain ethnic groups. For example, sickle cell anaemia is particularly common among black Caribbean, black African, and black British communities. Similarly women have higher rates of certain conditions, such as breast cancer, than men.

However, the vast majority of inequalities in health are not the result of biological or genetic differences. Instead they result from the circumstances...
and environments in which people live. Living environment and lifestyle can mitigate or exacerbate individual characteristics. For example, somebody with a family history of heart disease can decrease their chance of suffering a heart attack if they eat healthily and exercise regularly. Their chances of good health are also likely to be enhanced if they have good employment, an adequate income and decent housing. Indeed many of the factors that influence living environment and lifestyle are outside individuals’ control and are instead shaped by broader social, economic and political contexts. These wider determinants include a broad spectrum of factors that influence people’s experiences as individuals, as families and as communities.

The concept of social hierarchy is important here. This term is used to describe how power and resources are distributed across society. It includes education, wealth, income, social class, employment status and degree of influence. An individual’s relative position in the social hierarchy has been shown to influence their health and well-being. There is evidence that the gradient of the social hierarchy and the impacts that it has on health are not fixed. For example, in Sweden the difference in mortality rates between manual and non-manual workers is significantly less than in other European countries. These kinds of differences, and the fact that the extent of health inequalities changes over time indicates that policies and interventions do have the potential to reduce health inequalities.

Many Londoners experience multiple disadvantages which can exacerbate each other and lead to new problems. Individuals can find themselves in a downward spiral because of lifetime deprivation or because a single traumatic event such as divorce or job loss. Some groups such as refugees and asylum seekers, certain minority ethnic groups, older people and full-time carers are statistically much more likely to live in poverty, face discrimination and have inadequate access to support and services. As a consequence these groups experience much worse health and well-being than the general population.

Disadvantage can also become entrenched in certain neighbourhoods. People with low incomes often live in areas with poor housing, low quality environments and inadequate access to quality services because these areas are often more affordable to them. The health of these individuals is compromised by both their poverty and poor environment. Across London different boroughs have different average life expectancies dependent in part on the number of deprived neighbourhoods they contain. However, because deprivation can become concentrated at the neighbourhood level, even those boroughs with relatively high average life expectancy contain pockets of deprivation where life expectancy is significantly lower than the borough wide figure would suggest.
2 Inequalities in health and well-being in London

2.1 London’s unique characteristics

London has many characteristics that make it different from other large cities in the UK. Some of these characteristics contribute to and exacerbate health inequalities. However, others provide opportunities for action to reduce health inequalities. It is essential that action to tackle health inequalities builds on these characteristics. They include:

- **The size** of London’s population. The estimated total population of London is 7.52 million. This is by far the largest population of any city in the UK – more than seven times bigger than Birmingham and more than 10 times bigger than Glasgow.

- **The ethnic diversity** of London’s population. Half of the UK’s black, Asian and minority ethnic communities live in the capital. London’s minority ethnic population stands at 42 per cent. The 2001 Census indicates that there were 42 communities of over 10,000 people born in countries outside Britain living in the capital.

- **The age** of London’s population. London is home to nearly 1.63 million children and young people under the age of 18, accounting for almost 22 per cent of London’s total population. Almost 16 per cent of London’s population – 1.17 million people – are aged 60 or over.

- **The mobility** of London’s population. London has many immigrants, including high numbers of refugees and asylum seekers. Some of these groups live in London for only a short time. Many British people move into London when they are young adults and move out when they have families. In some parts of London there is a turnover of 20 to 40 per cent of patients a year on GP lists. In addition to its mobile resident population, London also receives one million commuters every day and around 30 million tourists every year.

- **The economic disparities** that exist within London. London is one of the world’s wealthiest and most successful economies, but includes some of the country’s poorest communities – over 600,000 or 43 per cent of London’s children live in households below the poverty line. This means that pockets of deprivation exist close to areas of extreme wealth.

- **The higher cost** of living in London, partly due to the chronic housing shortage and very high cost of housing.

- London’s rich cultural offer reflects the diversity within the city, is highly valued by its residents and is a major attraction for visitors from around the world.

- London has the most extensive public transport system of any European city. However, enabling the very large numbers of residents, commuters and visitors to move around London quickly and easily is challenging.
2.2 Life expectancy in London

The latest data based on information for 2003/2005 demonstrates that average life expectancy in both the UK and London continues to increase. On average a boy born in London in 2005 can expect to live 76.9 years, and a girl 81.4 years. However, in London there are significant differences in life expectancy for both men and women between and within boroughs as illustrated by the diagram below.

Figure 1 Differences in life expectancy within a small area of London

There are often large inequalities in life expectancy between electoral wards within London boroughs. For example within the borough of Camden life expectancy at birth for males ranges from 70 years in St Pancras ward to 81 years in Hampstead ward. For women life expectancy ranges from 76 years in Kentish Town ward to 84 years in Hampstead ward.

As well as being affected by living in a deprived area, life expectancy is influenced by a person’s position in the social hierarchy. The graph below shows that men in professional occupations (i) have an average life expectancy that is 3.5 years higher than men in skilled manual jobs (iii), while the difference between men in professional occupations and men in unskilled (v) work is over seven years.

Chart 1 Life expectancy by social class and gender, 2002-2005

Source: GLA analysis of data from National Statistics, Trends in Life Expectancy by social class 1972-2005
Infant mortality rates (IMRs) describe the percentage of babies who die in the first year of life. London’s IMR in 2002–2004 was 5.4 per 1,000 live births, which is similar to the rate in England as a whole (5.2). However, there are wide inequalities in infant mortality between London boroughs, as shown in Map 1 – below. The highest rates are found in Southwark, Newham and Haringey. In these boroughs infant mortality is almost double that in Wandsworth, Richmond and Kensington and Chelsea, the boroughs with the lowest rates. The inequality gap in London boroughs has doubled since the baseline year for the infant mortality national health inequalities target (1997–1999), although the boroughs with the highest and lowest rates have changed over time.


Source: ONS analysis by LHO ©Crown Copyright. All rights reserved. GLA (LA100032379) 2006

The LHO has identified certain groups in London that have higher levels of infant mortality. The ‘routine and manual’ socio-economic group has an IMR of 6.7 per 1,000 live births – 29 per cent higher than the rate in the general population.

The IMR is even higher for infants registered by the mother alone (sole registered) and for infants born to mothers aged under 20 at 8.9 and 8.7 deaths per 1,000 live births respectively. Further, deaths in the first year of life are more common among infants born to mothers born outside England & Wales, a rate of 5.9 per 1,000 and as high as 10.9 in births to mothers born in West Africa.12
There is a high degree of statistical association between infant mortality and low birth weight. Birth weight-specific mortality rates show that infant mortality decreases dramatically with increasing birth weight, while the rate of Sudden Infant Death Syndrome is four times higher in babies of low birth weight than in babies with birth weights of over 2500g. In addition, low birth weight is a risk factor for poor cognitive and physical development, behavioural disorders and a range of adult diseases.

Social class, estimated household income and lone-parenthood are all associated with the risk of low and very low birth weight, as is smoking. The incidence of low birth weight is twice as high among babies born to women who smoke as among babies born to non smokers.

The extent of child poverty in London, the dramatic increase in levels of childhood obesity in the last three decades (see page 23), and all the evidence showing the damaging effects of a poor start in life makes taking action to improve the health and wellbeing of children and young Londoners one of the Mayor’s highest priorities in this strategy.

2.4 Self-assessed health in London

Health is not just about life expectancy; it is also about mental and physical well-being and quality of life. Self-assessed health status is one way to describe the health of the population. There is evidence that people’s own assessment of their health is a good indicator of their health status, and among older people can be a good predictor of mortality. The 2001 Census asked respondents ‘over the last 12 months, would you say your health has on the whole been good, fairly good, or not good?’ Just over seventy per cent of Londoners reported that their health was ‘good’ which was the highest rate of any English region and compared favourably to the overall England rate of 68.7 per cent. A further 20.9 per cent of Londoners reported that their health was ‘fairly good’, while just 8.3 per cent of Londoners said their health was ‘not good’.

Maps 2 and 3 show the percentage of the population who reported their health as ‘good’ in the 2001 Census. This information has been standardised for age, as older people are less likely to report good health than young people. A standardised ratio of 100 indicates that the area has levels of good health equal to the average for England as a whole. Levels higher than 100 indicate higher than average good health, and levels lower than 100 indicate lower than average good health.

Map 2 shows that for men, Richmond, Kensington and Chelsea, and Bromley had the highest levels of self-reported good health, while Tower Hamlets and Newham had the lowest. Similarly Map 3 shows that for women Richmond, Kensington and Chelsea, Bromley, and City of London had the highest levels of
Map 2 Males, age-standardised ratio of reported good health by London borough, 2001

Source: ONS analysis by LHO ©Crown Copyright. All rights reserved. GLA (LA100032379) 2006

Map 3 Females, age-standardised ratio of reported good health by London borough, 2001

Source: ONS analysis by LHO ©Crown Copyright. All rights reserved. GLA (LA100032379) 2006
self-reported good health, and Tower Hamlets, Hackney, Islington, Newham, and Barking and Dagenham had the lowest.

There are also differences in levels of self-assessed health according to ethnic group. The percentage who reported their health as ‘not good’ was highest in the Bangladeshi and Pakistani ethnic groups and lowest among the white British, mixed white, Asian, black African and Chinese groups.

2.5 Prevalence of specific illnesses in London

Certain conditions are responsible for the vast majority of deaths both in London and across the UK. These conditions are sometimes referred to as “the big killers” and can be grouped under two broad headings – cardiovascular diseases and cancers. The section below provides some information on these and other significant diseases and health conditions in London. More detailed information can be found in the review of evidence109.

‘Cardiovascular diseases’ is a broad category that covers a number of specific health problems related to the circulatory system. In terms of mortality, coronary heart disease (CHD)110 and cerebrovascular disease (stroke) are particularly important. CHD is the leading cause of death among Londoners, accounting for 10,679 deaths in London in 2001. In the same year stroke was responsible for the deaths of 5,765 Londoners14. Estimates suggest that in London there are around 80-90 new diagnoses of CHD and 24 acute strokes per 10,000 population each year15. Cardiovascular diseases are also linked with other conditions such as diabetes and respiratory diseases that are themselves responsible for a significant amount of morbidity and mortality in London.

There are a large number of different kinds of cancer. The most common cancers for men and women in London are prostate cancer and breast cancer respectively. Together all cancers are responsible for approximately one third of deaths in London. The age standardised incidence rates for cancer in London in 2001 were 392 per 100,000 for men and 315 per 100,000 for women.

These “big killers” share a number of common risk factors. The most important of which are smoking, diets that are high in fat and insufficient in fruit and vegetables, and inadequate levels of physical activity.

In addition to the “big killers”, London’s population faces its own set of specific health challenges. The prevalence of infectious diseases such as TB and HIV is especially high in London. London accounts for approximately 40 per cent of TB cases in the UK and 57 per cent of England’s known cases of HIV16. High rates of sexually transmitted infections such as gonorrhoea, chlamydia and syphilis in London suggest that Londoners are particularly likely to engage in risky sexual behaviours. In addition, the city’s teenage pregnancy rate is high and is not declining at the same rate as that of other regions17.
Finally, the misuse of alcohol and drugs is a cause for concern in London. Londoners consume alcohol at lower levels and less frequently than the national average. Yet five per cent of Londoners (approximately 350,000 people) are dependent drinkers – meaning that they drink to an extent that is likely to be damaging to their health. There are approximately 74,000 problematic drug users in London. Problematic drug and alcohol use is associated with a wide range of physical and mental health problems.

In addition to the physical health problems described above, London has some of the highest rates of mental illness in England. In total approximately one million Londoners have had mental health problems. In terms of more severe mental illness, over 26,500 London residents were admitted to hospital for psychiatric treatment in 2003/04. This was significantly higher than the national average. London also has a considerably higher percentage of inpatients with psychotic disorders, at 23 per cent compared to a national average of 14 per cent. The Mayor believes that these levels of mental illness and distress are too high and that improving Londoners’ mental health should be a high priority not only for the health service, but for employers, local authorities, schools and society at large.
3 Why this Strategy now?

3.1 The Mayor’s duties related to health

This Health Inequalities Strategy is being developed as part of new responsibilities given to the Mayor of London by the Government within the 2007 Greater London Authority Act (see Appendix I for more details). The Act requires the Mayor to develop a strategy setting out ‘proposals and policies for promoting the reduction of health inequalities between persons living in Greater London.’

The GLA Act defines health inequalities as ‘inequalities in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants’ which it describes as:

(a) standards of housing, transport services or public safety,
(b) employment prospects, earning capacity and any other matters that affect levels of prosperity,
(c) the degree of ease or difficulty with which persons have access to public services,
(d) the use, or level of use, of tobacco, alcohol or other substances, and any other matters of personal behaviour or lifestyle, that are or may be harmful to health, and any other matters that are determinants of life expectancy or the state of health of persons generally, other than genetic or biological factors.

These new powers build on the Mayor’s existing duty to ‘promote improvements in the health of Londoners’ that was established by the 1999 Greater London Authority Act. In fulfilling this duty the Mayor has consistently emphasised the role that the wider determinants of health play in supporting or undermining well-being. He has actively considered health as a cross cutting theme in all Mayoral strategies and has sought to ensure that all opportunities to improve health are taken, and all potential negative effects on health minimised. This has included seeking the input and advice of the LHC that has led Health Impact Assessments of all the Mayor’s statutory strategies since 2000.

Under the GLA Act 1999 the Mayor has a duty to “promote health, equality of opportunity, and sustainable development.” He is responsible for the development of eight statutory strategies covering spatial development, the economy, culture, transport, ambient noise, biodiversity, waste and air quality. In addition to his statutory powers, the Mayor has developed many more strategies and actions under his general power to do anything that he considers will promote economic and social development, and environmental improvement in London. These include initiatives that have the potential to make a significant difference to health inequalities, such as the establishment of the London Child Poverty Commission, the London Living Wage campaign and the Older People’s Strategy. All these Mayoral strategies and initiatives involve
action on the wider determinants of health and have the potential to influence health inequalities as well as promote health for all.

In addition to the duties on health inequalities, the further powers given to the Mayor in 2007 require him to produce housing and adult skills strategies for London; strengthen his role over planning in the capital; and add strategic powers in a wide range of policy areas including waste, culture and sport, and climate change.

3.2 National and local context

This strategy will build on existing and planned action concerned with reducing health inequalities. It is being developed to take account of, and influence, relevant policies, research, targets, initiatives and action at the national, regional and local levels. Appendix 2 briefly summarises the policy context for action on health inequalities and further information on relevant national and regional policies and programmes is provided in the Mapping Report.

National Government policy and targets on health inequalities focus on reducing the gap in infant mortality across social groups and the difference in life expectancy at birth between those living in the most disadvantaged areas and the rest of the population. The national policy framework was first set out in *Tackling Health Inequalities, A Programme for Action (DH 2003)* and revisited in *Tackling Health Inequalities: What works? (DH 2005)*. Government recently announced its intention to review national progress on health inequalities and to develop a new strategy for continued action to tackle them.

There is a wide range of national policies that are relevant to health inequalities because they focus on the determinants of health such as poverty, worklessness, poor housing and low educational attainment. In addition, there are more focused policies that recognise the need for health service led interventions, such as reductions in smoking levels. The Government’s White Paper on public health, *Choosing Health: making healthier choices easier (DH 2004)*, set out the Government’s vision for how people can and should be supported to choose healthy options. More recently, *Health Challenge England - next steps for Choosing Health (DH 2006)* sets out the Government’s new approach to public health. In addition, there are policies that focus on improving “downstream” interventions, including *Our health Our care Our say: a new direction for community services (DH 2006)* which sets out a new model for health and social care provision.

In 2004 the Government established a Public Service Agreement (PSA) to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. Under this agreement the fifth of areas with the worst
health and deprivation indicators were designated as Spearhead areas, including 11 London boroughs. The PSA targets aim to see faster improvements in health in these areas compared to the average for England as a whole.

In addition, every London borough has a Local Strategic Partnership supported and convened by the Local Authority. Each borough and its partners must develop and deliver a Local Area Agreement, supporting progress towards a number of national and local targets including several of direct relevance to health inequalities.

3.3 Additional opportunities for change

In addition to the legal and policy context, there are a number of opportunities that support the development and implementation of an ambitious strategy to tackle health inequalities in London now. Together these opportunities combine to offer a unique chance to make a real difference to Londoners’ health that must be not be missed.

Opportunities related to the Mayor’s role:

- The Mayor’s commitment to lead action on health inequalities by addressing the underlying causes and new powers on health inequalities as described above.

- The Mayor’s new powers on housing, skills and climate change which, together with his existing powers such as those covering planning, transport and economic development, mean that he is uniquely placed to lead action on the underlying causes of health inequalities.

- The GLA Group’s experience of leading strategic change across London, working in partnership with national, regional and local organisations and using influence nationally and internationally to advocate for London.

London’s expertise:

- The huge expertise and capacity of community groups and voluntary organisations in London. There are over 60,000 voluntary and community groups in London. These groups play a vital part in supporting the delivery of a range of services as well as providing important advocacy and campaigning roles.

- The wealth of expertise and experience on health issues offered by the academic, public health, community and other experts based in London and their willingness to engage with this strategy.

- The achievements, experience, and further potential of key strategic partnerships in London, including the London Health Commission established
by the Mayor in 2000 to provide independent expertise and advice and to coordinate regional partnership action on health

**The opportunity of 2012:**
- The unique economic, social and environmental opportunities offered by hosting the 2012 Olympic and Paralympic Games and the potential to use these opportunities to tackle health inequalities.
- The ambition of the GLA, LDA, NHS and others to ensure the Games generate new enthusiasm and opportunities for Londoners to engage in more active and healthy lifestyles.
- The potential to build a lasting legacy for well-being and reduced health inequalities – from the physical infrastructure for sports, to the regeneration of parts of East London, and provision of new opportunities for training, employment and participation.

**The sustainability agenda:**
- The threat of climate change has created an imperative to develop a sustainable London. The need to find sustainable solutions also presents an opportunity to reduce inequalities, including health inequalities as environmental and social issues are inextricably linked.
- Increased public awareness about these issues provide new opportunities to encourage changes in how people live and has the potential to deliver benefits to both the environment and health
- The Mayor’s increased duties and powers on climate change and energy, as well as his existing role on related issues including transport, air quality, biodiversity and other environmental issues.

**Opportunities related to the NHS:**
- National Government’s increased investment in health over recent years.
- The inclusion, for the first time, of tackling health inequalities in the top six priorities for the NHS as set out in the NHS Operating Framework 2006/7.
- The commitment of NHS London to work with the Mayor to tackle health inequalities and ensure the emerging *Healthcare for London: a framework for action*\(^23\) includes a focus on health inequalities and corrects inequities in access to health services.

**Opportunities generated by the Government:**
- National Government’s increased recognition of the importance of action on the wider determinants of health to reduce health inequalities as
demonstrated in policy initiatives such as *Tackling Health Inequalities: Programme for Action* 2003.

- The wide range of national policies across Government departments related to the determinants of health and influenced by their programme to reduce health inequalities

**Opportunities at a local level:**
- Developments in partnership working at a local level including Local Area Agreements, as laid out in the Local Government White Paper ‘Strong and Prosperous Communities’, and Joint Strategic Needs Assessments detailed within the Local Government and Public Involvement in Health Bill 2007.

**International developments:**
- Increasing recognition of the importance of action on social determinants of health at an international level through the WHO’s *Commission on the Social Determinants of Health*, the UK Government’s participation in this initiative and the opportunities for learning offered.
4 Reducing health inequalities – approaches to action

4.1 Focus on the wider determinants of health
Over the last decade the public health community has argued for the wider determinants of health to be taken into account in formulating policy and action to improve health and reduce health inequalities. Similarly, the WHO Commission for the Social Determinants of Health urges public health professionals and other partners to look at the “causes of the causes” of health problems. Rather than, for example, focusing on single health behaviours such as smoking, diet or exercise, the Commission advocates multiple interventions that also address factors such as poverty, stress, and social exclusion, which affect individual lifestyles.

The mechanisms by which the wider determinants contribute to health inequalities are complex. Often the causality is indirect. None of the wider determinants work independently of the others. This makes exact attribution of cause and effect difficult. However, we can clearly identify a number of important dynamics.

Firstly, income is crucial in determining an individual’s access to good quality housing, healthy food and other positive choices and opportunities. Income is largely determined by access to education, training and employment as well as family background.

Secondly, knowledge and aspirations are partly based on family and community influence built up from early childhood. They are closely related to parental income and lifestyle, as well as formal education. Knowledge, direct experience of healthy lifestyles, aspirations for health and access to healthier options are crucial for the development and maintenance of health throughout life.

Thirdly, the physical environments in which people live influence health directly and indirectly. Physical environments can promote health and well-being through healthy design and use of space, for example by encouraging walking and cycling, or they can cause ill-health, for example through high levels of air pollution. In addition, the safety of communities and neighbourhoods is a critical factor in ensuring individuals can benefit from what their environment has to offer.

Fourthly, the level of empowerment an individual has plays a huge role in determining their sense of well-being. Empowerment includes the degree of control a person feels they have over their life and their ability to exercise that control. Studies have shown that insecurity and lack of control have a strongly negative effect on health. Unemployment, poverty and social exclusion can
disempower individuals. In the short-term, access to information, support and advocacy can help individuals maintain control over their lives.

Fifthly, the provision of services, including health and social services, education, transport, housing and leisure, play an important role in supporting health. An individual’s ability to access such services is related to income, knowledge, transport and empowerment. The quality of services is also important, as is their ability to meet the varied needs of diverse communities.

Finally, participation and a sense of belonging and purpose are crucial to well-being. Generally people need regular social contact and a sense that they are valued as an individual, to be healthy. Employment, in addition to generating a secure income, provides opportunities for achievement, recognition, social contact and support that are important for mental and physical well-being. Participation and a sense of belonging can also come from many other sources including volunteering, lifelong learning, family networks, community activism or faith groups.

These dynamics are illustrated in the diagram below.

**Figure 2 The determinants of health**

4.2 **Upstream and downstream considerations**
Sometimes interventions to tackle health inequalities are described as being either “upstream” or “downstream”. Upstream interventions aim to create the conditions that enable people to make healthier lifestyle choices and to promote health and prevent illness at an early stage. Examples include action on unemployment and education. Downstream interventions seek to respond to health problems once they occur. One example is action to improve access to health services.

Interventions are also described in terms of whether they focus on individual or structural factors. Interventions focused on individuals include those that address lifestyle factors such as diet, use of alcohol and smoking. Structural interventions include those that focus on the wider social, economic or environmental determinants of health as described above.

Health policies and resource allocations often focus on downstream or individual interventions looking at lifestyle. As stated above, lifestyle does indeed play a major role in health inequalities. However, the success of these interventions is significantly affected by upstream or structural factors – the wider determinants of health. So, for example, there is little point in advising people about healthy diets if they do not have access, or the necessary income to acquire healthy foods. Likewise, interventions to encourage people to stop smoking are less likely to be successful without addressing the factors that cause them to smoke in the first place such as peer pressure, stress, and anxiety caused by poverty, social exclusion and isolation.

Reducing health inequalities will require coordinated activity at a range of levels. Effective action to tackle downstream or individual factors, such as enabling people to adopt healthier lifestyles, has a far greater chance of success if it is accompanied by sustained action to address the upstream or structural causes of health inequalities.

4.3 **The role of health services**
Another important debate around how best to tackle health inequalities concerns the role of the NHS. Traditionally the primary role of the NHS has been to respond to illness or impairment and to promote health. Recently attention has shifted to recognising the importance of reducing health inequalities and considering the wider determinants of health, most of which are outside the control of the health service.

Yet the health service still has a vital role to play in reducing health inequalities. Access to good quality health information, support and healthcare is itself one of the wider determinants of health. Unequal access to health care services and
differences in the quality of health care can also cause health inequalities and exacerbate existing inequalities. Action to improve the quality of, and access to, health care across London, particularly for currently excluded groups, will play a crucial role in reducing health inequalities across the capital.

The NHS is also a major employer and as such has a significant influence on the health and well-being of its approximately 206,000 London employees. As a significant purchaser of goods and services, the influence of the NHS also reaches beyond its directly employed staff to thousands more working for contractors and suppliers.

The Mayor recognises that it is essential to work in close partnership with other agencies and organisations at the national, regional and local levels, particularly the NHS. He also recognises the importance of learning from, and building on existing initiatives and of contributing London’s experience to collective learning on health inequalities. In addition, the Mayor is committed to raising awareness of the contributions individuals, communities and organisations can make to promoting the physical and mental well-being of Londoners and will work with others to create conditions where all can play their part in reducing health inequalities.

Influencing the causes of health inequalities is a long-term agenda. Therefore this strategy looks 20 years ahead. However, current health inequalities in London also require more immediate action so this strategy sets out a range of actions that will have both short and longer term impacts.

4.4 Obesity: a case study

To illustrate the need to address both upstream and downstream issues and to support effective action by individuals, communities, health services and other organisations, the section below considers one health issue currently causing much concern – obesity. The Government has published a new cross-departmental strategy which seeks to reverse the trend in rising obesity and overweight, particularly among children.

However, any number of health issues could have been chosen to demonstrate a similarly complex picture.
Obesity: a case study

Obesity is one of the most widely discussed public health issues of the moment, with varying views about the solutions. In recent years the proportion of people who are overweight or obese has increased significantly across the UK, and London is no exception. Of particular concern is the increase in childhood obesity. This case study attempts to demonstrate the complexity of this issue and highlights the need for more coordinated responses at a range of levels.

It is important to distinguish between ‘overweight’ and ‘obese’. These are clinical terms that refer to a person’s body mass. Adults with a body mass index (BMI)\(^2\) between 25 and 30 kg/m\(^2\) are described as overweight, while those with a BMI greater than 30 kg/m\(^2\) are described as obese. For people with a BMI of over 25 kg/m\(^2\) the risks of health problems increase as their BMI increases. Being overweight and obese is linked to a wide range of health problems including cardiovascular conditions, type 2 diabetes, cancers and mental illness. In 2003 obesity caused approximately 4000 deaths in London, seven per cent of all London deaths, including 600 from heart attacks, 450 from strokes and high blood pressure and over 300 from cancers\(^3\).

The 2003 Health Survey for England shows that, in 2003, 18 per cent of men and 20 per cent of women in London were obese. This amounts to approximately 1.3 million obese adult Londoners\(^4\). The proportion of young people that were obese was just as high, with 20 per cent of people between the ages of 2 and 15 (0.25 million young Londoners) obese in the same year\(^5\). In 1975 only around eight per cent of children were overweight.

Diet and levels of physical activity are the direct determinants of body mass for the vast majority of people. High calorie, high fat diets are closely linked to being overweight and obese. Similarly people who are regularly physically active are much less likely to be overweight or obese than those who are more sedentary. The 2006 Active People survey by Sport England found that approximately 50 per cent of Londoners were ‘sedentary’ – meaning that they had done no 30 minute bouts of moderate intensity physical activity in the preceding three months\(^6\).

There are a wide range of social, economic and environmental factors that affect Londoners’ diets and levels of physical activity. These factors do not wholly account for, but have a significant influence on individual choices. Therefore to get people to change their behaviour action is needed to create conditions that make healthy choices easier.
Thinking firstly about social factors, the different diets of various groups of Londoners partly reflect social trends such as longer working hours. Reduced time for food purchasing and preparation has led to the consumption of more ready-made snacks and meals. This has a negative impact on food knowledge and cooking skills and their transfer from one generation to the next. Significantly, national evidence shows that children of obese parents are much more likely to be obese themselves. Increasing the flexibility of work should help to address this issue. More specific responses should focus on education to improve nutritional knowledge and food preparation skills for people of all ages.

Cultural traditions and preferences are also important. For example, national data shows that Chinese men and women consume fruit and vegetables more frequently than other ethnic groups, whereas Irish and Bangladeshi men and women consume high fat foods more frequently than other groups. Changing the kinds of fats used and developing lower fat versions of some traditional foods is one way of addressing these issues.

Similarly there are social and cultural reasons why some groups have low levels of participation in sport and physical activity. For example, levels of physical activity among disabled Londoners are very low. Disabled people face physical and social barriers because sports centres and open spaces are not designed in a way that is accessible to them, and because activities themselves are often structured around the needs and skills of able-bodied people. Participation is also lower among women than men, and particularly low among women who belong to certain faith groups due to requirements around privacy and the need for gender specific spaces. Promoting sport and physical activity among groups that currently have low levels of participation and tailoring services to their needs such as by providing women only sessions has been shown to improve participation levels among these groups.

In terms of economic factors, income is hugely important. People on lower incomes tend to consume relatively low amounts of fresh fruit and vegetables, and relatively high amounts of refined sugars, saturated fats, and salt. This is partly due to cost. High fat, high sugar foods often cost less than fruit, vegetables and lean meats, particularly when considered in terms of cost per unit of energy. However, direct cost is not the only consideration. Parents living on low incomes often comment that they regularly buy highly processed foods (such as burgers, pizzas and chips) for their families because they are confident that these foods will be eaten and they cannot afford to buy foods that their families might reject and waste. Clearly action to improve the availability of affordable healthy food is important here. Education about budgeting and preparing low cost healthy meals can also support people on small budgets to make good food choices.
Low-income groups also have lower levels of physical activity. The 2006 Sport England Active People Survey found that only 15 per cent of people in the lowest socio-economic groups reported regular participation in sport and active recreation, compared to 26 per cent of the highest socio-economic group (see map on page 66). In London the costs of participating in many forms of sport and physical activity (both in terms of facilities and equipment) are not affordable for people living on low incomes. Increasing low cost access to sporting facilities, and raising awareness about low cost options would be one way to address this. Promoting and supporting low cost physical activities such as walking and cycling also has potential to make a difference, especially as there is evidence that people living in low-income areas are more likely to travel as pedestrians.

While cost does not limit participation in walking, environmental factors such as urban design, and perceptions of safety do. Environmental equity is an important issue in London. Londoners living in deprived areas often breathe poorer quality air, have less access to high quality green space, and face higher perceived and actual levels of crime. Pedestrian injury rates are also higher among more deprived Londoners, with the rate amongst the most deprived tenth nearly three times that among the least deprived, for both adults and children. All of these factors can have a negative impact on levels of physical activity among deprived groups. The introduction of traffic calming measures and safe play zones can help to make local neighbourhoods safer for pedestrians and cyclists, as can the work of safer neighbourhood teams. At the strategic level environmental equity issues need to be considered when planning new developments and in regeneration initiatives.

Local environments affect diet too. Deprived areas often have fewer local food suppliers that stock fresh healthy foods. These areas are described as ‘food deserts’. For example in Newham more than two thirds of residents live more than 500 metres from a shop selling fresh fruit and vegetables. Work to improve the availability of healthy food options in deprived areas is therefore important. Other potential ways of improving the environments for healthy eating include increasing the provision of allotments so that local people are able to grow their own food. This would also help to increase physical activity.

In summary, this case study shows that reducing levels of obesity in London is a complex task. Action to address structural factors such as poverty or a degraded physical environment in a deprived area must be co-ordinated with programmes that support and persuade individual Londoners to eat a healthier diet or take more exercise.
5 The framework for the Health Inequalities Strategy

5.1 The Mayor’s vision for a healthier London
The Mayor is committed to making London the leading world city in tackling health inequalities in a systematic and determined way and achieving demonstrable results. To meet this commitment he will lead a programme of action to address the fundamental causes of health inequalities. This strategy aims to improve the well-being of all Londoners and narrow the gap between those with the best and worst health by:

- raising awareness about health inequalities, their causes, why they matter to all of us, and what we can do to reduce them
- tackling the barriers to opportunity and inclusion that affect mental, physical, and social well-being
- acting now to help those Londoners bearing the greatest burden of ill-health
- developing and promoting London as an exemplar healthy city where all individuals and communities can thrive and flourish.

5.2 Links to the Mayor’s vision for London
The Mayor has an overall vision for London as an exemplary, sustainable world city based on three interlocking themes:

- strong and diverse economic growth
- social inclusion to allow all Londoners to share in London’s future success
- fundamental improvements in environmental management and use of resources.

Tackling health inequalities is key to delivering this ambitious vision for London. The Mayor believes action to reduce health inequalities must be delivered in collaboration with communities and individuals – not imposed on them. Priorities for this strategy have been developed to reflect both the Mayor’s ambition for London and the knowledge, expertise, and health-related goals of a wide range of partners.

The framework below shows the six objectives designed to achieve the aim of the Mayor’s Health Inequalities Strategy.
There is a further ‘wrap-around’ objective’ on knowledge creation and learning that is intended to build on, and link together, all the other objectives, as follows:

6 To develop London as a world leader in generating knowledge about health inequalities and the use of shared learning to achieve sustained change.

This framework for the Mayor’s strategy is depicted in the figure opposite.

<table>
<thead>
<tr>
<th>The Health Inequalities Strategy will contribute to:</th>
<th>Through the following objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong, diverse long-term economic growth</td>
<td>To reduce income inequalities and minimise consequences of relative poverty</td>
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<td></td>
<td>To increase opportunities for people to access the potential benefits of work and other forms of meaningful activity</td>
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<tr>
<td>Social inclusivity to give all Londoners the opportunity to share in London’s future</td>
<td>To empower individuals and communities to take action to improve their health and well-being</td>
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<td></td>
<td>To improve the health of people living with illness or impairment</td>
</tr>
<tr>
<td>Fundamental improvements in London’s environment and use of resources</td>
<td>To develop and promote London as a healthy place for all – from neighbourhoods to the city as a whole</td>
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5.3 Core Principles

The Mayor has identified a series of principles to underpin the Health Inequalities Strategy and provide the basis on which progress in London is monitored and evaluated over coming years. These principles have been used to shape the Strategy and to prioritise action. They are:

- To promote both mental and physical well-being throughout people’s lives
- To develop both universal approaches to promote the health of all, and targeted policies to focus on groups most disadvantaged in health terms
- To promote a social model of health, with emphasis on wider determinants and on reducing inequalities that act as a barrier to well-being
- To recognise the need to reduce future health inequalities through long-term strategic action and also, through short-term initiatives, to address the needs of people currently experiencing health disadvantage
- To visibly and assertively influence Government, the NHS, and Local Authorities where national, regional or local programmes have potential to affect health inequalities in London.
6 Objectives, policies and proposed action

Making a difference to health inequalities means taking action across varied and far-ranging territory. The six high-level objectives set out in this section focus on aspects of economic, social and organisational life where the Mayor considers that taking co-ordinated action is most likely to deliver significant short and long-term benefits. Of course, the success of the Strategy will depend on public policy makers at all levels and the extent to which they take health inequalities into account in their planning and decision-making.

Each of the six objectives includes some discussion of the evidence as to why it is a priority for London. After each objective there are a series of more detailed policy statements and proposed actions, again each followed by some discussion of the rationale for that particular policy.

For some objectives there is also a text box entitled, **Focus on mental health** in recognition that mental illness is a significant issue in London, but is seldom given the prominence it deserves. This illustrates the Strategy’s approach to health – encompassing physical, mental and social well-being and the Mayor’s recognition of the critical importance of coordinated action across all these aspects of health.

This first draft of the Mayor’s Health Inequalities Strategy does not include a delivery plan specifying in detail how individual actions will be taken forward. Nor does it include specific targets or indicators. The Mayor expects NHS London, Primary Care Trusts and other health partners, London boroughs, schools and colleges, employers, and the widest range of other agencies to work with him to help deliver this strategy. He will consult key players to seek their support for and commitment to the actions as part of the process of developing the next draft of this strategy for public consultation. The final version of this strategy will include a detailed delivery plan setting out short and longer term actions, as well as specific targets and indicators. It will also describe in more detail the roles and responsibilities of other key London agencies in the delivery of this strategy.

**Objective 1: To reduce income inequalities and minimise consequences of relative poverty**

_Why this objective?_

Income plays a key role in determining health and well-being. A good income enables individuals to secure access to a decent standard of living and a healthy lifestyle. The term ‘income inequality’ describes the distribution of income across a population; the greater the difference between those earning high incomes and those earning low incomes, the greater the income inequality. The table below compares the distribution of income in London relative to Great
Britain as a whole in 2005/06. It shows that London has more people in both the highest and lowest income groups. The 2005/06 Family Resources Survey found that 13 per cent of London households had a total weekly household income of less than £200 while 25 per cent of London households had a total weekly household income of £1000 or more.\(^{39}\)

Table 1 Quintile distribution of income for individuals (whole population) after housing costs 2005/06

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Source: DMAG analysis of Department of Work and Pensions 2005/06 Family Resources Survey

Income inequality exists between different population groups and some are more at risk of living in poverty than others. Child poverty is of particular concern because early years are formative for the development of health and well-being. London continues to have the highest rate of child poverty in the UK; four out of ten children in London are living in income poverty, rising to more than half of children in Inner London. 60 per cent of children in lone parent families in London are in poverty compared to 50 per cent at national level; and 69 per cent of children in Bangladeshi and Pakistani families are in poverty compared to 57 per cent nationally.\(^{40}\)

High housing costs in London pose a particular problem. Middle or high income families are able to move out of London to meet their housing aspirations, leading to a concentration of poorer families in social housing. Through his draft Housing Strategy, the Mayor is working to reduce the negative impact of poverty by increasing the supply of affordable family housing.

There is a clear relationship between income inequality and health inequality. Research shows that people who earn lower incomes have shorter average life expectancy and higher levels of mental and physical illness or impairment than those who earn higher incomes.\(^{41}\) Chart 2 opposite shows the percentages of people in low, medium and high income groups who reported that they had experienced certain health problems, and clearly demonstrates that a health ‘gradient’ exists relative to income in terms of the UK’s major diseases. These ‘big killers’ are responsible for the vast majority of deaths across the country. This is also the case in London.
Increasing incomes for those in lower income brackets: why this focus?

Women working full-time in London are paid on average 23 per cent less per hour than men, compared to a UK average gender pay gap of 17 per cent. Employees from minority ethnic groups also tend to be paid less in London: they earn on average £9.43 per hour, compared with £11.93 per hour for white groups. Overall 30 per cent of employees from minority ethnic groups earn less than £7 per hour, compared with less than 18 per cent of those from white groups, and 20 per cent of women earn less than this level. Similarly, disabled people are more likely to earn less than their non-disabled peers, and to be in part-time or insecure employment.
Living Well in London

The Mayor’s Draft Health Inequalities Strategy for London

The high cost of living in London means that Londoners need higher earnings if the real value of working is to be equivalent to that elsewhere. However, many lower paid and part-time jobs pay no more in the capital than they do in other parts of the country.

Also, for those on low incomes, small increases in income result in significant reductions in tax credits and benefits, meaning that the financial rewards of working are often minimal. In addition, many low-income jobs in London do not offer paid sick leave or paid parental leave. This means that the income gained through paid employment is often less reliable than that provided through benefits.

Ensuring all workers receive a living wage would make a big impact on child poverty rates in London as two-fifths of children living in poverty live in households where at least one adult is in low-paid employment. Work needs to pay for those at the lower end of salaries scales and for those in part-time jobs.

For some people, however, paid employment is not an option due to health problems, caring responsibilities, age or other factors. For this reason it is also important to reduce poverty among those who are unable to work. Single parents, pensioners, those with full time caring responsibilities, disabled people and refugees and asylum seekers are particularly at risk from poverty due to inadequate social security benefits levels, making it particularly important that the higher costs of living in London are built into calculations of benefit levels. Provision of welfare rights advice and straightforward, accessible debt management services have also been shown to be very cost effective ways to increase incomes in low income households.
Reducing worklessness: why this focus?

Overall the unemployment rate in London is higher than in other parts of the United Kingdom, with 7.6 per cent of economically active Londoners out of work, compared to 5.3 per cent in the UK\(^4\). Too many individuals find themselves excluded from employment or under-employed for many reasons, including stigma and discrimination.

Only 45 per cent of lone parents in London are in paid work compared to 58 per cent of lone parents outside London\(^4\). Half of London’s disabled working age population are economically active compared to 79 per cent of non-disabled Londoners\(^6\), while 24 per cent of non-employed disabled people say they would like to work, compared to nine per cent of their non-disabled peers\(^7\). And among minority ethnic Londoners, the unemployment rate is over twice the rate of white Londoners (13 per cent and five per cent respectively)\(^8\) with considerable variation in rates between different minority ethnic communities.

There is limited data about faith groups and access to employment, but some evidence that Muslims in Britain have higher unemployment rates than people of other religions, and in London, as is the case nationally, the unemployment rate amongst Muslims is more than twice that of the general population. There is evidence that levels of employment are also particularly low among recently

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**Policy statement 1.2: Reducing worklessness**

The Mayor wants to reduce barriers to work focussing particularly on the needs of those currently excluded from the labour market.

**Proposed action**

The Mayor will:

- Campaign for better integration between health, housing and employment services to improve pathways to work.
- Press employers to increase availability of flexible working including quality part-time work.
- Further increase the availability of affordable and flexible high quality childcare.
- Work with Government and others to streamline processes for people making the transition from benefits or working in the informal economy into paid employment.
- Work with the LDA and LHC to identify and further promote effective ways of increasing the diversity of the workforce, with increased numbers of disabled Londoners and those from minority ethnic groups able to access employment opportunities.
arrived people, ex-offenders, older people, and people with long-term health conditions.

Unemployment rates among young people are very high, particularly for teenagers. Data from the 2006 Annual Population Survey shows that unemployment among those aged 16–19 was around 35 per cent, while for those aged 20–24, unemployment stood at 12 per cent. Amongst all 16 year olds nationally seven per cent are ‘not in education, employment, or training’ (NEET), rising to 11 per cent from the lowest social class groups. Characteristics associated with young people being NEET include poor educational attainment, persistent truancy, teenage pregnancy, use of drugs and alcohol, being looked after by the local authority, disability, mental health issues and involvement in crime and anti social behaviour. There is a strong correlation between the percentage of young people NEET and the performance of the wider labour market. Those areas with the highest proportion of young people NEET also have relatively high unemployment and low employment and economic activity overall. The highly skilled nature of much London employment may work against the very youngest age groups leaving full time education with poor or no qualifications, making it much harder for them to gain an initial foothold in the labour market and thus making it more likely that these individuals fall into the young people NEET group.

The following map shows at the spatial level how unemployment rates varied between boroughs in 2005 with Richmond-upon-Thames having the lowest rate at four per cent and Tower Hamlets the highest at 11 per cent.

Map 4 Unemployment Rates: London Boroughs 2005
Longer term barriers to work include low aspirations, educational under-achievement and lack of training. Opportunities to improve training and education may not be accessible to some individuals because of transport costs, fees, physical access and a lack of awareness about availability. More immediate barriers include location and accessibility of jobs, lack of flexibility regarding hours, limited availability of affordable childcare, and limited practical support to carers. Lack of access to affordable childcare keeps many people out of paid employment and training, especially among low-income families and those in deprived communities where provision may be scarce. Over twice as many lone parents (17 per cent) cited childcare costs as the main reason they did not work compared to couple mothers (eight per cent)\textsuperscript{10}. Housing Benefit tapers, especially for those in temporary accommodation, are also a significant disincentive to work.

Social housing providers are key to improving pathways to work and have the potential for integration with other services. Registered Social Landlords are being encouraged to engage with a much wider social agenda than just providing housing, such as employment services\textsuperscript{51} and financial inclusion work\textsuperscript{52}. The Hills Review of the future role of social housing makes the point that worklessness is high in social housing and it has not achieved the positive impact on employment rates that might be expected from the impact on work incentives that should arise from sub-market rents. The Mayor welcomes the emphasis on tackling worklessness in the Hills Review and supports the proposals for more integrated housing and employment support and more neighbourhood level employment initiatives\textsuperscript{53}.

**Policy statement 1.3: Reducing the negative impact of poverty**

The Mayor will work to protect people on low incomes from the associated negative health and social impacts, and improve access to timely advice and support to those at risk of poverty.

**Proposed action**

The Mayor will:

- Co-ordinate the development of interventions to increase financial security for people at points of transition in their lives such as leaving school, entering the workforce, leaving prison, acquiring an illness or impairment, leaving work, or becoming a parent or carer.
- Seek to increase investment in integrated early interventions to improve life chances, focusing on maternal, infant and child health and well-being.
- Support local authorities to further increase access to leisure and recreation facilities, including green spaces and rivers, for people on low incomes.
- Work with the London Development Agency to improve the affordability and availability of fresh, healthy food.
- Support local authorities and VCS groups to improve access to responsible lending, such as credit unions and banks, for people on low incomes.
Reducing the negative impact of poverty: why this focus?
Being unable to make ends meet or to participate in family and community life can cause long-term chronic stress, which has a direct negative impact on health. Such stress can also cause people to adopt behaviours that are damaging to their health. For example smoking rates are higher among men and women in routine and manual occupations (35 per cent of men and 31 per cent of women) than among those working in professional and managerial occupations (21 per cent and 18 per cent respectively).

The negative impacts of smoking and drinking alcohol are likely to disproportionately affect those on lower incomes. For example, the negative impacts of smoking on respiratory health are likely to be greater for a person living in damp housing. The costs of these activities can also place a greater financial strain on people on low incomes than those in more affluent groups.

People on low incomes have difficulty accessing the building blocks of a healthy lifestyle. Research into the process by which low income families make food decisions found that children in these families received more of their preferred foods, such as chips, beans, burgers and fish fingers, than their more affluent friends. The reason given for this was that the children were given the food they liked in order to avoid waste. Mothers felt that they could not afford more expensive foods like fruit, nor take the risk of buying nutritious foods their families might not eat.

Access to leisure and sporting opportunities is also limited by family income, as is access to safe public places and green space that can offer health benefits. Research by Sport England found that only 15 per cent of Londoners in the lowest socio-economic group regularly participate in sport and active recreation compared to 26 per cent of those in the highest socio-economic group.

London Swimming has identified ‘cost’ as one of the biggest barriers to people participating in swimming and other pool-based activity.

Finally, those on low incomes have inadequate access to financial advice, debt management and welfare rights. The lack of transparent information and advice about the real cost of financial products from large high-street lenders leaves many people vulnerable to increased debt. Their desperation is often exploited by private ‘loan sharks’ and other irresponsible lenders that have proliferated in deprived areas of London in recent years.
Objective 2: To increase opportunities for people to access the potential benefits of work and other forms of meaningful activity

Why this objective?

Employment is one of the most strongly evidenced determinants of health, and the potential health-related benefits of work extend well beyond income alone. People’s employment status and the nature of their work have a direct bearing on their physical and mental health, and even on their life expectancy. People’s satisfaction in work is related to a sense of making a valuable contribution and also to increased social contact and networks gained through employment. This extends to other forms of meaningful activity as well; volunteering contributes greatly to the well-being of many individuals and communities, while positive benefits can be gained through informal roles, such as parenting or caring, or through participation in learning. Societies that enable all citizens to play a full and useful role in social, economic and cultural life will be healthier than those where people face insecurity, exclusion and deprivation.

However, not all work provides satisfaction, just as not all employment lifts people out of poverty. Where people are unhappy at work, the costs can be grave both to employee and employer, and hence to London as a whole. Work-related stress, for example, is estimated to be the biggest occupational health problem in the UK, after musculoskeletal disorders such as back problems. In addition, there is clear evidence that hierarchies within workplaces can influence risk of health problems, and that limited control at work and an imbalance between effort and reward are bad for health.

The pool of untapped talent in the capital is vast. There are many well-qualified individuals among the unemployed, and many women, disabled and minority ethnic people are employed below their level of achievement or potential. Where individuals have good access to training and income, their health and that of their families is likely to grow stronger and their communities also benefit. The Mayor is clear that for London to continue to grow economically, we need to ensure that all sectors of our society can access opportunities to develop skills and participate in the economy. And, of course, London employers will themselves benefit by better promoting and securing the health and well-being of their workforce.
Policy statement 2.1: Valuing ‘good’ work
The Mayor recognises the value of work in increasing individual health and well-being and supports effective implementation of workplace well-being policies and anti-discrimination provisions.

Proposed action
The Mayor will:

• Demonstrate exemplary employment practices throughout the GLA group and urge other large public and private sector employers to do the same.
• Work to ensure that London’s employers are carrying out their statutory duties in relation to anti-discrimination legislation and proactively promoting diversity and inclusion.
• Support campaigns to increase Londoners’ awareness of their employment rights under current law, particularly people from excluded groups.
• Work with a range of employers from different sectors to promote the importance of investing in health and well-being at work, in partnership with the LDA and the LHC.
• Together with the LHC, work with the voluntary, statutory and business sectors to identify ways of improving the retention of and in-work support for disabled people and those with mental and physical health problems.
• Work with the NHS and employment services to develop return-to-work programmes to support disabled people and those with illness or other health-related problems back into employment.

Valuing ‘good’ work: why this focus?
Policy 1.2 focused on getting people into work; this policy is concerned with what work is like when you get there, and includes proposals intended to support people to remain in employment. It is clear that both people’s employment status and the nature of their work have a direct bearing on their physical and mental health. Factors shown to benefit workplace well-being include an environment that provides opportunities for participative decision-making, a positive reward structure for staff, and opportunities for training and progression.

There is a clear business case for healthy workplaces. Where employers introduce structures to enhance workplace well-being, potential benefits include reduced costs associated with an unhealthy workforce and an improvement in profitability for the organisation. For example, mental ill-health accounts for the loss of over 91 million working days each year in the UK, with half of all these attributed to anxiety and stress. The cost of sickness absence attributable to mental ill-health was estimated to be £4 billion annually in the UK in 2001. And the problem is not confined to absenteeism - the cost of reduced
performance at work due to depression is estimated to be five times larger than the cost associated with absenteeism\textsuperscript{63}.

Employers are becoming increasingly aware of the need to find ways to protect the health and well-being of all staff, to look after staff experiencing health difficulties, and to support people returning to work after illness. More generally, retaining and supporting people through common health complaints, injury or impairment is now seen as a more sensitive and cost-effective method of handling absence than dealing with the costs of redundancy and recruitment\textsuperscript{64}.

However, employees cannot benefit from these workplace well-being initiatives if they are facing discrimination and exclusion at work. A range of communities report this experience – people from some faith groups, minority ethnic communities, and those living with mental illness or HIV to name a few. Some employers report they find it a challenge to respond to some of the specific issues related to different employees, such as how best to deal with long-term health issues, how to recognise appropriate overseas qualifications, or how to deal with issues related to faith or culture. Despite this, there are exemplar employers in London that have implemented anti-discrimination policies and proactively promote their workplaces as inclusive, healthy, and positive in relation to diversity. The Mayor will continue to work to promote and disseminate such good practice, as well as challenging poorer practice.

**Policy statement 2.2: Progression and life-long learning**

The Mayor wants to extend opportunities for skill development and progression within and beyond the workplace, particularly for excluded groups.

**Proposed action**

The Mayor will:

- In his role as chair of the London Skills and Employment Board, work with employers in London to increase investment in training and the development of new skills in the workplace.
- Work with a range of partners to increase investment in ‘life skills’ training and to provide increased opportunities for life-long learning.

*Progression and life-long learning: why this focus?*

Londoners are generally better qualified than people in the rest of the UK, and London has a greater proportion of its workforce with the highest skills level, Level 5, than the rest of the UK. However, half of the London workforce has numeracy skills at the minimum level sought for 11 year olds (NVQ Level 1) or below, and 25 per cent have literacy skills at the same low level. A quarter of
the population are not qualified to Level 2 (the equivalent of at least five good GCSEs), and 14 per cent have no qualifications whatsoever. Cambridge Econometrics forecast an additional 290,000 high skill jobs between 2004 and 2014 in London, while jobs requiring levels 1 and 2 are set to decline. Skill issues cut across all the most disadvantaged groups in London, particularly those from minority ethnic groups, lone parents and those with disabilities.

Health problems, including depression and obesity, are more common in unskilled and low-income households. Further development of skills can have both a direct and indirect effect on health. Direct effects are brought about where people gain expertise and confidence in using information to help improve their health. Indirect effects are brought about where people use employment-related skills to improve their income and thus make a healthy lifestyle more affordable. One study suggests that moving 50 per cent of women currently without qualifications to Level 1 would have benefits of between £300 million and £1.9 billion per annum in terms of reduced obesity and depression.

‘Life skills’ assist individuals to deal with the challenges of everyday situations. This could include the development of communication skills, such as learning English as a second language, together with skills that allow people to live a healthy and productive life, such as decision making, understanding how to cope with anxiety and learning how to budget. Opportunities for life-long learning and the development of life skills can enable people to improve their self-esteem, be more active socially, and further develop decision-making skills. For example, many young Londoners draw on life skills to make informed choices around drug and alcohol use; while many older Londoners use opportunities for life-long learning to prevent or reduce their social isolation.

**Policy statement 2.3: Volunteering, caring and parenting**

The Mayor wants to improve recognition of a range of unpaid activities that contribute to London’s social and economic fabric, including volunteering, caring and parenting.

**Proposed action**

The Mayor will:

- Champion recognition of and rights for carers and parents, and promote access to practical and emotional support for people in these roles.
- Promote provision of and access to local volunteering schemes, particularly targeted at involving people from London’s most excluded communities.
- Continue to promote the benefits of volunteering, in particular through the 2012 Olympic and Paralympic volunteering programme.
Volunteering, caring and parenting: why this focus?

Work is broader than paid employment. Unpaid work, voluntary work, and work at home as parents and carers all underpin our economy and can give meaning to individual lives. In addition to the personal and social value, the financial value of unpaid work at home in the UK was estimated to be approximately £150 billion in 2002, the equivalent of an extra 15 per cent on gross domestic product (GDP) that year.

Four out of five carers are of working age; and three in five people will become carers at some point in their lives. Informal care is a vital part of the UK’s health and social care structure. However carers have not benefited sufficiently from London’s economic growth, and many find themselves in a caring role more from necessity than by choice. It is important that their work is recognised and that they are protected to avoid personal disadvantage as a consequence of their caring role. In particular, those carers also in paid work require flexibility from employers, as well as access to good support services, in order to remain in the workforce.

Meanwhile, volunteering contributes an estimated £36 billion of economic value every year, and VCS organisations contribute nearly £7 billion to GDP. Over and above this, there is a considerable amount of volunteering and ‘good neighbour’ involvement within more informal arrangements, such as those that occur within faith groups or through places of worship.

Volunteering benefits the individual volunteer, the organisation they support and the wider community.

There is good evidence that volunteering and participating in society more generally increase levels of health, well-being and social cohesion. Older people, for example, can benefit in terms of increased structure, direction and meaning to their life, a widening of their social networks, improvement of their vocational and interpersonal skills, and help in gaining access to employment, education and training. A number of volunteer programmes have been established to reduce the barriers for disabled people to volunteer. However, excluded groups are often not well represented in mainstream volunteering activities and are unaware of how to access these opportunities. Evidence has shown that there are weak links between minority ethnic community organisations in London and volunteer centres.
Employment: Focus on mental health

Employment can protect mental health by boosting confidence and self-esteem, but adults with long-term mental health problems have the lowest employment rate of any of the main groups of disabled people, with only 24 per cent in work in England overall. London has an even lower proportion of people with mental illness in employment than the England average.

Men and women who are unemployed have higher rates of mental health problems such as anxiety and depression than those in work. Unemployed men are more likely to experience substance misuse problems. People who are unemployed also have higher rates of physical health problems and premature mortality. Of all people coming onto incapacity benefits in London, 43 per cent have mental health problems as their main disability.

Whatever the relationship of cause and effect between depression and unemployment, mental health problems are clearly part of a cycle of exclusion, with withdrawal from society, loss of social networks, debt, and even homelessness, leading to worsening mental health. Prompt effective intervention in the early stages of depression is key to keeping people in work and low intensity interventions from primary care mental health workers may have long-term benefit in promoting a return to employment or other important social roles such as voluntary work.

However, in a 2001 survey, only 37 per cent of employers said they would be likely to employ someone with mental health problems, compared to 62 per cent who said they would be likely to take on someone with a physical disability. In the Social Exclusion Unit’s consultation on mental health and social exclusion, 83 per cent of respondents reported stigma and discrimination to be the main barrier.
Objective 3: To empower individuals and communities to take action to improve their health and well-being

Why this objective?
Empowerment is good for your health. People who do not have the opportunity to contribute to decisions and actions that affect their health are less likely to be well in the first place and, when ill, are likely to experience less benefit from treatment. Conversely, those who are able to participate in decision-making and action are more likely to experience good health.

At the community level, involvement in decision-making helps to build social cohesion, contributes to community safety, and increases levels of trust and tolerance between local people. Leading researchers argue that societies that enable citizens to play a full and useful role in social, economic and cultural life will be healthier than those where people face insecurity, exclusion and deprivation.

The Mayor believes that building ‘social capital’ of this kind presents a springboard for positive action to reduce health inequalities. Sometimes described as the ‘glue’ that holds societies together, social capital has been defined as ‘features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives.’ Research in this rapidly developing area of social policy indicates one key piece of learning for London: ‘healthy’ communities are characterised not only by close relationships between groups of residents of similar background, but also by acceptance of groups and individuals who live different kind of lives.

The Mayor is committed to fostering social capital in such a way that all Londoners are able to recognise and potentially build on the links among them. Increasing social networks also has the potential to increase awareness of healthy lifestyles, resulting in increased aspirations for health. To this end, the Mayor actively supported the LHC in its recent successful bid to the Big Lottery for the Well London programme that has secured £9.46 million to improve health and well-being through community-led action.

The Mayor recognises that the Voluntary and Community Sector (VCS) plays a key role in empowering individuals and communities by giving a voice to the many groups that make London such a diverse city. In November 2007, the Mayor re-stated his commitment to the London Compact, a framework set up by Government to improve the relationship and effectiveness of cross-sector working. The Compact sets out the principles by which regional bodies will work more closely with the VCS.

The Mayor also recognises and values the role of less formal community-led structures, faith groups, and community leaders. Voluntary and community
groups – within and beyond the VCS - play an important role in delivering a number of the Mayor’s strategies and initiatives, including the Older People’s Strategy and the Culture Strategy. In addition, they continue to have a significant impact on the priorities in emerging strategies, including this one and the Refugee Integration Strategy.

Policy statement 3.1: Individual action, community action
The Mayor wants to build the capacity and skills of individuals and communities to take control of their own health and play an active role in the health and well-being of others.

Proposed action
The Mayor will:

• Work with the NHS and other partners to increase the dissemination of health and well-being information, advice, support and skills in a wide range of settings with a focus on health issues of particular relevance to London
• Campaign for better support to parents and care-givers to develop their potential as health promoters within their families, schools and other community settings
• Promote training and qualifications in community development and participation, including incentives for colleges and training providers to offer qualifications for people who want to be more active in their community
• Champion the Well London programme and other key initiatives, and support the dissemination of good practice and effective learning.

Individual action, community action: why this focus?
Within London’s VCS, there is strong support for reducing health inequalities and a recognition that user involvement and community development are essential components of a successful approach to achieving this. During initial consultation for this draft strategy, the VCS stressed their experience that user involvement and community development can empower individuals and communities, improve service delivery and reduce social exclusion. Voluntary and community organisations believe they should play a central role in this work as they have the trust of their communities and can advocate for them.

The Mayor is committed to working with a range of agencies, including the VCS, education and skills providers, and health and social care organisations, to build capacity within London’s communities to take control of their own health and support the health of others. In particular, he is concerned to increase opportunities for individuals to develop skills and share learning in community
development and participation. Such learning would lead to greater engagement in decision-making that affects health and well-being.

**Policy statement 3.2: Culture and health**
The Mayor believes cultural activities offer a powerful route to health and social inclusion and an approach to tackling health and other inequalities.

**Proposed action**
The Mayor will:

- Support increased access to a range of cultural events and activities that are designed and managed by local people.
- Broker agreement with schools, health and other community facilities for free use of facilities for cultural activities that encourage the broadest local participation.
- Promote the benefits of sport and physical activity and work with partners to increase levels of participation across London.
- Support the use of the arts and media to challenge stereotypes and perceptions and generate debate about health and exclusion issues.

**Culture and health: why this focus?**
Cultural activity includes a wide array of pursuits associated with the arts, sport and heritage. It contributes to the overall well-being of the community, whether through small-scale informal activities or major public events. The positive health impacts of sport and physical activity are widely recognised. The broader benefits of a wide range of cultural activities are also significant. These activities contribute to the development and maintenance of social capital, offering shared experiences either through direct participation or through attending events and supporting others.

The Mayor’s Cultural Strategy outlines a range of ways in which decision makers can draw on culture to help tackle social exclusion and improve the health of Londoners. Culture also offers an effective means of supporting intergenerational and intercultural contact, increasing community cohesion and reducing concerns about community safety. At whatever level it takes place, cultural activity tends to draw those involved into reflection, debate and discussion. New perspectives on social and community issues emerge, with accompanying possibilities for fresh insight and action.

The scope of culture and cultural activities can also extend to challenging stereotypes and perceptions. In 2006 the Arts Council launched the ‘arts debate’ a large-scale programme of research and consultation about the value of the arts. A substantial number of respondents identified that one of the most
valuable characteristics of the arts is their ability to challenge people, question assumptions and undermine stereotypes. Respondents valued the arts as a means of reaching out to the socially excluded and in tackling difficult social problems such as drug misuse, crime and teenage pregnancy75.

Culture Northwest’s Think Tank ‘Britain Over 50’ is an example of the above, organised by the Northwest Culture Observatory to challenge the stereotypes of older people as a drain on society. It identified that the cultural sector can lead work in this area by ‘speaking differently’ and using positive language to move beyond the headlines to ‘humanise the debate’76.

Objective 5 outlines the potential benefits of making further, imaginative use of London’s local streets and public spaces.

Policy statement 3.3: the Voluntary and Community Sector (VCS)
The Mayor believes the Voluntary and Community Sector (VCS) has a vital part to play in tackling health inequalities in London.

Proposed action
The Mayor will:
• Use his profile and leadership to support the role of the VCS in reducing health inequalities, and promote the need for the sector to be properly funded and resourced.
• Urge main public sector commissioners of services to involve VCS organisations in the design and delivery of services and support communities in providing services where appropriate.

The voluntary and community sector: why this focus?
The VCS delivers services and activities ranging from health promotion initiatives to support and advice for a range of communities. The organisations and groups vary in size from those run by one or two people to charities employing large numbers of staff. As well as delivering services they also play an important part in giving a voice to individuals and communities that make London such a diverse city.

In London, the VCS employs over 249,304 people, 6.4 per cent of London’s working population – and 38 per cent of the total charity employees in England and Wales. It is estimated that 11,783 charities work with children and young people; 6,012 with older people and 3,940 with disabled people. The significance of their work on health inequalities extends beyond working with particular groups. Six thousand one-hundred and thirty charities work on culture and leisure activities; 7,185 on economic well-being; 12,934 on
education and lifelong learning; 2,250 on environment; 6,289 on health and well-being; and 1,704 on housing”.

**Policy statement 3.4: Active citizens**
The Mayor wants to build the capacity of public services to actively involve communities and individuals.

**Proposed action**
The Mayor will:
- Continue to develop and promote exemplar models for involving individuals and communities.
- Urge the NHS, local Government and the police service to share and adopt identified good practice on effective approaches to involving communities.
- Establish a Mayoral awards scheme that recognises public sector organisations which demonstrate excellence in involving local communities and individuals.

**Active citizenship: why this focus?**
The Mayor believes that all Londoners should be able to participate in action and decision making that affects their mental and physical well-being. At present, the processes by which decisions are made by, and for, public services can exclude some groups. Sharing and adopting good practice on involving communities, such as by involving the VCS in decisions about commissioning, would be an effective means of ensuring services reach those at most risk of social and economic exclusion.

The Mayor has established relationships with some of London’s most excluded groups. This has been through regional partnerships, such as the LHC and the Greater London Alcohol and Drugs Alliance, and through groups supported by the Mayor to facilitate engagement with wider communities, including the London Older People’s Strategy Group, Mayor’s Refugee Advisory Group and the Young Londoners Network. He also works closely with regional bodies responsible for the delivery of a range of public services. Therefore he is well-placed to support public services in developing the appropriate policy frameworks, skills and competence to involve people in a meaningful way.
Participation: Focus on mental health

Mental health improvement is an essential part of addressing health and social inequalities. The National Service Framework for mental health calls on health and social care to promote mental health for all, working with individuals and communities to combat discrimination against individuals and groups with mental health problems and promote their social inclusion.

Employers, communities, voluntary sector agencies and individuals all have a role to play in supporting the development of services, promoting mental health and well-being, supporting individuals who are experiencing mental health problems, and working together in preventing vulnerable people from harming either themselves or other members of the community.

Participation in work, education, cultural activities, neighbourhood initiatives all increase social capital and promote well-being. Simply knowing your neighbours and feeling part of the local community in some way can reduce isolation. Participation and involvement at all these levels can make a real contribution to individual’s mental health.
Objective 4: To improve the health and promote social inclusion of people living with illness or impairment

Why this objective?
Public services have a vital part to play in improving individuals’ health and wellbeing, promoting independence and aiding recovery from injury and illness. Health and social care services are obviously essential but other services, such as transport, housing, leisure facilities and libraries, also play a key part in supporting people to stay well and cope with or recover from illness.

In London, unequal experiences of ill health are compounded by inequalities in access to services. Levels of funding and service provision vary across London boroughs and Primary Care Trusts, as do eligibility criteria and charging policies for some services. As a result access to public services can be dependent on where people live rather than on their needs. In addition, those Londoners who are most vulnerable, and most in need of health or social care services, may be least likely to know how to access services and what their rights to them are.

Many communities report that when they try to access public services, they experience a range of physical, practical, or attitudinal barriers. Furthermore they report that some services are of poor quality and do not meet the specific needs of London’s diverse communities. This is a particular issue in relation to the provision of more personal services, such as health and social care, where sensitivity to cultural issues and individual needs are critical if services are to be acceptable and effective.

The Mayor believes that London’s health services should be world-class. As well as aiming for excellence, the capital’s health services must also make a substantial contribution to reducing health inequalities. In particular, sustained effort is required to address the ‘inverse care law’ where NHS resources have historically been disproportionately distributed resulting in some areas of highest health need receiving the lowest relative level of NHS spend.


There is a range of existing Mayoral Strategies that are relevant to improvements in health and social care services. These include the London Plan,
the Older People’s Strategy and the Refugee Integration Strategy. This strategy builds on polices and proposals in those strategies that are relevant to reducing health inequalities.

**Policy statement 4.1: Equitable and accessible public services**

The Mayor wants to see equitable provision of world-class health, social care and other public services, with improved local access to responsive, appropriate and co-ordinated services planned around individual need.

**Proposed action**

The Mayor will:

- Challenge the NHS in London to make a more equitable allocation of resources and facilities.
- Lobby Government for more adequate social care funding for London and a national framework setting out social care entitlement.
- Require/influence public services to monitor, evaluate and demonstrate how they are meeting the needs of their populations, particularly more vulnerable groups.
- Ensure better collaboration between TfL and the NHS to plan locations of new health services and transport links, and to improve physical access to existing NHS sites while also supporting shifts in modes of travel.
- Work with public services to improve and promote the accessibility of their provision, including provision of high quality language support.

**Equitable and accessible public services: why this focus?**

Evidence shows that the provision of healthcare services is subject to significant geographical variations across London. Map 5 shows the provision of full time equivalent GPs per 1000 age-need weighted population in 2004. It shows that an inverse relationship exists between local health need and resource distribution (insert an example of the inverse care law). The proportion of GPs per 1000 population (weighted for age and need) is significantly lower in the more deprived areas of north and east London.
Geographical variations in provision of services are accompanied by variations in the quality of care. The Quality and Outcomes Framework (QOF) measures the quality of care provided by GP practices. For coronary heart disease, the Primary Care Trusts (PCTs) with the highest average QOF scores amongst their practices are those in the south and west of London. This means a patient with coronary heart disease in Richmond is likely to get better care than one in Newham.

Furthermore, some vulnerable individuals and communities face additional barriers in accessing healthcare services. For minority ethnic groups and some recent migrants, cultural differences and communication barriers can make interactions with health and social care services difficult and sometimes offensive. Issues related to concepts of ‘normality’ can add to the negative experience of lesbian, gay, bisexual and transgender people and deaf and disabled people. The lack of timely access to language support is a significant barrier for people who do not have English as a first or preferred language, including British Sign Language (BSL) users. Difficulties in arranging for appropriate support such as interpreters or advocates can lead to lengthy delays in care, with consequent negative effects on outcomes.
Similar barriers associated with a lack of knowledge about rights and limited provision of appropriate services also affect homeless people. Other factors such as opening times, appointment procedures, location and discrimination also negatively influence access levels among homeless people and other high need groups such as drug and alcohol users and sex workers. Research by Kensington and Chelsea PCT found that the local areas with the greatest health need have the shortest GP opening hours, and offer the poorest extended hours service.79

More formal barriers such as legislation limit access to services for people recently arrived in London, particularly asylum seekers. A survey of asylum seekers in London found that 95 per cent of respondents had been refused GP registration at least once in the preceding 12 months.80 This issue is exacerbated by a lack of knowledge on the part of both service providers and service users about legal entitlements to public services.

There are also wide-ranging and significant inequalities in access to social care in London. The term ‘social care’ refers to a variety of services, mostly provided and funded by local authorities, but some provided by VCS organisations and funded through other sources. It includes a range of services provided to individuals in their own homes – personal care, help with domestic tasks, provision of meals and so on – and services provided in the community such as day centres.

There are concerns that there has been a lack of Government focus on reforming social care and that these services have not received adequate increases in funding. There are specific concerns that central Government funding is failing to keep pace with the demands of an ageing population. As a result of this several London boroughs have recently taken steps to ration certain social care services leading to the possible exclusion of many vulnerable people.81

Local authorities are increasingly applying higher charges for the provision of some social care services. This raises an additional barrier to many individuals and families and in some cases prevents them from accessing the support they need to remain independent.

In a Disability Agenda survey, nine out of ten members of the public said it was important that social care support enabled people to stay at home. Hospice user groups report that a lack of social care provision prevents many people from returning home for end of life care. However, the complexity of the social care system and the range of different eligibility thresholds across London mean that some people are unable to navigate the system to access the services they need. In addition, some community groups experience a lack of flexibility and responsiveness of social care services, for example some minority ethnic
communities find that the current design of services does not meet their cultural expectations and requirements.

Other public services such as leisure and recreation also play an important role in supporting Londoners’ health and well-being. The importance of equitable access to a full range of services to enhance well-being and promote social inclusion is a recurrent theme in the GLA’s work with a range of communities. For example, refugee groups cite libraries as one of the public services that actively support their integration to London, and older people report the importance of a wide variety of local community services and facilities to maintaining their independence.

The contribution already being made by services and facilities of this kind – and the potential contribution that could be made to reducing health inequalities – needs to be explored further and maximised. For example, there are some interesting “bibliotherapy” initiatives using libraries to enable individuals to access self-help advice about managing illness, and other schemes that combine the provision of English Speakers of Other Languages (ESOL) training with the provision of health information and advice. In addition, there are schemes to facilitate access to local leisure services and to support people to take up walking or other activities to support their recovery from physical or mental ill-health.

Public transport makes a critical contribution to ensuring services are accessible and co-ordinated planning of transport routes and interchanges with decisions about locations of public services is essential. Furthermore efforts are needed to enhance access to health services for particularly vulnerable groups through improvements to dedicated services such as dial-a-ride schemes.
Rights to health and social care: why this focus?
The Mayor believes all Londoners are entitled to both improved access to health and social care services and more choice in terms of what kind of care is available to them and who provides it. He considers access to healthcare to be a right for all Londoners from the day of arrival and is concerned about the exclusion of some people, for example asylum seekers, from some health services. Lack of access to primary health care and advice and preventative services have a significant negative impact both on individuals and their families and on broader public health.

Individuals need to be informed and enable to take advantage of the full range of choices available to them. Clear routes to information and advice about services, as well as access to the services themselves, are particularly challenging in London where the population is so mobile. Community groups highlight a
widespread need for accessible service-related information and advice in a form that links in with other aspects of people’s lives and enables them to further develop their knowledge, confidence and skills regarding their health and well-being.

One opportunity to proactively provide information is when people arrive in London as refugees, students, or migrants from elsewhere in the UK or from other countries. This is particularly important for people who are vulnerable or already experiencing problems when they arrive, such as asylum seekers, or young people fleeing problems at home.

Further opportunities to provide co-ordinated, rights-based information arise at a range of key points of transition in people’s lives such as becoming a parent or carer, losing a job, getting a home, or leaving prison or rehabilitation. At these points, many people are in contact with at least one public service, and could be provided with more comprehensive information about the range of other services which they are entitled to this could actively support their health and well-being.

In addition, people need to know what they can expect from services and how to challenge decisions if they are denied access to public services, or what to do if the quality of services is unacceptable. VCS organisations and some faith groups currently play a vital role in providing advice, support and advocacy for individuals facing these situations, and their role in facilitating access to services should be more fully recognised.

Finally, those providing services need to be trained and supported to recognise service users’ rights and needs and to facilitate access to relevant services. Many already marginalised groups, such as homeless people or those living with mental illness, report that they feel further excluded by initial responses when trying to access primary health care and other services. Similarly, some people are discouraged from accessing services by their concerns about confidentiality and the need to disclose personal information, such as HIV status or problem drug use.

Work on all of these issues could be enhanced by public awareness campaigns that provide accurate information about health issues and challenges in London and what can be done to promote health and well-being.
Preparatory work for this strategy has emphasised the importance of strengthening commissioning processes in order to ensure appropriate access to services, improve overall quality of services, and redistribute resources to prevent further disadvantage and promote the health of excluded communities and groups.

Evidence from a range of sources demonstrates that commissioning is currently variable across London, resulting in inequitable access to services. For example, services to homeless people, ex-offenders, people with alcohol-related problems, mental illness, sexual health issues or HIV vary considerably depending on which Primary Care Trust or borough people live in. The Mayor believes that this “postcode lottery” is unacceptable and service provision decisions should be based on assessment of needs and risk, not on the basis of where people live.

In discussing access to services with the GLA, many VCS groups and service providers make a compelling case for more pan-London commissioning to meet the needs of very excluded groups and those with particularly complex needs. In some cases joint commissioning might be most effective across a cluster of PCTs and boroughs, rather than across London as a whole, but the need for more coordinated commissioning is clear. Some stakeholders also advocate more flexible approaches to determining eligibility for services to better recognise the particular needs of very mobile groups, including those having to relocate.

**Policy statement 4.3: Commissioning health and social care**

The Mayor wants to see improvements in the commissioning of health and social care across London and improvements in the quality of services available to all Londoners.

**Proposed action**

The Mayor will:

- Expect increased pan-London commissioning and cross-Primary Care Trust work to improve services to the most disadvantaged groups and Londoners living with complex needs.
- Explore the development of pan-London NHS registration and other schemes to increase the access of highly mobile and excluded groups to health services.
- Support commissioners to work with an increasingly diverse range of providers, including VCS organisations, and to work together with them to drive up the quality of service.
- Lobby for increased investment in preventative and health-promoting activities, and ensure that public health campaigns target and actively engage the most disadvantaged groups of Londoners.
- Encourage greater user-involvement in influencing commissioning and in scrutinising the accessibility and quality of local service.
because of insecure housing, or those excluded because of complex issues such as drug misuse.

One positive aspect of the diversity of local service provision is that there has been a great deal of innovation in the design and delivery of different services across London. The next stage of developing this strategy will include more work to identify and highlight what seems to be working to provide good services to excluded groups.

The need to further invest in developing commissioners’ skills has been recognised by the NHS and local government. Evidence from various stakeholders emphasises the need to support commissioners to work collaboratively with community groups to more comprehensively assess local needs, for example through Joint Strategic Needs Assessments, as the basis for sound commissioning decisions. In addition, it is important that commissioners are more actively encouraged to recognise the value of a more diverse range of service responses.

A theme related to improving commissioning practice is the need for wider and better collaboration on decision-making and service evaluation. Ongoing changes to patient involvement structures in the health service have destabilised some public involvement structures and led to a loss of continuity and expertise. There is a need to invest in building skills, capacity and good-will for increased public engagement in Local Involvement networks and local Overview and Scrutiny Committees, among other structures. Many stakeholders also argue for better collaboration between service commissioners and providers so there is more focus on shared evaluation and learning, rather than only concentrating on contractual arrangements.

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Policy statement 4.4: Providers of health and social care

The Mayor wants to see increased diversity in the health and social care workforce, and further development of the ability of all providers to competently meet diverse community needs.

Proposed action

The Mayor will:

- Work with a range of others to encourage young Londoners from diverse backgrounds into NHS and social care careers.
- Work with the NHS and others to support refugee and migrant professionals in gaining work in the NHS by removing barriers, including simplifying qualification conversion, and by offering language training and other support.
- Encourage provision of increased training and support to equip front-line staff and service providers to recognise and better meet the needs of London’s diverse communities.
Providers of health and social care: why this focus?

There is a need for the staff profiles in mainstream public services to become more representative of the communities they serve. All communities in London include people from minority ethnic groups, disabled people, LGBT people, older people and so on. All of these people are service users or patients at some point in their lives, as well as being potential employees for health and social care services.

Service providers that are representative of the local community can be particularly effective in contributing to the delivery of high quality culturally appropriate services. Patients and service users gain from coming into contact with members of their own community both as providers of services and as potential role models working in health and social care. More generally, models of community-led service provision should be encouraged.

There is a need for more proactive work to encourage members of London’s diverse communities to consider health and social care careers. For example, there is a need for outreach work to young people from minority ethnic groups, and for increased offers of work experience or apprenticeships to facilitate entry to health services for communities who have historically been under-represented. Similarly the diversity of the workforce could be enhanced by increased recognition of transferable skills, including those acquired in informal carer roles, and more streamlined processes for recognising relevant overseas qualifications from migrants including refugees.

Delivering the policies and priorities set out in Objectives 1 and 2 in this draft strategy is of crucial importance to support both the recruitment and retention of staff in health and social care jobs. These roles tend to be undervalued, particularly social care, and active work to recognise the contribution of the health and care workforce is vital, as are initiatives to support the progression and well-being of people in these roles.
Accessible and equitable services: Focus on mental health

London’s unique characteristics mean that mental health needs in the capital differ from those in other regions. London has higher rates of more common mental health problems and severe mental illness than the national average, according to ‘needs indicators’. The capital has high levels of homelessness and single-person households, both of which are associated with higher levels of mental illness. Also, London has a large refugee population and self-reported mental health problems are around five times higher among refugees than in the general population. The British Medical Association (BMA) found that two-thirds of refugees had experienced significant anxiety or depression.

People with serious mental health problems are more likely than others to experience medical conditions such as strokes, coronary heart disease or respiratory disease before the age of 55. They die on average 10 years younger than other people as a result of physical ill health. In addition, there is evidence that people with severe mental illness are more likely to have less knowledge of HIV and to engage in unprotected sex.

The high demand for mental health services in London appears to be matched with by levels of provision, much of which is better than average and is innovative compared with other regions. For example, London has significantly higher numbers of people receiving care through assertive outreach and crisis resolution services and has many more fully integrated community mental health teams compared to the national average. London has significantly higher rates of GP-registered patients identified as having severe mental illness and who are receiving follow-up GP care. However, we do not know the true extent of the population with mental health problems who are without the appropriate treatment or support they require.

People with mental illness from minority ethnic communities in London face a number of particular challenges and barriers in accessing appropriate services. Some individuals are more likely than the average population to be treated in inpatient and forensic psychiatric services, and black people are less likely to be offered ‘talking therapies’ than the white population. Individuals from minority ethnic groups can find mental health services difficult to access because of language problems or cultural issues. To date London is not doing well on the provision of community development workers, who are central to the ‘Delivering Race Equality in Mental Health’ action plan, which aims to reduce inequalities in access to, and experiences of, mental health care for minority ethnic groups.
Objective 5: To develop and promote London as a healthy place for all – from neighbourhoods to the city as a whole

Why this objective?

Londoners’ chances of living a long and healthy life differ according to where they live. There is a difference of almost seven years between London boroughs with the highest and lowest life expectancy. While these differences are partly the result of socio-economic factors, they also indicate that certain places in London are more conducive to good health than others. The quality of housing and the physical layout of neighbourhoods, their transport links and the services on offer, are highly relevant to health. Factors such as the availability of affordable, healthy food, opportunities for physical activity, and the extent to which the design of public space reduces actual and perceived risks of crime are particularly important.

Local environmental quality also has significant impacts on health. Poor air quality is linked with respiratory and cardiovascular disease, particularly affecting children and young people, while the provision of high quality, well-maintained open space has been shown to have positive effects on both physical and mental health. There are strong links between environmental quality and deprivation. Many areas with poor air quality, high levels of noise and deficiencies in quality green space tend to also have high levels of deprivation.

At the national level, a range of policies and programmes aim to improve the physical environments in which people live, especially in the most deprived areas. A recent study of the impact of 25 years of regeneration work on 20 of the most deprived housing estates in the UK has shown that with sustained investment and long-term co-ordinated action across public agencies it is possible to turn around very deprived areas, though achieving this positive change is not easy.

The Mayor has significant powers in the planning and management of London’s urban environment. His strategies on planning and development, transport, air quality, waste, noise and biodiversity together with forthcoming strategies on housing, water, climate change adaptation and mitigation and energy contain a huge number of policies and proposals that are relevant to health and are already making a difference to the health of Londoners. This strategy will not re-state all of these policies but will focus on the opportunities within these areas to address health inequalities.
Policy statement 5.1: Planning a healthy city

In line with his London Plan policies, and using the spatial planning system, the Mayor will ensure that new developments are designed and constructed in ways that improve health and reduce health inequalities.

Proposed action

The Mayor will:

- Ensure that all major planning applications and Local Development Frameworks take full account of the need to provide more good quality affordable housing, and seek to optimise positive impacts on physical and mental health.
- Further develop social infrastructure planning models to ensure that new developments make a proper contribution to the provision of health-related services.
- Ensure that new residential developments have accessible transport links, including high quality walking and cycling opportunities.
- Ensure the regeneration opportunities associated with the 2012 Olympic and Paralympic Games support the delivery of improved infrastructure for sport and physical activity across London.

Planning a healthy city: why this focus?

Planning has the potential to affect health on a number of levels. Well-planned neighbourhoods are safe and attractive. They can create opportunities for employment and economic development, ensure equitable access to green spaces and leisure facilities, enable safe and sustainable transport systems and provide good access to an array of local services.

The Mayor’s overarching strategy, the London Plan, includes policies on all aspects of spatial development, from housing to transport to design of urban space, all of which are relevant to health and health inequalities. The Plan also contains specific policies to help integrate planning and health issues in new developments and states that boroughs should ensure that major new developments promote public health. The Best Practice Guidance (BPG) on Health Issues in Planning provides additional guidance on these topics. In addition, the Further Alterations to the London Plan include policies to address health inequalities and the determinants of health.

The shortage of affordable housing is a major problem for many Londoners and a driver for new development. There are almost 60,000 homeless households living in temporary accommodation in London. For this reason the Mayor’s draft housing strategy focuses on the provision of affordable family housing and delivering more housing is a major priority for the Mayor. Currently housing developers have to consider health in their analyses of factors such as noise.
levels, air quality, access to transport and green space. These analyses provide good information about general health impacts but are sometimes less robust in their consideration of potential impacts on health inequalities. This could mean that more vulnerable residents of new developments end up exposed to more negative environmental factors.

Planners and developers also face significant challenges in meeting the need for new housing, while ensuring that the necessary social infrastructure is in place. Social infrastructure refers to the services and facilities that are required by people living in a local area. It includes transport, schools, community centres and places of worship, health and social care services, retail outlets and leisure facilities such as parks and sports centres. Ease of access to this infrastructure is essential for health. Social infrastructure planning models will help planners to consider deficits and surpluses in current provision, and to develop custom-built solutions that have considerable potential to reduce health inequalities.

Transport services are a particularly important aspect of social infrastructure. Lack of access to public transport is most often an issue for women, children, disabled people, people from minority ethnic groups, older people and people living on low incomes. Transport systems that enable low-cost active travel such as walking and cycling can benefit health directly by increasing physical activity levels, particularly among low-income groups.

Similarly the availability of affordable fresh food at local shops and restaurants makes it easier for local people to choose healthy diets. The availability of fresh food varies across London, and tends to be lower in areas of high deprivation, where there is a proliferation of fast food shops and restaurants. The Mayor’s Food Strategy provides the framework to take forward work to increase availability of affordable, fresh and healthy food in deprived areas of London. Options for improving the availability of fresh food include supporting shops, supermarkets and restaurants that provide healthy food options, and improving access to allotments amongst those groups that currently have low levels of use.

In addition to ensuring that the right issues are considered in the planning of new developments, planning for the regeneration of existing areas that have poor levels of health is very important for reducing health inequalities. In particular, the regeneration of East London in preparation for the 2012 Olympic and Paralympic Games offers an unprecedented opportunity to secure lasting environmental, economic, health and social benefits to the lives and opportunities of local communities and the rest of the capital, as well as those of future generations. The Olympic sporting facilities are being constructed in an area of London that suffers from some of the highest levels of deprivation and some of the poorest health outcomes in the country. The whole project will deliver increased levels of affordable housing, a variety of employment and skills

“There is no local supermarket in Shoreditch, but we have worked with local shops to stock certain foods used in the healthy eating sessions.”

The Shoreditch Trust (a charitable regeneration agency)
opportunities, and new facilities for the benefit of local communities. The Olympics must deliver a significant ‘health legacy’ through reductions in poverty, improved local environments and increases in Londoners’ levels of physical activity.

Despite this huge opportunity, previous Olympic games have not been particularly successful in increasing levels of physical activity. Part of the challenge of the health legacy for 2012 will be to ensure that the Games delivers sustainable sporting opportunities across all parts of London, and encourages increased physical activity amongst all Londoners, including deprived groups and disabled people.

The Mayor has made increasing the number of Londoners getting involved in sport the first of his five ‘legacy commitments’ for 2012. Action has already begun. For example, 60,000 Londoners took part in the ‘Summer of Sport 2007’, while the ‘Inclusive and Active’ plan will increase the number of disabled people involved in sport by 45,000 between now and 2012.

Policy statement 5.2: Improving London’s physical environment
The Mayor will bring forwards physical improvements in areas of London that are deprived, physically run-down and not conducive to good health.

Proposed action
The Mayor will:

- Improve the quality of open spaces (including natural green spaces) and support the involvement of diverse local communities in their planning, design and management.
- Continue to invest in initiatives to improve air quality, and reduce the impact of air pollution on health, focussing on sustainable modes of transport and exposure to air pollution.
- Work in partnership with a range of organisations to raise awareness about, and address, environmental equity issues in London.
- Ensure that decisions and activities across the GLA group are aligned to improve health in the areas of London that currently have the poorest levels of health.

Improving London’s physical environment: why this focus?
London’s physical environment is characterised by a wide array of open spaces. These include green spaces, such as parks, allotments, commons, woodlands, natural habitats, recreation grounds, playing fields, agricultural land, burial grounds, amenity space, children’s play areas, including hard surfaced playgrounds, and accessible countryside in the urban fringe. Civic spaces, such
as squares, piazzas and market squares also form part of the open space network\textsuperscript{88}.

London’s public realm provides space for social and cultural gatherings and events, physical activity, and for moments of tranquillity. All of these factors have positive impacts on mental and physical health. International studies have found that people are more likely to engage in frequent physical activity in locations that have high quality green space. \textsuperscript{89} Evidence shows that levels of physical activity vary significantly across London, as illustrated by Map 6 below.

**Map 6  London Region Participation Estimates by Middle Super Output Area**\textsuperscript{90}

Participation is defined as the percent of the adult population participating in at least 30 minutes of sport and active recreation (including recreational walking and cycling) of at least moderate intensity on at least 3 days a week.


Research has also found that the likelihood of positive health effects increases with increasing ease of access to open spaces (both in terms of distance and presence of barriers such as large highways) attractiveness and size. There are many areas of London where open spaces are poor quality due to negative factors such as littering, fly-tipping, graffiti, and the presence of derelict land or buildings. There are also a considerable number of areas that are deficient in open space and ‘access to nature’. The Mayor defines areas as ‘deficient’ if residents are more than one-kilometre actual walking distance from access to wildlife sites\textsuperscript{91}.
Air quality is another factor that has significant impacts on the health of Londoners and varies across different parts of the city. In 2005 it was predicted that particulate (PM10) pollution in London caused 1,031 premature deaths and another 1,088 hospital admissions. Poor air quality particularly affects the most vulnerable in society, the very young, older people and those with existing cardiovascular and respiratory conditions. Air quality can also indirectly affect the health of people in vulnerable groups because perceptions about low air quality can lead them to spend less time outdoors. Not only are people in these groups more vulnerable to the effects of poor air quality, they are also more likely to be exposed to it. Deprived communities are often located in areas of below average air quality such as near to major roads.

Road transport is a major source of pollutant emissions in London. In 2003, road transport emissions were responsible for 41 per cent of nitrogen oxide and 67 per cent of PM10 emissions. Freight vehicles and personal transport vehicles such as cars and taxis were responsible for a significant proportion of these emissions. A number of Mayoral initiatives seek to reduce the impacts of transport on air quality. A London-wide Low Emission Zone (LEZ) will be in force from February 2008. The LEZ will help to improve air quality by charging the drivers of the most polluting vehicles for driving in the city.

Further, Transport for London (TfL) is working to increase the levels of sustainable forms of transport such as walking and cycling. This work can improve air quality while also providing low-cost opportunities for physical activity. Since TfL was formed in 2000, there has been a five per cent shift away from car usage and an 83 per cent increase in cycling levels on red routes. There are now an estimated 480,000 cycle journeys across London every day.

Reduced vehicle traffic and increased walking and cycling would also reduce noise levels across London, especially around major roads. Noise can have negative impacts on mental and physical health, disrupt sleep patterns, cause stress, and at very high levels, lead to hearing loss. Analysis of the London Road Traffic Noise Map produced for the Department for Environment, Food and Rural Affairs (Defra) indicated that people living in social rented homes, flats and apartments were more likely to live in noisier areas and less likely to live in quieter ones.

Geographical analysis of access to open space and nature sites, air quality and noise show that residents of certain areas of London are exposed to multiple environmental factors that are not conducive to good health. Many of these areas are in inner London boroughs that have high levels of deprivation. Across the GLA group there is an opportunity to further align Mayoral programmes spanning planning, housing, transport, skills and economic development, to achieve positive change in those areas that are currently not conducive to good health and have the worst health outcomes.
Safe and accessible London: why this focus?
Fears around crime and community safety can make people reluctant to interact with other members of their local community, to walk, use public transport, or go out after dark. Victims of crime often suffer severe psychological distress, which can subsequently lead to mental health problems. The design and maintenance of public spaces and transport routes has the potential to reduce perceived and actual risks of crime.

The Metropolitan Police’s Safer Neighbourhoods scheme is designed to cut crime and make communities feel more secure, by giving a neighbourhood its own dedicated team of six officers. The Safer Neighbourhoods teams are supported by 21 borough-based Safer Transport teams, a joint project between the MPS and Transport for London delivered in partnership with British Transport Police (BTP). Visible policing, promoting safety, and addressing anti-social behaviour are key components of Safer Neighbourhoods. Recent surveys have shown that local communities who have benefited from the work of these teams feel safer when walking alone at night, are less fearful of crime and more likely to feel that anti-social behaviour and crime levels have improved.

The poor quality and lack of accessibility of open spaces described under the previous policy objective presents particular barriers to certain groups of Londoners, such as older people and children and young people, who are less likely to travel large distances from their homes for recreational purposes, and disabled people who have particular access requirements. For children and young people, being able to play within their local neighbourhoods and have
safe and attractive play spaces within walking distance of their homes is essential for their healthy development and well-being. The Mayor has developed a practical toolkit to assist boroughs in providing local children with high quality, free play opportunities, and he has also developed Supplementary Planning Guidance on the use of benchmark standards in the preparation of Play Strategies. Further targeting of those groups least likely to use their local open spaces has the potential to significantly reduce health inequalities.

As stated under the previous objective, roads can act as a barrier to the use of public spaces. One reason for this is fears about road safety. The victims of road traffic accidents come overwhelmingly from the more disadvantaged areas of London. Adult and child pedestrians in the most deprived areas of London are 2.5 times more likely to be killed or seriously injured in a road traffic accident than their counterparts in the least deprived areas. The Mayor’s Transport Strategy aims to reduce road traffic danger principally by reducing traffic volumes and vehicle speeds. The Accidental Injury Task Force identified a number of interventions that are likely to have the biggest impact on unintentional injury in the short-term. For road accidents these were: 20 mph speed limits in areas of higher pedestrian activity; local child pedestrian training schemes and safe travel plans; systematic road safety intervention in inner city areas; and advice and assessment programmes for elderly car drivers.

“We should be thinking about roads which are for walking and cycling not just lanes and really tackling London’s obesogenic environment. The Mayor should be bold in creating more incentives not to drive and providing alternative forms of transport.”

Tower Hamlets Primary Care Trust and the London Borough of Tower Hamlets

Policy statement 5.4: Sustainable approaches to health and the environment
The Mayor will make more explicit links between long-term planning on actions related to the environment and actions to improve health and well-being, prioritising climate change adaptation and mitigation.

Proposed action
The Mayor will:
- Lead the planning of ‘exemplar developments’ that are sustainable, energy efficient and address issues leading to health inequalities.
- Champion integrated approaches to addressing fuel poverty focussing on housing quality and energy efficiency.
- Raise awareness about the health impacts of unavoidable climate change – focusing on the impacts of heat and flooding on vulnerable groups.

Sustainable approaches to health and the environment: why this focus?
The Mayor has made tackling climate change central to his administration. In particular he has led the development of a wide range of initiatives to reduce London’s carbon dioxide emissions. There is significant potential for work in this area to also reduce health inequalities.
The potential health impacts of a shift to more sustainable forms of transport were discussed earlier in this chapter. Initiatives to improve the energy efficiency and reduce greenhouse gas emissions from existing housing stock also offer opportunities to reduce the negative health impacts of poor quality housing and fuel poverty.

Local authorities are required to ensure all social rented housing and 70 per cent of vulnerable households in the private sector meet the Decent Homes Standard, meaning that they must be warm, have reasonably modern facilities, meet the minimum statutory standard for fitness, and be in a reasonable state of repair\textsuperscript{100}. Recent figures indicate that 38 per cent of London’s local authority homes do not yet meet the Decent Homes Standard. The proportion of unfit homes is particularly high in some inner London boroughs\textsuperscript{101}. The impacts of poor quality housing are often exacerbated by fuel poverty – the inability of a household to keep their home warm at acceptable cost\textsuperscript{112}. Approximately 360,000 London households were affected by fuel poverty in 2007\textsuperscript{113}. Causes of fuel poverty include low income, high-energy prices and low energy efficiency standards of dwellings.

The health consequences of poor quality housing and fuel poverty can be severe. Low indoor temperatures, damp, mould and poor maintenance are linked to a variety of physical and mental illnesses including respiratory conditions, anxiety, depression and in extreme cases hypothermia. Vulnerable groups such as homeless people, Gypsies and Travellers, asylum seekers and people with mental health problems are more likely to reside in low-standard accommodation. Fuel poverty has been associated with a significant number of avoidable winter deaths, particularly among older people\textsuperscript{114}.

There are a number of programmes across London such as the London Warm Zone and the Mayor’s Green Homes Programme that aim to increase thermal efficiency of housing by improving insulation and heating systems and providing advice about energy savings measures\textsuperscript{102,103}. The Mayor intends to increase public awareness that many of these actions designed to mitigate against climate change also have potential to offer significant health benefits, particularly for people who currently do not have good health.

Conversely, unavoidable climate change has the potential to increase health inequalities, particularly as a result of heat, extreme weather events and flooding. It is clear that these changes will have differential impacts on various groups of Londoners.

London’s summer temperatures are predicted to increase by 3.5°C by the 2050s and by up to 5°C in the 2080’s\textsuperscript{104}. Heat-related illnesses range from heatstroke and dehydration to damage to the brain and other vital organs\textsuperscript{105}. Extreme heat
can also exacerbate the negative impacts of air pollution on respiratory and cardiovascular health. Certain groups such as older people, and those living with long-term conditions will be particularly vulnerable to the direct and indirect impacts of heat. In addition people in lower socio-economic groups will be more vulnerable partly because they tend to have higher levels of long-term ill health but also because environmental factors such as poor quality housing and lack of access to green space will make them more vulnerable to the negative effects of heat. There were an estimated 600 ‘excess deaths’¹¹¹ in London during the August 2003 heat wave. Most of these deaths were among older people who were over 75 years of age¹⁰⁶.

Extreme weather events and flooding can affect health directly by causing injuries and drowning, and by contaminating water and land. Evidence also shows that stress and anxiety about personal and familial safety and the loss of possessions during floods can lead to ongoing mental health problems¹⁰⁷. The potential negative consequences are much greater for those on lower incomes, many of whom do not have insurance. ONS statistics show that that 45 per cent and 58 per cent of the households in the two lowest income deciles respectively have home contents insurance, compared with an average 77 per cent for the UK population as a whole¹⁰⁸.

All activities to adapt to climate change must consider the needs of those groups most likely to experience negative health impacts and raise awareness among these groups and the wider population about how these negative impacts can be avoided.
Healthy places: Focus on mental health

The standard of people’s housing has major implications for their mental health. Overcrowding, living in temporary accommodation and sharing amenities for cooking, food storage and washing are all associated with stress and depression. Homeless children are three or four times more likely to have mental health problems than other children, as well as behavioural problems such as aggression, hyperactivity and impulsive behaviour that can damage their progress at school.

Housing design also matters. A review of studies found that residents living in poor quality high-rise accommodation reported more mental ill-health symptoms than those living in traditional-style dwellings. A study by Greenwich PCT found that factors such as damp, noise, the look of an estate, local community facilities, people’s sense of safety and access to green open spaces were all relevant to the mental health and well-being of residents. Design for London (The Mayor’s Urban Design Unit) is developing guidance, linked to the Mayor’s Housing Strategy, to identify the key factors necessary for the delivery of high standards of design in high-density developments.

There is clear evidence that being cold indoors harms mental and physical health and contributes to the numbers of excess winter deaths. Research into energy efficiency and housing has shown that dealing with fuel poverty among low-income households alone does not solve the underlying problem of energy inefficiency or cold homes. This can only be solved by improvements to the housing stock, improvements to the levels of insulation, air tightness (with appropriate ventilation) and heating systems.

There is strong evidence for the effect of social and community factors on mental well-being; for example, fear of crime reduces social cohesion and increases the isolation of already vulnerable groups and individuals. A quarter of Londoners who responded to the 2004/05 British Crime Survey reported a high level of anxiety about violent crime, higher than the 17 per cent in England as a whole.

On the other hand, high levels of social cohesion and informal social networks could in principle help promote mental well-being. However, according to the 2005 General Household Survey Londoners have poorer social networks and support overall and are less likely to speak to relatives by phone or talk to neighbours on a weekly basis compared to all other regions in England. Having fewer informal networks means some Londoners are in greater need of formal methods of support.
Objective 6: To develop London as a world leader in the creation of knowledge about health inequalities and the use of shared learning to achieve sustained change.

Why this objective?
As a global city with a diverse population and a large number of internationally recognised universities and research centres, London is well placed to lead in research and knowledge creation on action to reduce health inequalities. In addition, the breadth of the GLA Group’s role on health determinants and the Mayor’s leading role on health inequalities, offer enormous potential to learn about health issues within wider programmes for social, economic and environmental change.

However, in London, as elsewhere, there is sparse dialogue between researchers, practitioners in health and social care, and community groups working with local people. This results in a lack of comprehensive evaluation and feedback on health promoting initiatives and continued loss of opportunities to develop shared understanding of good practice. In addition, we know that the unique characteristics of London’s population pose specific challenges for the rollout of some national policies and programmes. There is therefore a critical need for London-specific monitoring and evaluation.

The Mayor promotes a learning culture where those involved in creating knowledge through research or action at all levels are supported to identify, share and benefit from learning in a systematic manner. The core purpose of developing and embedding this learning culture is to galvanise collaborative action to reduce health inequalities rather than continuing to describe them. This objective will focus on London-specific challenges and opportunities as well as learning from and contributing to national and international best practice.

The policies below will be shaped and supported by ongoing work with the LHC to identify high-level indicators for monitoring and evaluating progress to reduce health inequalities in London.
Policy statement 6.1: Collaborative approaches to better learning

The learning derived from service user involvement and community engagement can empower individuals and communities, improve service delivery and reduce social exclusion. However, responses to this strategy’s “Issues and Priorities” paper revealed that health and social care services place high value on quantitative data but too often downplay the importance of qualitative evidence. For example, some PCTs were experienced as judging qualitative evaluations of VCS preventative services as ‘not robust’. This results in insecure funding for these services, even when they are highly valued by communities and could help to reduce health inequalities. In addition, it represents continued missed opportunities to enhance the evidence base by making better use of the wide and diverse range of evidence sources in London.

Collaborative approaches to better learning

This strategy will seek to ensure that participative approaches to research, which explicitly seek to build the skills and expertise of both the researchers and the research subjects, are put in place. It will build on the growing recognition of the value of more participative and empowering approaches to research, exemplified by some of the GLA’s work with disabled Londoners and refugee groups. The keen involvement of academics, VCS groups, policy makers and practitioners provides an exciting opportunity to ensure London is at the forefront of new approaches to research. The intention is to work together in

“There is potentially an extremely rich source of evidence and data, generated using qualitative techniques, which needs to be embraced in the evidence base...inequalities in health and the human pain and misery that flow from them are too great to be ignored on the grounds of philosophical or methodological problems.”

Health Development Agency, Integrative Approaches to Qualitative and Quantitative Evidence (2004)
the further development and delivery of this strategy to ensure affected communities are at the heart of defining research questions, designing the methodology, delivering the research, and assisting to interpret and apply the results.

**Policy statement 6.2: Investment in research and development**
The Mayor wants to see increased levels of investment into research on the most effective approaches to reducing health inequalities.

**Proposed action**
The Mayor will:
- Press for the Department of Health and health sector research institutions to increase investment in public health issues and health inequalities considerations.
- Campaign for improved data capture and analysis about health issues and outcomes within diverse communities, and for increased consideration of equalities information in policy and resource decisions.
- Support initiatives to build capacity in the VCS to monitor and evaluate interventions and add to the existing evidence about what works for different communities.
- Measure, evaluate and publicly report on the development and delivery of his Health Inequalities Strategy and the health inequalities aspects of his other strategies.
- Encourage other policy and decision-makers to use health inequality impact assessments, preferably as part of an integrated impact assessment processes, to predict changes in health outcomes and identify ways to measure change.

**Investment in research and development**
The Mayor recognises the importance and value of research into the development of new technologies and ever-more sophisticated responses to illness and injuries. However, he is concerned that there is not an equivalent level of investment in broader public health interventions dealing with the wider determinants of health and “upstream” health-promoting interventions.

Better research and improved sharing of knowledge about what works and what does not work to reduce health inequalities will enable those working in this area to replicate success and avoid the pitfalls of less effective approaches. This research needs to be accompanied by robust and well-resourced structures to facilitate enhanced data capture, evidence building and knowledge transfer.

As well as issues about the type of interventions research focuses on, there are widespread concerns about the limited focus on who does and does not benefit
from a range of health-related interventions. This has been highlighted by the annual *Health in London* reports published by the LHC (www.londonshealth.gov.uk), and continues to be a concern raised by many public health and community partners in London.

The Mayor welcomes and contributes to ever-more sophisticated mapping and analysis of the geographical distribution of inequalities within London. However, he too is concerned that our understanding of health inequalities is constrained by the limited capture of data about the distribution of inequalities between communities of identity, as opposed to communities of place. For example, we are able to access detailed information about cancer and survival rates based on where people live, but – except for incomplete data provided by Hospital Episode Statistics – are still not able to routinely consider rates or outcomes for different minority ethnic communities. And, despite ongoing campaigning for change, information about ethnicity is still not routinely recorded when deaths are registered, nor adequately recorded when births are registered, so understanding of factors related to life expectancy remains incomplete.

In addition to securing increased investment of research and development resources, preparatory work on this strategy has highlighted the potential to better harness learning capacity within existing structures and processes such as the GLA group. For example, capturing the evidence of the impacts of existing Mayoral Strategies, such as the Economic Development Strategy and the work of the LDA, thereby increasing understanding of the health effects of urban regeneration. The application of Health Impact Assessments and Integrated Impact Assessments by the GLA and LHC has already demonstrated the potential to incorporate health considerations and measures into a range of strategies.

**Policy statement 6.3: Information for change**

The Mayor wants to see improved co-ordination of learning across London to enable a wide range of stakeholders to co-create and share learning for change.

**Proposed action**
The Mayor will:

- Work with a range of interested parties to identify the most effective way to provide accessible information and learning about health inequalities in London
- Facilitate opportunities for active identification, gathering and sharing of relevant research and learning from a diverse range of sources
- Encourage an increased focus on organisational learning within and between key regional and local players, including the GLA Group and NHS London
- Continue to work with the LHC and London Health Observatory to gather data and information to monitor health inequalities in London over the course of this Strategy.
Information for change
The need for better collation and sharing of knowledge has been emphasised both in the evidence-gathering for this strategy and in ongoing discussions with a wide range of stakeholders. Many partners report that potentially useful information is held within organisations or reported only to funders to justify expenditure, but inadequately used to evaluate what is making a positive impact on health outcomes. VCS groups and a range of service providers expressed the clear view that decision-makers need to make better use of their existing knowledge resources and information sources in order to reduce health inequalities.

Public debates on public policies are often framed by limited analysis of cost (to taxpayers) and cost of implementing services such as the London Congestion charging scheme. Sharing information about the health benefits of public policies and ‘true’ costs (taking into account health and environmental impacts), should help Londoners to better engage in key public debates.

Action uninformed by knowledge is unlikely to bring about sustainable change. However, owners and producers of knowledge – in academic institutions and in the community – may have limited capacity to ensure their knowledge is available to decision-makers and insufficient influence to ensure it is actively considered in policy-making. In addition, the pressure on academic institutions to compete with each other for funding and recognition acts as a disincentive to collaboration on knowledge-creation. Similarly, policy-makers and funding bodies seldom co-ordinate their approaches to research, resulting in continued duplication of effort on some issues, whilst others remain absent from the evidence base.

Many VCS and statutory organisations also expressed a keen interest in hearing more about what others are doing on health inequalities. Similarly, many service providers highlighted the limited opportunities they have to share experience and learning with each other, outside the formal commissioning processes, to improve their own practice and explore what was working and what seemed less effective. Across the board, stakeholders want to see this strategy focus on improving their access to information and ideas about good practice, and providing opportunities for shared learning across sectors and communities.

The Mayor will work with a range of partners to explore the most effective and sustainable ways of gathering and sharing information to make better use of what is known to influence decisions and future action. In addition, the ongoing development and delivery of the strategy will focus on making sure the GLA and partners generate and make use of ever more comprehensive information about the range of interventions for health and their outcomes for diverse communities.
**Focus on mental health**

There is strong research evidence endorsing the value of efforts to promote positive mental well-being. Evidence-based interventions for better positive mental health and well-being include access to problem-solving skills, self-help, and Cognitive Behavioural Therapy (CBT), parenting skills courses, programmes to promote language and cognitive development and literacy skills.

Making everyone mental health literate will help people to have the information they need to keep well and to support behaviour change. It can also encourage people to seek help earlier and access care, support and treatment earlier. Valuing people’s actual experience of living with mental illness is a key component of this agenda. Part of this approach will be to ensure that key public services workers are mental health literate and mental well-being literate, so that they understand the importance of being responsive to such issues in their day-to-day working practices.
7. Next steps

This is the Mayor’s draft Health Inequalities Strategy published for consultation with the London Assembly, the GLA Functional Bodies (the London Development Agency, Metropolitan Police Authority, London Fire and Emergency Planning Authority, and Transport for London) and NHS London.

A public consultation draft will be made available for a period of formal consultation later in 2008. Leading up to this, the Mayor will continue to work with the London Health Commission, NHS and public health partners, London boroughs, employers, community groups and the widest range of other agencies to develop the public consultation draft and to plan delivery of this strategy.

The public consultation draft will also be informed by recommendations from an Integrated Impact Assessment being carried out on the strategy. A report of that Assessment will be published alongside the public consultation draft.

In addition, the public consultation draft will include a detailed delivery plan setting out short, medium and longer-term actions and plans. In addition, it will describe the roles and commitments of a range of organisations and sectors in tackling health inequalities in London and will specify the indicators and targets against which progress will be measured and reported.

If you have any enquiries about this process please email health.inequalities@london.gov.uk.

Information on the development of the Mayor’s health inequalities strategy and documents supporting this draft strategy is available at http://www.london.gov.uk/londonissues/health.jsp.
Appendix 1 – summary of the Mayor’s legal duties regarding health

**The Mayor’s new duties and powers**
The Health Inequalities Strategy is being developed as part of new responsibilities given to the Mayor of London by the Government within the Greater London Authority Act (2007). Clause 1 of section 22 of the Act describes additions to the GLA Act (1999) that relate to the Mayor’s Health Inequalities Strategy. The Act states that section 309E of the Act should be inserted, with clause 2 of this section stating that ‘The Strategy shall contain the Mayor’s proposals and policies for promoting the reduction of health inequalities between persons living in Greater London.’ Clause four of this new section specifies that ‘the Strategy must:

(a) identify any issues that appear to the Mayor to be major health issues where there are health inequalities between persons living in Greater London,

(b) identify those inequalities,

(c) specify priorities for reducing those inequalities,

(d) describe the role to be performed by any relevant body or person for the purpose of implementing the strategy.’

Clauses four and five of section 309F provide the following definitions:

‘“Health inequalities” means inequalities in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants.

“General health determinants” are:

(a) standards of housing, transport services or public safety,

(b) employment prospects, earning capacity and any other matters that affect levels of prosperity,

(c) the degree of ease or difficulty with which persons have access to public services,

(d) the use, or level of use, of tobacco, alcohol or other substances, and any other matters of personal behaviour or lifestyle, that are or may be harmful to health, and any other matters that are determinants of life expectancy or the state of health of persons generally, other than genetic or biological factors.’
Sections 23 and 24 of the Act also extend the Mayor’s previous general duty to promote improvements in the health of Londoners across all of his strategies, so that he now must also seek to promote a reduction in health inequalities between Londoners. In addition, section 21, clause one of the Act states that the Regional Director of Public Health for London will act as the Health Advisor to the Greater London Authority and section 22, clause one states that the Health Advisor will collaborate with the Mayor in the preparation of the Health Inequalities Strategy.

These new powers build on the Mayor’s existing duty to ‘promote improvements in the health of Londoners’ that was established in the 1999 Greater London Authority Act. In fulfilling this duty the Mayor has consistently emphasized the role that the wider determinants of health play in supporting or undermining well-being. Consequently, he has included health as a cross cutting theme in all Mayoral strategies with a view to ensuring that all opportunities to improve health are taken, and all potential negative effects on health minimised.
Appendix 2 – a brief overview of national, regional and local policy context for action on health inequalities

There is already a great deal of action concerned with reducing health inequalities. This action takes the form of policies, research, targets, initiatives and action at the national, regional and local levels. It represents an important resource that this strategy must learn from, build on and contribute to. This section briefly summarises that activity, with a focus on health-specific policies. There are numerous other national and regional policies and programmes of relevance to health inequalities, and further information on these is provided in the Mapping Report.

National
National Government policy and targets on health inequalities focus on reducing the gap in infant mortality across social groups and the difference in life expectancy at birth between those living in the most disadvantaged areas and the rest of the population. The national policy framework was first set out in Tackling Health Inequalities, A Programme for Action (DH 2003) and revisited in Tackling Health Inequalities: What works? (DH 2005). Government recently announced its intention to review national progress on health inequalities and to develop a new strategy for continued action to tackle them.

There is a wide range of national policies that are relevant to health inequalities because of their focus on the determinants of health such as poverty, worklessness, poor housing and low educational attainment. In addition, there are more focused policies that recognise the need for health service led interventions, such as reductions in smoking levels, and action on the wider determinants of health. The Government’s White Paper on public health, Choosing Health: making healthier choices easier (DH 2004), set out Government’s vision for how people can and should be supported to choose healthy options. It aims to improve health for all, but also seeks to reduce health inequalities. Health Challenge England - next steps for Choosing Health (DH 2006) sets out the Government’s new approach to public health, which aims to ensure that all sectors of society can contribute to the nation’s health.

In addition, there are policies that focus on improving “downstream” interventions, including Our health Our care Our say: a new direction for community services (DH 2006) which sets out a new model for health and social care provision, giving greater choice and control to the people using services.

Regional
Under the GLA Act 1999 the Mayor of London is responsible for the development of eight statutory strategies covering spatial development, the economy, culture, transport, ambient noise, biodiversity, waste and air quality.
Further powers granted in 2007 require the Mayor to produce housing and adult skills strategies for London; strengthen the Mayor’s role over planning in the capital; and add strategic powers in a wide range of policy areas including waste, culture and sport, health and climate change.

All the Mayoral Strategies involve action on the wider determinants of health and, therefore, have the potential to influence health inequalities. Consequently, the LHC has undertaken health impact assessments on all the Mayor’s strategies as an integral part of their development.

The Mayor also has a duty to ‘promote improvements in the health of Londoners’ that was established in the 1999 Greater London Authority Act. In fulfilling this duty the Mayor has consistently emphasized the role that the wider determinants of health play in supporting or undermining well-being. Therefore, he has included health as a cross cutting theme in all Mayoral strategies with a view to ensuring that all opportunities to improve health are taken, and all potential negative effects on health minimised.

In addition to his statutory powers, the Mayor has developed many more strategies and actions under his general power to do anything that he considers will promote economic and social development, and environmental improvement in London. These include initiatives that have the potential to make a significant difference to health inequalities, such as the London Child Poverty Commission, the London Living Wage campaign and the Older People’s Strategy.

Alongside the Mayor, there are a number of other organisations and partnerships operating at the London regional level that work to influence the health and well-being of Londoners. These include:

- **NHS London** is the strategic health authority for London, responsible for developing and implementing a strategy for health and healthcare in London and for managing the performance of healthcare providers in the capital. In July 2007 it published *Healthcare for London: A Framework for Action* that outlines a vision for the future of London’s health services. The framework rightly acknowledges that the NHS has a major role to play in tackling health inequalities in London, but that action by the health service alone will never overcome health inequalities in London.

- **Government Office for London** (GOL) represents central Government across the capital, delivering policies and programmes for eleven central Government departments in a joined up way, and making London’s case in Whitehall.

- **The Regional Public Health Group** acts as the Department of Health’s presence in London and carries out a wide range of public health responsibilities.
The London Health Observatory is one of a network of nine Regional Public Health Observatories in England. Its role includes monitoring health, healthcare and disease trends and it highlights areas for action, identifying gaps in health information, carrying out projects to highlight particular health issues and evaluating progress by local agencies in improving health and reducing inequality.

The London Health Commission was established by the Mayor in 2000. The Commission works in partnership with agencies across the capital to reduce health inequalities and improve the health and well-being of all Londoners through co-ordinated action to improve the determinants of health across London. Members of the Commission are drawn from across London and all sectors and represent a wide range of interests. The Commission itself has no statutory powers, functions or funding. Instead, its work programme is delivered through resources and expertise provided by its members and key partner agencies.

London Councils (formerly the Association of London Government) represents the 32 London boroughs, the City of London, the Metropolitan Police Authority and the London Fire and Emergency Planning Authority. It lobbies for more resources for London, works to help member councils deliver better services, and to promote better cross-borough and pan-London working, develops policy and runs a range of services.

In London, every borough has a Local Strategic Partnership (LSP) supported and convened by the local authority. Each LSP must involve other local statutory and non-statutory partners including the NHS (usually led by the Primary Care Trust), the police service, local skills agencies, the VCS, and the local business sector. The role of the LSP is to bring together public services, business and VCS organisations to develop local sustainable community strategies and joint strategic needs assessment. These strategies should describe how health and well-being will be improved and health inequalities reduced at the local level.

In 2004 the Government established a Public Service Agreement (PSA) to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. Under this agreement the fifth of areas with the worst health and deprivation indicators were designated as Spearhead areas. The PSA target aim to see faster progress in the Spearhead areas compared to the England average. Achievement of the targets will be assessed on the outcomes for this Group in 2010. The Spearhead group covers 70 local authorities and 88 Primary Care Trusts (PCTs), including eleven London boroughs, which are Hammersmith and Fulham, Haringey, Islington, Barking and Dagenham,

Local Area Agreements (LAAs) introduced in 2004/5 as a pilot and were rolled out over the subsequent two years to all upper tier local authorities in two further ‘rounds’. Their aim is to provide councils and the LSPs with greater autonomy and influence, to shape local plans and reconfigure services in response to the varying aspirations of communities in different localities. They provide an additional tool for actors concerned with reducing health inequalities locally. The types of subject areas covered, whose funding has been either pooled or aligned in the 1st round of LAAs include:

- Smoking cessation
- Teenage pregnancy
- Child and adolescent mental health
- Substance misuse
- Sexual health
- Falls prevention
- Physical Activity
- Obesity

Mandatory outcomes to improve health and reduce health inequalities have been specified for boroughs who negotiated 2nd and 3rd round LAAs in 2007. Outcomes were specified in two categories:

- Guidance for Spearhead areas was to reduce health inequalities between the local authority area and the England population by narrowing the gap in all-age, all-cause mortality.
- And for all other areas to reduce health inequalities within the local area, by narrowing the gap in all-age, all-cause mortality.

Every borough in London currently has an LAA with specific links to over 55 PSA health and social care targets. Within the LAA process London boroughs have committed to work in achieving PSA targets on health or social care across several themes, mainly:

- Safer communities
- Adult health and well-being
- Tackling social exclusion and promoting equality
- Children and Young People
- Stronger communities
- Local economy
- Environmental sustainability
Appendix 3  Summary of the Mayor’s proposed objectives, policies and action to reduce health inequalities

Income and poverty

Objective 1: To reduce income inequalities and minimise consequences of relative poverty

Policy statement 1.1: Increasing incomes for those in lower income brackets
The Mayor wants all Londoners, including those on pensions and benefits and those in paid employment to receive an appropriate ‘living income’ for London.

Proposed action
The Mayor will:

• Campaign for all working Londoners to receive the London Living Wage as a minimum and lead work with large employers to achieve wider commitment to this aim.
• Lobby for London’s pensions, benefits and tax credit structures to reflect the higher costs of living in London and establish a ‘London Living Income.’
• Work with NHS London to ensure welfare rights and debt management advice services are co-located with primary care services.

Policy statement 1.2: Reducing worklessness
The Mayor wants to reduce barriers to work focusing particularly on the needs of those currently excluded from the labour market.

Proposed action
The Mayor will:

• Campaign for better integration between health, housing and employment services to improve pathways to work.
• Press employers to increase availability of flexible working including quality part-time work.
• Further increase the availability of affordable and flexible high quality childcare
• Work with Government and others to streamline processes for people making the transition from benefits or working in the informal economy into paid employment.
• Work with the LDA and LHC to identify and further promote effective ways of increasing the diversity of the workforce, with increased numbers of disabled Londoners and those from minority ethnic groups able to access employment opportunities.
Policy statement 1.3: Reducing the negative impact of poverty
The Mayor will work to protect people on low incomes from the associated negative health and social impacts, and improve access to timely advice and support to those at risk of poverty.

Proposed action
The Mayor will:

- Co-ordinate the development of interventions to increase financial security for people at points of transition in their lives such as leaving school, entering the workforce, leaving prison, acquiring an illness or impairment, leaving work, or becoming a parent or carer.
- Seek to increase investment in integrated early interventions to improve life chances, focusing on maternal, infant and child health and well-being.
- Support local authorities to further increase access to leisure and recreation facilities, including green spaces and rivers, for people on low incomes.
- Work with the London Development Agency to improve the affordability and availability of fresh, healthy food.
- Support local authorities and VCS groups to improve access to responsible lending, such as credit unions and banks, for people on low incomes.

Employment

Objective 2: To increase opportunities for people to access the potential benefits of work and other forms of meaningful activity

Policy statement 2.1: Valuing ‘good’ work
The Mayor recognises the value of work in increasing individual health and well-being and supports effective implementation of workplace well-being policies and anti-discrimination provisions.

Proposed action
The Mayor will:

- Demonstrate exemplary employment practices throughout the GLA group and urge other large public and private sector employers to do the same.
- Work to ensure that London’s employers are carrying out their statutory duties in relation to anti-discrimination legislation and proactively promoting diversity and inclusion.
- Support campaigns to increase Londoners’ awareness of their employment rights under current law, particularly people from excluded groups.
- Work with a range of employers from different sectors to promote the importance of investing in health and well-being at work, in partnership with the LDA and the LHC.
• Together with the LHC, work with the voluntary, statutory and business sectors to identify ways of improving the retention of and in-work support for disabled people and those with mental and physical health problems.
• Work with the NHS and employment services to develop return-to-work programmes to support disabled people and those with illness or other health-related problems back into employment.

Policy statement 2.2: Progression and life-long learning
The Mayor wants to extend opportunities for skill development and progression within and beyond the workplace, particularly for excluded groups.

Proposed action
The Mayor will:
• in his role as chair of the London Skills and Employment Board, work with employers in London to increase investment in training and the development of new skills in the workplace.
• work with a range of partners to increase investment in ‘life skills’ training and to provide increased opportunities for life-long learning.

Policy statement 2.3: Volunteering, caring and parenting
The Mayor wants to improve recognition of a range of unpaid activities that contribute to London’s social and economic fabric, including volunteering, caring and parenting.

Proposed action
The Mayor will:
• Champion recognition of and rights for carers and parents, and promote access to practical and emotional support for people in these roles.
• Promote provision of and access to local volunteering schemes, particularly targeted at involving people from London’s most excluded communities.
• Continue to promote the benefits of volunteering, in particular through the 2012 Olympic and Paralympic volunteering programme.
Participation

Objective 3: To empower individuals and communities to take action to improve their health and well-being

Policy statement 3.1: Individual action, community action
The Mayor wants to build the capacity and skills of individuals and communities to take control of their own health and play an active role in the health and well-being of others.

Proposed action
The Mayor will:

• Work with the NHS and other partners to increase the dissemination of health and well-being information, advice, support and skills in a wide range of settings with a focus on health issues of particular relevance to London.

• Campaign for better support to parents and care-givers to develop their potential as health promoters within their families, schools and other community settings.

• Promote training and qualifications in community development and participation, including incentives for colleges and training providers to offer qualifications for people who want to be more active in their community.

• Champion the Well London programme and other key initiatives, and support the dissemination of good practice and effective learning.

Policy statement 3.2 : Culture and health
The Mayor believes cultural activities offer a powerful route to health and social inclusion and an approach to tackling health and other inequalities.

Proposed action
The Mayor will:

• Support increased access to a range of cultural events and activities that are designed and managed by local people

• Broker agreement with schools, health and other community facilities for free use of facilities for cultural activities that encourage the broadest local participation

• Promote the benefits of sport and physical activity and work with partners to increase levels of participation across London

• Support the use of the arts and media to challenge stereotypes and perceptions and generate debate about health and exclusion issues.
Policy statement 3.3: the Voluntary and Community Sector (VCS)
The Mayor believes the Voluntary and Community Sector (VCS) has a vital part to play in tackling health inequalities in London.

Proposed action
The Mayor will:

- Use his profile and leadership to support the role of the VCS in reducing health inequalities, and promote the need for the sector to be properly funded and resourced.

- Urge main public sector commissioners of services to involve VCS organisations in the design and delivery of services and support communities in providing services where appropriate.

Policy statement 3.4: Active citizenship
The Mayor wants to build the capacity of public services to actively involve communities and individuals.

Proposed action
The Mayor will:

- Continue to develop and promote exemplar models for involving individuals and communities.

- Urge the NHS, local Government and the police service to share and adopt identified good practice on effective approaches to involving communities.

- Establish a Mayoral awards scheme that recognises public sector organisations which demonstrate excellence in involving local communities and individuals.
Public services

Objective 4: To improve the health of people living with illness or impairment

Policy statement 4.1: Equitable and accessible public services
The Mayor wants to see equitable provision of world-class health, social care and other public services, with improved local access to responsive, appropriate and coordinated services planned around individual need.

Proposed action
The Mayor will:
- Challenge the NHS in London to make a more equitable allocation of resources and facilities.
- Lobby Government for more adequate social care funding for London and a national framework setting out social care entitlement.
- Require/influence public services to monitor, evaluate and demonstrate how they are meeting the needs of their populations, particularly more vulnerable groups.
- Ensure better collaboration between TfL and the NHS to plan locations of new health services and transport links, and to improve physical access to existing NHS sites while also supporting shifts in modes of travel.
- Work with public services to improve and promote the accessibility of their provision, including expectations about improved provision of high quality language support.

Policy statement 4.2: Rights to health and social care
The Mayor supports rights-based approaches to health and social care provision, with better information and support to increase access to services and informed choice about options.

Proposed action
The Mayor will:
- Work with the VCS and service providers to promote better understanding of patients’ rights and entitlements, including those of refugee communities, and increase resources to VCS organisations facilitating access for excluded groups.
- Work with NHS London and community partners to increase awareness of public health issues, with a focus on key health challenges for London and messages targeted to reach “at risk” groups.
- Expect NHS London to ensure that new community health centres offer services beyond basic healthcare and achieve high standards for user participation and health promotion.
• Support provision of ‘Welcome to London’ information packs for new residents, including refugees, migrants and students, and more coordinated advice at points of transition to provide information on how to access public services and what to expect from those services.

• Press Government not to introduce measures that require health care staff to charge for NHS services or refuse access to health care for failed asylum seekers or other vulnerable foreign nationals.

• Challenge stigma associated with mental illness and other health issues, and encourage action to support the social and economic inclusion of people living with long-term conditions.

Policy statement 4.3: Commissioning health and social care
The Mayor wants to see improvements in the commissioning of health and social care across London and improvements in the quality of services available to all Londoners.

Proposed action
The Mayor will:

• Expect increased pan-London commissioning and cross-Primary Care Trust work to improve services to the most disadvantaged groups and Londoners living with complex needs.

• Explore the development of pan-London NHS registration and other schemes to increase the access of highly mobile and excluded groups to health service.

• Support commissioners to work with an increasingly diverse range of providers, including VCS organisations, and to work together with them to drive up the quality of service.

• Lobby for increased investment in preventative and health-promoting activities, and ensure that public health campaigns target and actively engage the most disadvantaged groups of Londoners.

• Encourage greater user-involvement in influencing commissioning and in scrutinising the accessibility and quality of local service.
Policy statement 4.4: Providers of health and social care
The Mayor wants to see increased diversity in the health and social care workforce, and further development of the ability of all providers to competently meet diverse community needs.

Proposed action
The Mayor will:
- Work with a range of others to encourage young Londoners from diverse backgrounds into NHS and social care careers.
- Work with the NHS and others to support refugee and migrant professionals in gaining work in the NHS by removing barriers, including simplifying qualification conversion, and by offering language training and other support.
- Encourage provision of increased training and support to equip front-line staff and service providers to recognise and better meet the needs of London’s diverse communities.

Healthy places

Objective 5: To develop and promote London as a healthy place for all – from neighbourhoods to the city as a whole

Policy statement 5.1: Planning a healthy city
In line with his London Plan policies, and using the spatial planning system, the Mayor will ensure that new developments are designed and constructed in ways that improve health and reduce health inequalities.

Proposed action
The Mayor will:
- Ensure that all major planning applications and Local Development Frameworks take full account of the need to provide more good quality affordable housing, and seek to optimise positive impacts on physical and mental health.
- Further develop social infrastructure planning models to ensure that new developments make a proper contribution to the provision of health-related services.
- Ensure that new residential developments have accessible transport links, including high quality walking and cycling opportunities.
- Ensure the regeneration opportunities associated with the 2012 Olympic and Paralympic Games support the delivery of improved infrastructure for sport and physical activity across London.
Policy statement 5.2: Improving London’s physical environment
The Mayor will bring forwards physical improvements in areas of London that are deprived, physically run-down and not conducive to good health.

Proposed action
The Mayor will:

- Improve the quality of open spaces (including natural green spaces) and support the involvement of diverse local communities in their planning, design and management.
- Continue to invest in initiatives to improve air quality, and reduce the impact of air pollution on health, focussing on sustainable modes of transport and exposure to air pollution.
- Work in partnership with a range of organisations to raise awareness about, and address, environmental equity issues in London.
- Ensure that decisions and activities across the GLA group are aligned to improve health in the areas of London that currently have the poorest levels of health.

Policy statement 5.3: Safe and accessible London
The Mayor will promote places that are safe, accessible and promote social cohesion.

Proposed action
The Mayor will:

- Continue to support the work of Safer Neighbourhood Teams and a range of other community, voluntary and statutory sector programmes to improve community safety and reduce fear of crime.
- Lead major campaigns to encourage Londoners to enjoy their city’s streets, parks and natural green spaces focusing particularly on young people and those groups who currently do not use them.
- Support the development of local initiatives to promote intergenerational understanding and mutual respect between different groups.
- Introduce road traffic calming measures in areas with high accident rates.
Policy statement 5.4: Sustainable approaches to health and the environment
The Mayor will make more explicit links between long-term planning on actions related to the environment and actions to improve health and well-being, prioritising climate change adaptation and mitigation.

Proposed action
The Mayor will:
• Lead the planning of ‘exemplar developments’ that are sustainable, energy efficient and address issues leading to health inequalities.
• Champion integrated approaches to addressing fuel poverty focusing on housing quality and energy efficiency.
• Raise awareness about the health impacts of unavoidable climate change – focusing on the impacts of heat and flooding on vulnerable groups.

Knowledge and learning

Objective 6: To develop London as a world leader in the creation of knowledge about health inequalities and the use of shared learning to achieve sustained change.

Policy statement 6.1: Collaborative approaches to better learning
The Mayor believes that all sources of learning, including informal and community knowledge about health inequalities, should be accorded their proper value and taken into account in policy development and resource decisions.

Proposed action
The Mayor will:
• Support the development of more participative approaches to research by brokering partnership between academia and the Voluntary and Community Sector (VCS), and supporting investment in building community capacity for research.
• Encourage researchers to actively engage communities in research design and delivery, and to seek community intelligence as well as published research when gathering evidence.
• Encourage decision makers to build consideration of community and individual experience into the evaluation of interventions and decisions about future resource allocation.
• Build robust evaluations of new processes and learning into GLA Group initiatives, and lobby partners to do likewise with their own work with an increased focus on enhancing data regarding equalities groups.
Policy statement 6.2: Investment in research and development
The Mayor wants to see increased levels of investment into research on the most effective approaches to reducing health inequalities.

Proposed action
The Mayor will:

• Press for the Department of Health and health sector research institutions to increase investment in public health issues and health inequalities considerations.

• Campaign for improved data capture and analysis about health issues and outcomes within diverse communities, and for increased consideration of equalities information in policy and resource decisions.

• Support initiatives to build capacity in the VCS to monitor and evaluate interventions and add to the existing evidence about what works for different communities.

• Measure, evaluate and publicly report on the development and delivery of his Health Inequalities Strategy and the health inequalities aspects of his other strategies.

• Encourage other policy and decision-makers to use health inequality impact assessments, preferably as part of an integrated impact assessment process, to predict changes in health outcomes and identify ways to measure change.

Policy statement 6.3: Information for change
The Mayor wants to see improved co-ordination of learning across London to enable a wide range of stakeholders to co-create and share learning for change.

Proposed action
The Mayor will:

• Work with a range of interested parties to identify the most effective way to provide accessible information and learning about health inequalities in London.

• Facilitate opportunities for active identification, gathering and sharing of relevant research and learning from a diverse range of sources.

• Encourage an increased focus on organisational learning within and between key regional and local players, including the GLA Group and NHS London.

• Continue to work with the LHC and London Health Observatory to gather data and information to monitor health inequalities in London over the course of this Strategy.
Endnotes

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63 Kessler & Frank, 1997 (USA)

64 The Work Foundation, Fit For Work? Musculoskeletal Disorders and Labour Market Participation, September 2007

65 Crisis, Missed opportunities: The case for investment in learning and skills for homeless people, 2006.


67 GOL website, http://www.gos.gov.uk/gol/People_sustain_comms/Thirdsector/

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102. Warm Zones was set up in 2001 as a pilot funded by DEFRA aimed at mitigating fuel poverty. Seven years on and supported by EDF Energy, the London Warm Zone has expanded far beyond the original pilot in the London Borough of Newham to cover 18 boroughs.
103. http://www.london.gov.uk/insulation
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110. Coronary heart disease is also known as ischaemic heart disease and includes angina, heart attacks and heart failure.
111. www.london.gov.uk/mayor/health/docs/his_rhi_mapping.pdf
112. A household is fuel poor if it spends more than 10 per cent of its income on all fuel use to maintain a satisfactory heating regime.
113 DEFRA/DTI, UK Fuel Poverty Strategy, 2001: www.berr.gov.uk/energy/fuel-poverty/strategy/index.html A satisfactory heating regime is generally defined as 210°C in the living room and 180°C in other occupied rooms – the temperature recommended by the World Health Organisation.

114 Calculated by subtracting the number of expected deaths from the number of observed deaths.

115 Calculated by subtracting the number of expected deaths from the number of observed deaths.


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Chinese
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Vietnamese
Nếu bạn muốn có bản tài liệu
nay bằng ngôn ngữ của mình, hãy liên hệ theo số điện thoại hoặc địa chỉ dưới đây.

Greek
Αν θέλετε να αποκτήσετε αντίγραφο του παρόντος
eγγράφου στη δική σας γλώσσα, παρακαλείστε να
επικοινωνήσετε τηλεφωνικά στον αριθμό αυτό ή ταχυ-
dρομικά στην παρακάτω διεύθυνση.

Hindi
यदि आप इस दस्तावेज की प्रति अपनी
मान्य में चाहते हैं, तो कृपया निम्नलिखित
नंबर पर फोन करें अथवा नीचे दिये गए
पते पर संपर्क करें

Bengali
আপনি যদি আপনার ভাষায় এই দলিলের প্রতিলিপি
(কপি) চান, তাহলে নিচের ফোন নম্বরে
বা ঠিকানায় অনুগ্রহ করে যোগাযোগ করুন।

Turkish
Bu belgenin kendi dilinizde
hazırlanmış bir nüshasını
edinmek için, lütfen aşağıdaki
telefon numarasını arayınız

Punjabi
ਤੇ ਮਾਰਧਾਤਨ ਧਿਆ ਸਮਾਨਪ੍ਰਦੀ ਲਚੀ ਇਕ ਜਾਂ ਅਧਾਰ ਮਾਰਧਾਤਨ ਧਿਆ ਲਚੀ ਦੀ ਰਚਨਾ ਕਰਨ ਦੀ ਤਰ੍ਹਾਂ ਹੁੰਦੀ ਹੈ।

Arabic
إذا أردت نسخة من هذه الوثيقة بلغتك، يرجى
الاتصال بفم الهاتف أو مراسلة العنوان
أعلاه

Gujarati
શે તમને આ કૃતિની નકલ તમારી ભાષામાં
ઓહી હોમ તો, ફોન કરી આપણના નંબર પર
સંપર્ક કરો. આવશ્યક નીચે સમાચાર અને સંપર્ક સાચો.