

Report

London Health Commission and the Environment Committee of the Assembly

Health Impact Assessment – Draft Economic Development Strategy

1 Principles underpinning the Health Impact Assessment

On 17 January 2001, the London Health Commission discussed a framework for taking forward the health impact assessment (HIA) of the draft Economic Development Strategy. The following underpinning principles for the HIA were agreed:

- the aim was to make a **positive contribution** to the emerging strategy – to be constructive and ‘add value’ to it.
- there was consensus that there is a **two-way traffic** between health and economic development. Not only can economic development affect Londoners’ health, but also Londoners’ health can have a significant bearing on economic development. Therefore, health is a **mainstream** issue for economic development and this should be reflected in the strategy.
- in assessing the impact on health of the draft economic strategy, use should be made of a **broad definition of health** – not just the absence of illness, but the physical, mental and social well-being of Londoners.
- addressing health inequalities should be seen as central to the HIA process, and not a separate process.
- there are **different types of health inequalities** – for the purposes of this HIA, inequalities between socio-economic groups are considered to be of particular importance. However, of particular concern too are health inequalities experienced **by children and young people, black and ethnic minority groups and people with disabilities**.
- area-based regeneration can have complex effects. It can both **reduce and exacerbate health inequalities**, because of its effects on surrounding communities.
- the **National Health Service** has a vital role to play in London’s economic development, not just as a provider of clinical services, but as one of the largest employers and users of resources in the capital.

- **sustainability** is a key issue of concern. The HIA needs to anticipate the medium- and long-term effects of the strategy, as well as its more immediate influence.
- work on this HIA should refer to the earlier Health Impact Assessment of the **London Transport Strategy** and is expected in its turn to inform future GLA strategies and health impact assessments.

2 Main findings and recommendations

The main findings and recommendations of the HIA on the draft Economic Development Strategy are outlined in this section. These findings and recommendations come from three main forums for discussion, debate and scrutiny:

- half-day rapid appraisal workshop on 2 February 2001
- meeting of the Environment Committee on 13 February 2001
- meeting of the London Health Commission on 27 February 2001.

The Assembly and the London Health Commission commissioned a review of selected research evidence relevant to the draft Economic Development Strategy to inform the HIA. This evidence is described further in Section 3 of the report.

Rapid appraisal workshop – establishing key points

The rapid appraisal workshop for the HIA took place at the King's Fund on 2 February 2001. Approximately 55 people attended, drawn from a range of sectors and levels of seniority.

After an initial plenary meeting, which included a presentation on the Draft Economic Development Strategy by Marie Winckler, Acting Director Operations and Local Strategies, LDA, participants moved into small groups to discuss selected clusters of policy objectives from the Strategy, along with related action proposals.

These groups shared their thoughts and recommendations in a final plenary, offering a range of key points in response to the Strategy.

Developing the recommendations

The key points ranged from over-arching 'analysis points' to practical suggestions for action. These key points were further explored and tested at meetings of the Environment Committee and the London Health Commission. In the process, the key points were shaped into focused recommendations.

These are outlined below. The broad 'analysis points' are linked to the relevant chapter in the main body of the Strategy document. Where focused suggestions for action are made, specific proposals for additional action are shown. Where there is supporting evidence for the recommendations, references are made to relevant Sections in Appendix 1.

2.1 Highlighting health

- 1 Acknowledge that health outcomes are central to a successful economic development strategy, and add health as a key policy objective in the Charter for London put forward by the Draft Economic Development Strategy

- *see overall Strategy*
 - Evidence supporting this recommendation can be found in Sections 1.1, 1.2 and 1.5 in Appendix 1.
- 2 Include health outcomes as success criteria for regeneration
 - *additional action proposal – policy objective 9 ‘Strengthening London’s Capacity’*
 - 3 Acknowledge the two-way relationship between health and economic development – a healthy workforce is a competitive one
 - *see policy objective 4 ‘Improving Business Competitiveness’*
 - Evidence supporting this recommendation can be found in Section 1.5 in Appendix 1.
 - 4 Consider, where appropriate, requiring LDA-funded projects and businesses to carry out health impact assessment on their plans and programmes and to lead by example – and bear in mind the fact that small businesses may need advice and support on health-related matters
 - *additional action proposal – policy objective 3 ‘Meeting London’s Key Challenges’*
 - 5 Where the LDA does not lead on particular action proposals in the Strategy, to indicate who will take the leading role
 - *see summary of policy objectives and actions*
 - 6 The LDA to acknowledge the crucial role played in the regeneration of deprived areas of London by the NHS, the statutory sector and major charities – as employers and contractors, for example – and to consider inviting the NHS and local authorities to be key signatories to the Strategy
 - *see overall Strategy*

2.2 Promoting genuine sustainability

- 7 Acknowledge that wealth creation is not necessarily about health creation – and aim to draw out and address potential mutual benefits and disbenefits of social, economic and environmental strands of sustainability, with the goal of working with organisations and communities to achieve a dynamic balance among the different kinds of sustainability (see box below, ‘On virtuous cycles’)
 - *see policy objective 8 ‘Developing the Sustainable World City’*
 - Evidence supporting this recommendation can be found in Section 1.5 in Appendix 1.
- 8(a) Acknowledge the stress involved in travelling in London, for work or other reasons, and also the stress associated with the intensity, competitiveness and complexity of life and work in London
- 8(b) Promote action research to identify, quantify and mitigate the potential stress-related effects of economic growth in London
 - *additional action proposal – policy objective 3 ‘Meeting London’s Key Challenges’*
- 9 Make sure that work on the GLA’s different strategies (in particular, transport/air quality, spatial development and waste) goes ahead in a co-ordinated way, and takes full account of the health dimensions involved,

including the impacts of the strategies on the health and well-being of disabled people

- *additional action proposal – policy objective 3 ‘Meeting London’s Key Challenges’*

10 Acknowledge the importance of promoting social inclusion – for example, by working closely with the voluntary sector and local authorities to engage communities in identifying needs and developing initiatives

- *additional action proposal – policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*
- Evidence supporting this recommendation can be found in Section 3 in Appendix 1.

11 Take account of the complex effects – positive and negative – of continuing to develop London’s international transport links

- *see policy objective 1, ‘Promoting London as a Place for People and Business’*

12 Review the increased risk of fragmented activity on the ground arising from the conceptual split between ‘social’ and ‘economic’ – for example, GOL is responsible for the National Strategy for Neighbourhood Renewal, not LDA

- *see policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*

13 The LDA to accept congratulations for the support of social enterprise in the strategy

- *see policy objective 4, ‘Improving Business Competitiveness’*

On virtuous cycles

The Draft Economic Development Strategy uses the term ‘sustainability’ in three significantly different ways.

- **Economic sustainability** – the capacity of London’s economy to go on growing, and creating more wealth
- **Social sustainability** – the regeneration of community, concentrating on the need for the wealth creation to be used to improve housing, access to education, employment and social inclusion
- **Environmental sustainability** – the need to ensure that as Londoners we minimise our impact on the environment, and ultimately come to live within our allowable environmental space.

The document has many excellent suggestions for delivering each of these sustainability agendas, but these are more often than not considered in isolation one from the other. There is insufficient recognition of:

- the need to pursue each in concert with the others
- the inevitable conflicts which will occur if each is pursued independently.

In fact, a population’s quality of life and health is dependent on each of these separate types of sustainability being developed within the envelope of the others. For good health, the waxing of one cannot be at the cost of the waning of another. The evolution of a vibrant economy cannot be at the cost of our relationships with each other, the social arrangements which we enjoy, or our relations with the built environment, nature and thus with the planet. When, as in the LDA document, the pursuit of one of these objectives is not set within the context of the others, the commitment to improvements in the quality of life, and thus the health of Londoners in the LDA document, is seriously compromised. So also will be the commitment to finding and developing policies which **do** advance each of the three objectives at the same time.

Policies of this kind are sometimes known as **virtuous cycles**. The development of these should be a key practical task for all who wish to improve the health of Londoners.

Housing – one example

Housing provides an initial, brief example. New housing has to be energy efficient if objectives in that policy area are to link with energy efficiency objectives. Conservation is a simple way to make an economic measure contribute to social, health and environmental gain. The Economic Development Strategy could be used to bring pressure on businesses to invest in sustainable housing – energy conservation/double glazing and heating should be supported as an area of business growth.

Source: Robin Stott (unpublished)

2.3 Addressing health inequalities

- 14 Press for change in legislation, and for planned ‘gateways to employment’, to allow easier access for disadvantaged people to work (e.g., asylum seekers and refugees) and, as a result, gain health benefits associated with being employed
 - *additional action proposal – policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*
 - Evidence supporting this recommendation can be found in Sections 1.1 and 1.2 in Appendix 1.
- 15 Take care in setting targets for raising the proportion in employment in disadvantaged areas – in particular, work to ensure that the targets are genuinely relevant to local conditions, and are ‘joined up’ with other targets in use locally
 - see policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’
- 16 Be innovative in recruitment practices and in responding to training, development and educational needs of London’s diverse population – for example, by linking education and training confederations with Learning & Skills Councils
 - *additional action proposal – policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*
 - Evidence supporting this recommendation can be found in Section 1.2 in Appendix 1.
- 17 Acknowledge that area-based regeneration can have complex effects, both reducing health inequalities (through bringing in capital investment and creating jobs and social networks for local people, for example) and exacerbating these inequalities (for example, through highlighting the situation of disadvantaged communities just outside regeneration zones, and individuals/groups living in disadvantaged ‘pockets’ in better-off areas)
 - *see policy objective 9, ‘Strengthening London’s Capacity to Deliver’*
 - Evidence supporting this recommendation can be found in Sections 1.2, 1.3, 1.5 and 2.1 in Appendix 1.
- 18 Develop a facilitative/supportive role with regeneration partnerships, offering a framework which can be used across the capital for:
 - identifying communities (including communities of interest as well as geographically based communities)
 - carrying out needs analysis
 - developing programmes of community consultation and involvement
 - evaluating regeneration projects in a way that will capture learning points for the development of more effective support for local regeneration initiatives.
 - *additional action proposal – policy objective 9, ‘Strengthening London’s Capacity to Deliver’*

- 19 Acknowledge that paid full-time employment is not an option for everyone – but other options can bring significant health benefits and need to be promoted (e.g. volunteering)
- *additional action proposal – policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*
 - Evidence supporting this recommendation can be found in Sections 1.1, 1.2 and 3.4 in Appendix 1.
- 20 Address issue of unequal access to affordable, nutritious food (see box below).
- *additional action proposal – policy objective 3, ‘Meeting London’s Key Challenges’*

Food for thought

Unequal access to food is a well documented issue. Over the years, commercial pressures have led to fresh food outlets in many deprived areas being closed down. The alternative way of obtaining fresh food is to make a journey to a supermarket – often not possible by public transport. The spread of out-of-town supermarkets aimed at car users have caused big problems for many inner city communities, who are left with corner shops which do not carry a large or varied stock.

People who cannot easily get to the supermarkets are thus surviving on corner shop food, usually canned or processed, or the local chip shop. Their diet suffers, and consequently their health also. The overall effect is to increase the inequalities in health already suffered by deprived communities. Some community development programmes have worked at addressing this problem. For example, Bromley by Bow Community Centre either grows or buys in fresh fruit and vegetables which it sells at cost to the local people.

A meeting of front-line health and social services staff in Knightsbridge described one striking local feature. Housing association tenants who live a stone’s throw from an internationally known specialist food hall have real problems accessing affordable healthy food. Local supermarkets do not stock the cheaper ranges, as their less well-off customers do not spend enough to be of real interest to them.

Source: Linda Sheridan (unpublished)

2.4 Helping those in work

- 21 Find ways of supporting people in work (e.g., improved provision of child care) so that they can in practice gain the health benefits that can be associated with employment
- *additional action proposal – policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*
 - Evidence supporting this recommendation can be found in Section 1.2 in Appendix 1.

- 22 The LDA to consider taking a proactive role in promoting healthy working environments and in persuading employers to offer healthy working conditions
- *additional action proposal – policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*
 - Evidence supporting this recommendation can be found in Section 1.3 in Appendix 1.
- 23 The LDA to be aware of the potential negative impacts of employment on health (e.g. higher levels of sickness resulting from stressful or insecure jobs) and to exert its influence in favour of the creation of good quality employment opportunities
- *see policy objective 7, ‘Empowering London’s Communities and Supporting Disadvantaged People into Work’*
 - Evidence supporting this recommendation can be found in Section 1.2 in Appendix 1.

3 Identifying relevant evidence

The Assembly and the London Health Commission commissioned a review of selected research evidence relevant to the draft Economic Development Strategy to inform the HIA.

One of the advantages of health impact assessment as a technique is that it provides a framework in which quantitative and qualitative evidence can be balanced and combined. Both types of evidence are integral to the process. In this case, the review of research provides the quantitative evidence; and the findings of the rapid appraisal workshop (see Section 2) make up the qualitative evidence.

3.1 The scope of the evidence

As with most rapid appraisals, there was time to consult only that evidence that was readily available.

Two sources of evidence were used to prepare a condensation of the evidence relevant to the Draft Economic Development Strategy (see *Acknowledgements* below). Sections 2.2 and 2.3 of this report contain a summary of this evidence – presented in diagrammatic and in text form. A full description is available as a separate document.

The focus of both sources was *regeneration* – but, of course, regeneration initiatives *per se* are not the totality of the contents of the strategy.

The links between economic development and health – and indeed between regeneration and health – are as yet far from clear. Many factors come together to create city-wide and local effects, and in many situations it is difficult to establish clear-cut linkages.

It is important, however, that practitioners and others have the opportunity to have access to evidence in this field and to use research findings to help them make informed decisions. There is a need therefore both for further review of existing research and for new research. The participants in the rapid appraisal workshop research expressed the desire that ways should be found of facilitating work of this kind.

The following gaps/conflicts appear in the evidence collected for the HIA.

General gaps in evidence

- The researcher was not aware of an HIA in this subject area having been undertaken for a city population of 7–8 million. Most of the evidence base is generated from small-scale studies, either featuring small numbers of people (in comparison) or areas *within* a city/urban conurbation.
- The evidence about the health effects of economic prosperity is equivocal: Brenner believes mortality is reduced, although provides no causal mechanism(s) to explain this, whereas Graetz believes mortality increases.

Specific gaps in evidence

- Effect/impact on regions that are neighbours to London – Section 2 of Draft Strategy (similar reasons as given under *General*, see above).
- Targeting funding in such a large population – see Proposal 2E of Draft Strategy (would this have a noticeable ‘population’ effect, in addition to any impacts on the targeted communities/groups?)
- The effect of fair employment practices on health (as opposed to the converse) – see Proposal 1E), and fair and inclusive recruitment practices (see Proposal 7C).
- Promoting economic diversity, particularly in relation to the quality of employment in various sectors (see, for instance, list given under Proposal 5A).
- Development of social enterprise on a large scale.
- Development of the workforce/lifelong learning initiatives/skills development (Section 6) – evidence equivocal; in the context of obtaining jobs, and of quality of jobs available to those ‘trained’, evidence equivocal/lacking; partnerships between education and business, evidence lacking.
- Community empowerment and health – a few HIAs at present looking at this, but source of published evidence would be in the community development literature, some of which has not been rigorously evaluated.
- The impact of e-commerce and telecommunications industries on health.
- The balance of public/private investment in schemes to achieve health gain (meeting commercial needs, *and* other needs, e.g. affordable housing, employment for resident population).
- Provision of appropriate childcare (see Proposal 7I).
- Business infrastructure (see Proposal 3D), and site/premise availability (see Proposal 3E).

There are then a substantial number of gaps in the evidence base. Because of this, there are many areas where it has not been possible to match evidence with the recommendations arising out of the rapid appraisal workshop (see Section 2).

3.2 The evidence on health and regeneration: an executive summary

Summarised below is the evidence covering the impact on health of employment, unemployment, working conditions, housing and homelessness, social networks and social capital.¹ Further details on this evidence are attached as Appendix 1.

¹ David Woodhead, Fellow in Public Health at the King’s Fund, prepared this executive summary. It is derived from paper and figures by Ison, E (2001) A condensation of some of the evidence base relating to regeneration and health. Oxford University. The publications from which the information was originally taken by Ison are cited in *Acknowledgements*.

Reviews of relevant literature confirm that social and economic factors have an impact on health and that there remain major inequalities between the worse off and the best off people in society. The contents of two of those reviews are summarised here.

Unemployment increases mortality (in all major cause categories) and the longer somebody is unemployed the greater the chance they have of dying prematurely. Unemployed people have higher levels of illness (shown by use of health services as well as other indicators), including heart disease, mental ill health and associated poor well being. The families of unemployed people experience higher levels of poor health and poverty. Unskilled and semi skilled adults, young and disabled people are more likely to become unemployed. Unemployment tends to make these people ill. Ill health can contribute to their becoming unemployed in the first place.

Employment can correlate with a higher incidence of some forms of physical and mental illness. people in poor quality, stressful or insecure jobs with poor pay experience higher levels of mortality and sickness than their counterparts in jobs that bring greater satisfaction with better pay and conditions. Poor working conditions can cause musculoskeletal problems, heart disease and stroke, mental illness and poor well being. People who have varied jobs and have control over what they do experience lower levels of illness. Where the threat of redundancy is present, workers and their families may experience higher levels of illness.

Poor housing affects health. People who live in poor housing often have low incomes, (e.g. single parents, unemployed people and pensioners). They have higher levels of mental illness and poor well being as well as higher incidences of other physical conditions including asthma. They are more likely to experience fuel poverty, to use health services disproportionately and to smoke. Damp, mould and cold cause numerous health problems including respiratory problems, aches and pains, chronic sickness and disability. Children are especially affected. Heating systems and the provision of new housing can improve health. Infestation, accidents and fire are common in high rise blocks. There is some evidence that people who live in poor areas that are close to affluent and/or regenerated ones experience this in ways that adversely affect their health.

The process of **improving housing** can be stressful and disruptive for tenants. Relocation to new housing (on temporary or permanent bases) can have a negative effect, in the short term, on well being and mental health. These effects can be minimised by meaningfully involving tenants, developing ways to promote their participation in decision making and keeping them informed. Alternatives to moving include improving current housing stock with minimal disruption and providing appropriate financial support for tenants. However, in areas of multiple disadvantage other factors continue to have a negative impact. These may be off set where initiatives to reduce poverty, unemployment and social exclusion accompany housing improvement schemes.

Homeless people, rough sleepers and their children and people living in temporary accommodation (a high proportion of whom are from black and ethnic minorities, many are asylum seekers and refugees) suffer high rates of illness generally. Examples include problems relating to child bearing, mental illness, respiratory problems, nutrition and dental health. They are also exposed to more risks (including violence, sexually transmitted infections and drugs and substances). Homelessness may cause children to feel unsettled and become aggressive, and has significant effects on family relationships. Homeless people are more likely to use hospital services, less likely to use primary care and are often readmitted to hospital as emergencies after discharge. Black and ethnic minority homeless people are less likely to access health services.

Some evidence suggests that people who are socially isolated and/or feel marginalised, who do not have strong sense of belonging to a community or neighbourhood and/or do not participate in local groups, experience higher levels of mental and physical ill health. **Strengthening social networks, building capacity and investing in ‘social capital’** are important in developing effective responses that build prosperous, healthy communities.

Acknowledgements

The following unpublished sources were used in the preparation of the text and the condensation of the evidence base:

- Cave, B., Curtis, S., Aviles, M. and Coutts, A. (2000 – Draft) *Health impact assessment ... a toolkit for regeneration schemes in East London*. Queen Mary, University of London.
- Elliott, E., Landis, R. and Popay, J. (2000 – Draft) *Regeneration and Health: A Methodological and Substantive Review of Research*. Nuffield Institute for Health, University of Leeds

Report

London Health Commission and the Environment Committee of the Assembly

Health Impact Assessment – Draft Economic Development Strategy

Appendix 1

Health Impact Assessment of the Greater London Authority's Economic Development Strategy

*A condensation of some of the evidence base relating
to regeneration and health*

Contents

Purpose	3
Acknowledgements and sources	3
Key to references	3
Notes to readers	3
Section 1 The effects on health of unemployment and other employment-related factors	
1 Unemployment	4
2 Employment	6
3 Poor working conditions	7
4 Job insecurity, risk of unemployment, threat of redundancy	8
5 Economic prosperity	8
Figures 1–3	
Section 2 The effects on health of housing and homelessness	
1 Housing conditions	12
2 Repossession	19
3 Homelessness	19
Figures 4 and 5	
Section 3 The effects on health of social capital	
1 Social contacts	26
2 Social networks	26
3 Social support	27
4 Membership in voluntary groups	27
5 Civic participation	27
6 Civic trust	28
7 Social integration	28
8 Social integration, civic involvement and religiosity	28
9 Qualitative analysis	29

Purpose of this document

This document has been prepared to assist the rapid appraisal of the GLA's Economic Development Strategy.

Acknowledgements and sources

This paper and figures have been prepared by Erica Ison, The Institute of Health Sciences, Oxford, from the following unpublished sources:

- Cave, B., Curtis, S., Aviles, M. and Coutts, A. (2000 – Draft) *Health impact assessment ... a toolkit for regeneration schemes in East London*. Queen Mary, University of London.
- Elliott, E., Landis, R. and Popay, J. (2000 – Draft) *Regeneration and Health: A Methodological and Substantive Review of Research*. Nuffield Institute for Health, University of Leeds.

The figures have been developed from the evidence bases featured by the teams from Queen Mary and the Nuffield Institute of Health.

The Greater London Authority are indebted to the teams at Queen Mary, University of London, and the Nuffield Institute of Health for their generosity in allowing unpublished work (at the time of writing) to be used as an underpinning for the appraisal of the potential health impacts of the draft Economic Development Strategy.

Key

The following system is used to refer to sources cited in the above two studies

(**QM**) – followed by a *number* refers to sources listed in the 2000 Draft Toolkit

(**NIH**) – followed by *author(s)* refers to sources listed in the 2000 Review of Research

Notes to readers

The evidence base on the health effects of different types of transport prepared by the team at Queen Mary, University of London, has not been included in this condensation as a rapid appraisal of the Draft Transport Strategy has already been completed (and several reports containing evidence circulated previously).

No attempt has been made to assess the *quality* of the evidence presented here.

Section 1

The effects on health of unemployment and other employment-related factors

This section condenses findings in the following five areas:

- 1 Unemployment
- 2 Employment
- 3 Poor working conditions
- 4 Job insecurity, risk of unemployment, threat of redundancy
- 5 Economic prosperity.

1 Unemployment

The relationship of some of the main factors leading to poor health in the unemployed are shown in Figure 1.

Unemployed people suffer:

- increased mortality (QM 71, 74 – applies to men)
- increased mortality with long-term unemployment (QM 71, 78)
- a higher risk of premature mortality (QM 86).

The increase in mortality: causes may include:

- all major causes (QM 86 – applies to men)
- cardiovascular conditions (QM 71, 72 – excess mortality, 82)
- suicide (QM 71, 82)
- accidents (QM 71), and injuries and poisoning (QM 86 – applies to young men)
- cancer (QM 71).

People who are unemployed suffer:

- increased morbidity (QM 86).

Increase in morbidity: the increase in morbidity can arise from an increase in morbidity for:

- heart disease (QM 79).

It could be mediated through:

- an increase in the level of cholesterol (QM 78)
- a decrease in immunity (QM 78).

It is reflected in an increase in:

- self-reported illness (QM 79, 82)
- medications taken (QM 82)
- the number receiving disability pensions (QM 77).

It is reflected in increased use of health services, as shown by an increase in:

- visits to the doctor (QM 54 – and about more illnesses, 82)
- referrals to hospital as outpatients (QM 54)
- visits to hospital (QM 54)
- admissions to hospital (QM 82)
- hospitalisation for cardiovascular disease (QM 69).

However, **men made unemployed through redundancy** can experience a decrease in the rate of admissions for musculoskeletal conditions and accidents, which may result from no longer being exposed to a high-risk work environment (QM 69).

Unemployed people suffer disturbances to their **mental well-being**; they experience:

- boredom and despondency (QM 70)
- sense of lack of control (QM 80)
- decreased hope for control (QM 62)
- stress (QM 62)
- anxiety (QM 60, 78, 79)
- depression (QM 60, 62, 78, 79, 80), and clinical depression (QM 55)
- psychological disturbance (QM 73 – applies to young people who were initially employed and psychologically normal)
- a negative effect on pre-existing mental symptoms (QM 67)
- self-harm (QM 60, 78)
- suicide (QM 60, 71, 78, 82).

Families of unemployed people:

- there is excess risk of death in the wives of unemployed men (QM 87)
- wives of an unemployed husband are at risk of physical abuse (QM 105)
- children and families can experience a ‘pathological impact’ (QM 60)
- families with an unemployed head of the household are at highest risk of poverty (QM 91)
- the level of benefits received by unemployed households in which there are dependent children are not adequate (QM 92–94).

Inequality of impacts of unemployment on health

‘Unemployment is an important determinant of inequalities in the health of adults of working age in Britain: those people lower down the social scale are hit hardest.’

(QM 83–85).

People at **highest risk of the adverse effects of unemployment** are:

- middle-aged men (QM 60)
- the economically marginal , e.g. women attempting re-entry into the labour force (QM 60)

- young people who have recently left school (QM 60)
- children in families in which the primary earner is unemployed (QM 60).

One study found the adverse effects of job loss were confined to those who were satisfied in their former jobs (QM 64).

People most likely to become unemployed are:

- those suffering from poor health (QM 2, 80, 81) – a selection effect
- those who have mental distress and medical diagnoses (QM 81 – applies to involuntary dismissal)
- young people who are under the age of 25 years (QM 98)
- those who have lower levels of educational attainment and other skills (QM 95), or who do not have skills (QM 96)
- disabled people who have no educational qualifications (QM 97).

What works? – Unemployment and health

- People able to gain employment have a case rate 23% lower than their peers who remain unemployed (QM 64 – using particular GHQ scores).
- Re-employment reverses the effect of psychological disturbance in unemployed young people who were psychologically normal and not initially in ill health prior to unemployment (QM 73).
- Schemes run with the aim of improving skills levels in young people have had mixed results from evaluation. Results range from finding that training increases the likelihood of obtaining a ‘good job’ to finding that some schemes may fail the most disadvantaged (QM 99–104).

2 Employment

Some of the main factors that may have an effect on the health of people who are employed are shown in Figure 2.

- **People who are employed** report significantly lower levels of health disorder than do students or the unemployed (QM 64).
- Among **employed people** :
 - the highest levels of health risk are experienced by dissatisfied workers, and the lowest levels by satisfied workers (QM 64)
 - those whose quality of work deteriorates reported less well-being (QM 64)
 - rates of absenteeism were higher (30%) for those who had decreased job control when compared with those who had increased job control, and higher (10%) for those who had decreased social support when compared with those who had increased social support (QM 76– co-worker support especially important for women).

➤ Inequalities associated with employment

- Loss of job control poses a greater health risk for older, higher income workers (QM 76).

3 Poor working conditions

People working under poor conditions can experience:

- premature death (QM 79)
- increased low back pain (QM 79), and increased risk of musculoskeletal disorders (QM 2)
- increased cardiovascular disease (QM 79), and increased risk of coronary heart disease (QM 2)
- mental illness (QM 2), and disturbances to mental health (QM 64).

The **increase in morbidity** is reflected in:

- an increase in sickness absence (QM 2, 79).

The **following working conditions** can have a negative impact on health:

- stress (QM 2, 79)
- lack of control over work (QM 79)
- low level of control exacerbated by demands of work (QM 79), and imbalance between psychological demands and control (QM 2, 114)
- low pay (QM 78)
- exposure to hazards (QM 2, 78)
- job insecurity (QM 78) – *see below*.

Moreover, the impacts on health of poor working conditions are often associated with a high risk of unemployment (QM 78).

➤ Inequalities in exposure to poor working conditions

- Exposure to high demand and low control is more common among lower socioeconomic groups (QM 115).

What works? – Employment and health

Improvements in health during employment can be achieved by:

- increasing the variety and understanding of the different tasks in a production process (QM 116 – applies to psychosocial health)
- workforce participation in identification of problems and their solutions (QM 116 – applies to psychosocial health)
- improving the quality of the work (QM 64)
- increasing the level of satisfaction with the job/work (QM 64).

In addition, the enhancement of management skills in the current and future workforce may bring about a culture and practice amenable to a health-promoting work organisation (QM 2).

Note: Psychosocial health included in the extended HSE campaign ‘Good Health is Good Business’ (QM 199).

4 Job insecurity, risk of unemployment, threat of redundancy

People whose jobs are insecure, or who are at risk of unemployment or under threat of redundancy can experience negative impacts on their health:

- an increase in the level of stress (QM 70)
- an increase in the level of serum cholesterol – no evidence of dietary change (QM 72 – risk of unemployment in middle-aged men)
- a decrease in the level of serum calcium – no evidence of dietary change (QM 72 – risk of unemployment in middle-aged men)
- changes in norepinephrine excretion, serum creatinine, serum uric acid and serum cholesterol (QM 61 – associated with stress of job termination).

In addition, **those at risk of unemployment** are more likely to accept working conditions damaging to health (QM 78).

For the **families** of those under threat of redundancy, there can also be negative impacts on health:

- an increase in the morbidity of families from the time the job was secure to when job loss was imminent or had occurred (QM 53) – this was manifest as increasing dependency on the doctor, and presenting symptoms being increasingly hard to diagnose and treat, problems less clear-cut, more psychosomatic distress, and disorders less responsive to simple interventions
- an increase in morbidity of spouses during the period when the job was insecure (QM 54).

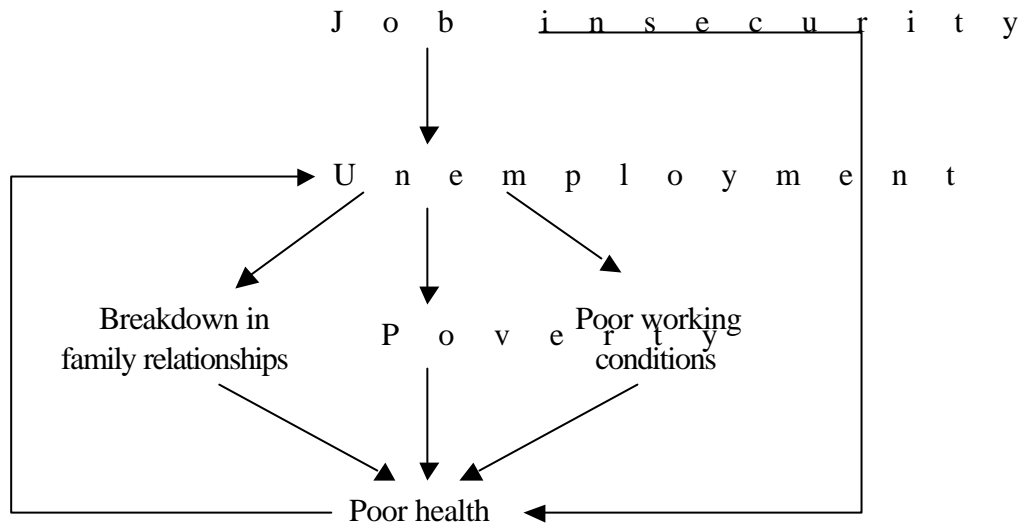
➤ Inequalities in exposure to job insecurity

- Changes in the nature of work over the last 2 decades – greater job insecurity as a result of increased market flexibility and deregulation of employment contracts – have affected the lower end of the labour force more (QM 109–112).

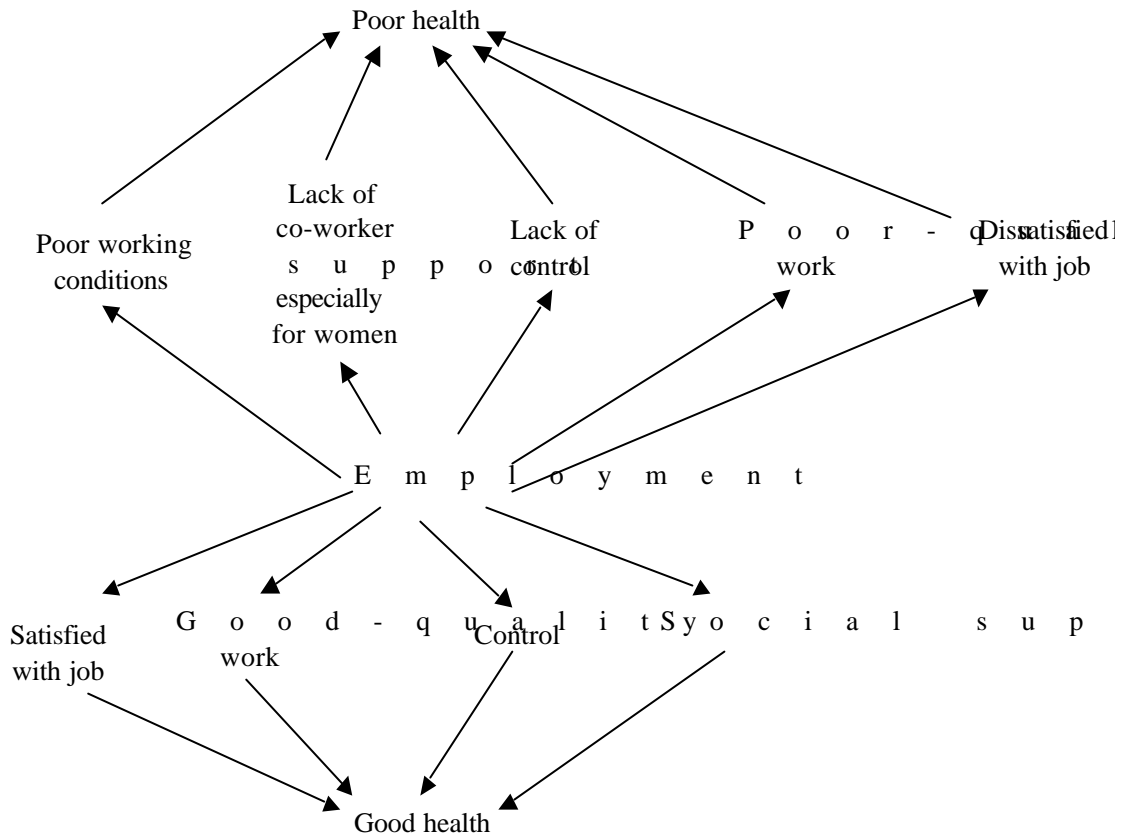
5 Economic prosperity

The potentially negative effects of economic prosperity are shown in Figure 3 (QM 58).

F i g u r e 1

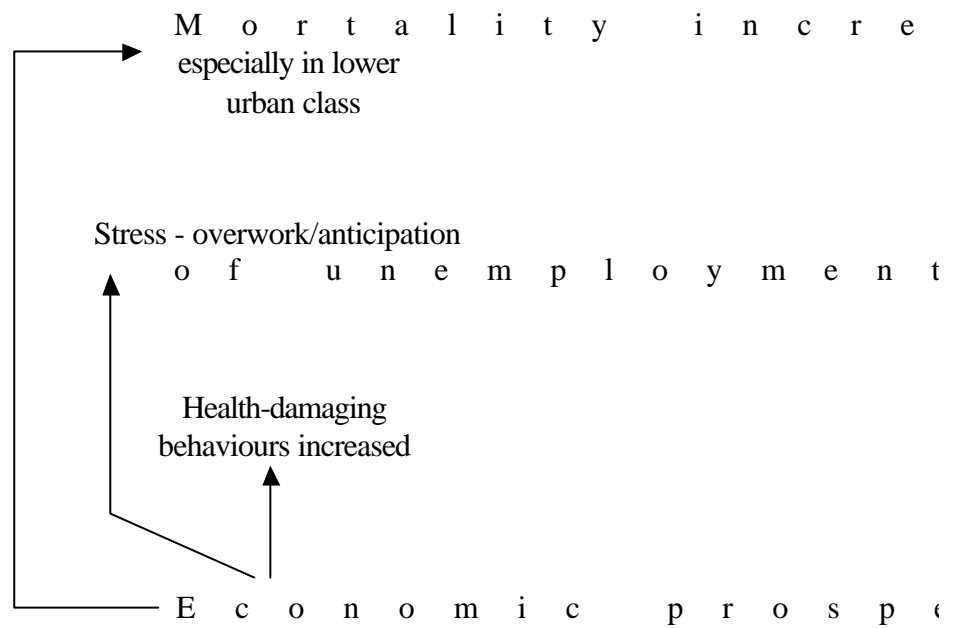


EBGLA/Figure1. ppt/ 9 . 1 . 0 1



E B G I p p t A 9 / . F l i . g 0 u l r e 2 .

Figure 3 (QMW58)



J a n 2 0 0 1 / F i g u r e 5 / 9 . 1 . 0 1

Section 2

The effects on health of housing and homelessness

This section summarises findings of research under the following three headings:

- 1 Housing conditions
- 2 Repossession
- 3 Homelessness.

The relationship of some of the main factors leading to poor health as a result of housing or homelessness are shown in Figure 4.

1 Housing conditions

Inhabitants of houses in which there are **adverse housing conditions** suffer from:

- emotional stress (QM 170 – adults and children)
- high levels of anxiety and depression (NIH Ellaway)
- feelings of being ‘run down’ (NIH Ellaway – applies to women affected by their children’s ill health)
- higher rates of mental illness, especially for women (QM 169)
- high levels of asthma (NIH Ellaway).

Children exposed to adverse housing conditions suffer from higher rates of stomach cancers later in life (QM 153).

Inhabitants of houses in which there are adverse housing conditions:

- have high levels of smoking (NIH Ellaway)
- have frequent consultations with health professionals (NIH Ellaway)
- experience fuel poverty (NIH Ellaway).

These experiences are reflected in high rates of prescription of drugs to treat asthma and depression (NIH Ellaway).

Damp, mould and cold

The inhabitants of houses in which there are conditions of damp, mould and cold experience higher rates of:

- chest problems (QM 155)
- respiratory problems – more likely to affect children (QM 159)
- wheezing and chesty coughs – twice as likely to be suffered (QM 163)
- asthma (QM 155, 158, 159)
- rhinitis (runny nose) (QM 155, 159)
- alveolitis (inflammation of the lungs) (QM 155, 159)
- other allergies (QM 159)
- gastrointestinal upsets (QM 159)
- aches and pains (QM 159)

- nervousness (QM 159).

There is a high prevalence in this group of:

- respiratory diseases (Hunt in QM 154)
- chronic sickness and disability (QM 156, 157).

This group also experience:

- increased emotional strain (Hunt in QM 154)
- increased susceptibility to diseases (other than respiratory) (Hunt in QM 154)
- higher levels of a range of symptoms – there is a dose–response relationship between the number of symptoms and the number of housing problems independent of smoking and socioeconomic factors (QM 160).

Children who inhabit houses with the above conditions experience:

- higher levels of a range of symptoms – there is a dose–response relationship between the number of symptoms and the number of housing problems independent of smoking and socioeconomic factors (QM 160)
- in the long term, a negative influence on physical, social and emotional development (Hunt in QM 154)
- wheezing (QM 161, 162 – parental reports; QM 163 – these children twice as likely to suffer as children sleeping in dry rooms)
- chesty coughs (QM 163 – these children twice as likely to suffer as children sleeping in dry rooms)
- nocturnal coughing (QM 161, 162 – parental reports)

Children living in these conditions are also absent from school due to chest trouble (QM 161, 162 – parental reports).

The **group** most vulnerable to cold and damp houses are:

- low-income households with no paid workers, including the unemployed, the retired, and single parents (QM 156, 157).

Quality of housing design

- Housing for which industrialised building techniques, poor workmanship and poor materials were used, especially system-built tower blocks of the 1960s and 1970s, are prone to infestation by cockroaches. The inhabitants of housing in which there are cockroach infestations suffer from higher rates of stress and disease relating to that infestation (QM 168).
- Inhabitants of high-rise buildings are more prone to serious accidents, e.g. falling from windows and balconies, and have less chance of escaping from fire (QM 135).

Relocation

Those people who are relocated suffer from:

- severe grief at the time of relocation (NIH Fried)
- sadness and depression 2 years after relocation (NIH Fried).

➤ **Inequalities associated with:**

Housing conditions

- Poor housing conditions are more prevalent among groups with low income (QM Hill).
- Households in disadvantaged circumstances are likely to be worst affected by accidents (QM 166).
- Most deaths arising as a result of accidents to children were caused by residential fires in poor-quality social housing and temporary accommodation (QM 46).

Housing tenure

- People living in council housing are more likely to die before the age of 65 years than owner occupiers (QM 145).
- Childhood mortality can be related to housing status (QM 171).

Location of housing

- Households in low-income multi-ethnic areas are at greatest risk of violence (QM 173).

Regeneration initiatives

- People living in areas just outside regeneration initiatives may be disadvantaged (NIH); levels of stress and depression in these people were exacerbated by the experience of being left out (NIH Ambrose).
- Regeneration may create or exacerbate social division within neighbourhoods (NIH Forrest & Kearns; NIH Cattell & Evans; NIH Silburn *et al.*).

What works? – Housing conditions and health

What works? – Installation of a heating system

- Elimination of dampness and mould prevented a further deterioration in the health of children – there was a general deterioration in all symptomatic health, and although symptoms associated with mould/damp decreased or stayed the same there was an increase in aches and pains, sore throat, persistent cough, tiredness and temper tantrums (QM 126). Improvements in housing conditions may increase resistance to illness but may be insufficient to ameliorate symptoms in areas of multiple disadvantage (QM 126; NIH Hopton and Hunt).

What works? – Housing renewal

- For some people, the process of housing renewal was stressful and damaging to health – aggravation of psoriasis, tension in inter-family relationships, nervousness, weight loss – whereas for other it was enjoyable and rewarding – happiness and excitement (QM 127). Those who were able to establish control over what was happening had a more positive experience, but this also depended on how much control the individual wanted and the negotiability of the level of control (QM 127; NIH Allen).
- Up to 35% of residents in one area reported that they were stressed by the renewal process, and 58% said the process was too long and the uncertainty was affecting their health (NIH Green *et al.*).
- However, the process of housing renewal can be associated with positive outcomes – improved psychosocial health, reduced fear of crime, less damp – after refurbishment, but the population in whom these positive outcomes were recorded was different to the population studied before refurbishment (QM 131; NIH Wadham).
- Provision of central heating and security measures were most strongly associated with reported improvements in health; new decorations were linked to improvements in depression and psychological problems (NIH Shepherds Bush Housing Association – preliminary results).
- Physical improvements to buildings and improvements to security and overall attractiveness of the area gave rise to health improvements (NIH Inverclyde Housing Investment Study – Ellaway). The experience of being ‘decanted’ to other accommodation while improvements were taking place was stressful in several ways (NIH Ellaway).
- A programme of refurbishment and demolition and rebuilding was associated with a marked reduction in the duration and severity of illness episodes (self-evaluation), and fewer consultations with health professionals, but despite these health gains health measured in terms of population indicators is not improving (NIH Limehouse Fields and Ocean Estates Study – Ambrose).

- Housing improvements have been associated with a reduction in self-reported episodes of ill health and use of services (NIH), an improvement in health-related behaviours (NIH), e.g. reduced smoking, improved diets, positive attitude to life in general, and participation in community participation (NIH Ambrose; NIH Ellaway); these findings have been supported by changes in prescription rates for drugs for depression and asthma (NIH). However, health improvements may result as much from the wider impact of housing improvement initiatives on neighbourhood conditions (NIH), e.g. revitalising social space by improving the opportunities for social interaction and integration (NIH Turok *et al.*), and improving access to nearby environments, services and leisure facilities (NIH).
- Housing improvements that lead to the eradication of the causes of debt, e.g. energy efficient homes, are linked to positive health benefits (NIH Ellaway *et al.*).
- Unforeseen costs to residents can arise as a result of housing renovation (NIH Ellaway *et al.*).

Ways to maximise the benefits of housing renewal

- Offer choice of contractor from an approved list (QM 127; NIH Allen)
- Encourage direct relationship with those who carry out the work (QM 127; NIH Allen)
- Involve tenants in the details of the renewal (QM 127; NIH Allen)
- Involve tenants in the design process (NIH Ellaway)
- Consider whether the work has to be carried out during the tenancy or why it needs to be done at a particular time (especially important for elderly residents) (QM 127; NIH Allen).

However, isolated improvements to housing alone are unlikely to be sufficient to improve health in areas of multiple disadvantage (NIH Hopton & Hunt); poverty and other housing benefits to be gained from heating improvements (NIH).

What works? – Rehousing

- For those people being rehoused, health problems were not solved immediately (QM 128). The following continued: self-reported chest-related problems, breathing problems, and gastric problems; injuries; disturbances in psychosocial health (QM 128). Some of the properties the families moved into were in a poor state of structural repair, and the majority of families (72%) faced financial difficulties in moving to a new home (57% needed a loan) (QM 128). There was a detrimental effect on children's schooling (45% of household had children who had missed periods of schooling due to homelessness) and children's access to developmental, medical and dental checks (QM 128). For families, there was a detrimental effect on access to primary care (QM 128).
- Enforced rehousing into either temporary or permanent residence has a negative impact on health and social relationships (NIH Ellaway; NIH Green *et al.* – stress and worry about the process, and mental health); alternative accommodation was often poor (NIH). Decanting can be particularly stressful for elderly residents (NIH).
- Rehousing does not have a dramatic effect on either physical or mental health – gains in satisfaction tend to be offset by perceived adverse changes in social networks and social support; rehousing may require considerable adaptation to new location (studies in QM 126).

Ways to maximise the benefits of rehousing

- Financial assistance to move, furnish and redecorate the new home (40% reported this to be the most useful help at resettlement) (QM 128)
- Prompt assessment and receipt of housing benefit (QM 128)
- Provision of information about rehousing through effective communication systems to lower uncertainty in residents (NIH).

What works? – Rehousing on the basis of medical priority

- For those rehoused on the basis of medical priority, self-reported depression were the two conditions most likely to have undergone a change – over two-thirds of people experiencing these conditions reported a change, the majority reporting an improvement (QM 129). Respondents felt that relocation had least effect on learning difficulties, metabolic disorders, skin diseases and diseases of the kidney, liver and bladder (QM 129). Psychological distress was associated with residential change when it was prompted by reasons beyond the mover's control; rehousing can be particularly depressing for women and older people (QM 129). In this study, movers were allowed choice over location of the new property, and had the potential to secure better access to close relatives for their social support networks (QM 129).

What works? – Increasing the social mix of a residential area

- The presence of home owners helps to alleviate the stigma of residence on a deprived estate, but owner-occupiers have limited influence on social networks among housing estate residents and limited influence on patterns of social inclusion – physical proximity leads to limited social contact between the two groups (QM 130).

What works? – Regeneration initiatives

- Differences in mortality rates among low-income countries suggest that investment in social policies that produce health-enhancing assets, e.g. ensuring that women have access to education, are likely to result in better population health (NIH). For instance, in the State of Kerala, India, mortality rates approach those of wealthier industrialised countries (despite relatively low income per capita); this may be related to the equitable nature of resource distribution – there is a greater number of redistributive policies and there have been decades of public investment in human resources, e.g. promoting gender equality and improving education (NIH Lynch *et al.*; NIH Kabir & Krishnan).
- Area-based regeneration initiatives have only limited potential to improve health: the root causes of health inequalities (poverty) are not addressed, and impacts within the renewal area are not seen outside that area (NIH).
- Poverty reduction/income maximisation projects within regeneration initiatives are associated with improved health, e.g. provision of access to skills training and employment (NIH).

Ways to maximise the benefits of regeneration initiatives

- Communication with residents to highlight initiatives that have been implemented, particularly social and economic regeneration initiatives which are not necessarily ‘visible’ (in comparison with physical improvements in a locality), e.g. training, employment, crime prevention, and leisure (extrapolation from NIH Forrest & Kearns)
- Involvement of local residents in the process of implementation (extrapolation from NIH Forrest & Kearns; NIH Ambrose), particularly decision-making (extrapolation from NIH Forrest & Kearns)
- Gaining an understanding of the history, structure and social relations of the community(ies) involved to guide ways forward for the project (NIH Forrest & Kearns)

- Recognition of neighbourhoods as areas of historical social significance to residents, and the implications of any change to them (NIH Marris), and building on people’s history associated with specific places (NIH Fried; NIH Gans)
- Involvement of local residents in research, e.g. the collection of data and the design of questionnaires relevant to local concerns (NIH Ambrose; NIH Brownhill & Darke) – a handbook has been designed to guide local people in participating in research (NIH Walker *et al.*) – techniques such as participatory rapid appraisal and Planning for Real can be used (NIH)
- Involvement of local residents in the evaluation of regeneration initiatives (NIH), while being aware that (1) partnerships can be dominated by a particular viewpoint (NIH Anastacio; NIH Forrest & Kearns), and there is a need to ensure community representatives are truly representative and communicate with other residents, and (2) it is difficult to involve particular sections of the community, e.g. young people and people from ethnic minority groups (NIH Anastacio; Fitzpatrick *et al.*) – it is important to develop appropriate structures to accommodate lay and professional contributions (NIH Nottingham Partnership) – an audit tool to assess the effectiveness of participation has been developed (NIH Anastacio; NIH Burns & Taylor).

2 Repossession

People who have their house repossessed suffer from:

- poor mental health (QM Nettleton *et al.*)
- poor physical health (QM Nettleton *et al.*)
- depression (QM Nettleton *et al.*)
- stress (QM Nettleton *et al.*).

Repossession also has an effect on:

- social status and identity (QM Nettleton *et al.*)
- personal and family relationships (QM Nettleton *et al.*)
- children (QM Nettleton *et al.*)
- quality of life (QM Nettleton *et al.*)
- future aspirations (QM Nettleton *et al.*).

3 Homelessness

People who are homeless suffer from:

- rates of chronic illness 2.5-fold that of the general population (QM 134)
- mental health problems (QM 144), or mental illness (QM 145) – the condition worsens as homelessness continues (QM 146)
- alcohol-related problems (QM 144)
- exacerbation of the ageing process (QM 134)

- an increased risk of violence (QM 151, 152 – applies to women)
- an increased risk of rape (QM 151, 152 – applies to women)
- an increased risk of HIV infection (QM 151, 152 – applies to women), and higher rates of HIV infection (QM 134 – applies to young people)
- higher rates of Hepatitis B and C (QM 134 – applies to young people)
- higher rates of sexually transmitted diseases, other than HIV and Hepatitis B and C (QM 134 – applies to young people).

In addition, people who engage in criminal activity often do so after a period of homelessness – homeless people can be both criminal and criminalised (QM 172).

Homeless **families** suffer from:

- a high rate of respiratory illness (QM 134)
- a high rate of gastrointestinal illness (QM 134)
- poor perinatal outcomes (QM 134)
- problems in pregnancy and labour (QM 134)
- a higher rate of mental illness related to stress (QM 134)
- accidents in the home (QM 134).

Homeless **children** are more susceptible to:

- disturbed sleep (QM 134)
- poor eating (QM 134)
- overactivity (QM 134)
- bedwetting and soiling (QM 134)
- aggression (QM 134).

Homeless children experience higher rates of:

- accidents (QM 134)
- infectious disease (QM 134).

Rough sleepers suffer from the following health problems:

- chronic chest conditions 3-fold greater than in the general population (QM 144)
- breathing problems 3-fold greater than in the general population (QM 144)
- musculoskeletal problems 3-fold greater than in the general population (QM 144)
- difficulties in seeing 3-fold greater than in the general population (QM 144)
- frequent headaches 3-fold greater than in the general population (QM 144).

Single and homeless people suffer from the following health problems:

- arthritis (QM 134, 149)
- bronchitis (QM 134, 149)
- cellulitis (QM 134, 149)
- chronic obstructive airways disease (QM 134, 149)
- epilepsy (QM 134, 149)
- foot problems (QM 134, 149)
- infestation (QM 134, 149)
- mental illness – psychosis and personality disorder due to alcohol-related illness and drug misuse (QM 134, 149)
- poor dental health (QM 134, 149)
- poor nutrition (QM 134, 149)
- skin diseases and infections (QM 134, 149)
- trauma (QM 134, 149)
- tuberculosis (QM 134, 149).

Homeless people and those in temporary accommodation suffer from the following:

- chronic chest conditions – prevalence twice as high as that in general population (QM 144)
- relatively high rates of chest infection (QM 150)
- breathing problems – prevalence twice as high as that in general population (QM 144)
- frequent headaches – prevalence twice as high as that in general population (QM 144)
- musculoskeletal problems – prevalence twice as high as that in general population (QM 144)
- difficulties in seeing – prevalence twice as high as that in general population (QM 144)
- relatively high rates of gastroenteritis (QM 150)
- relatively high rates of stress (QM 150)
- relatively high rates of skin disorders (QM 150)
- accidents (QM 150 – high rates in children; QM 165 – families are particularly likely to suffer).

In addition, personal and parental relationships are undermined (QM 150).

Those at most risk of becoming homeless are those who become acutely mentally ill and have restricted access to inpatient stay (Leff in QM 134).

People who are likely to suffer from mental illness and have an associated risk of homelessness are:

- the socially disadvantaged
- the unemployed
- those living in overcrowded accommodation

- those living in poor housing.

Refugees or asylum seekers suffer from:

- a relatively high prevalence of common physical and mental health problems, arising from trauma prior to or during flight to host country (QM 147)
- a multiplicity of health and social problems, which may be acute at the time of arrival arising from separation of families, adjusting to new circumstances, and coping with the trauma of past events (QM 134).

Use and perception of health services

- Many young people recently made homeless do not have access to healthcare (QM 144).
- Some homeless people are reluctant to register with GPs (QM 140), due to low expectations of their own health status and of health services in general; there are low rates of registration with GPs among black people, who have low levels of satisfaction with GP and primary care services (QM 137).
- However, as homeless people perceive GPs and Accident & Emergency depts to be stigmatising, there is a low level of use, but they would use health services more and present earlier if the services were presented in a sensitive and accessible way (QM 148).
- A greater number of those people who are homeless (26%) report an inpatient hospital stay in the previous year when compared with the general population (9%) (Stern *et al.* in QM 135 – applies to rough sleepers and those in supportive housing projects).
- Homeless people are more likely to experience:
 - emergency re-admission to hospital (QM 134, 139, 140), because they can be lost to follow-up after discharge
 - poorer outcomes of healthcare (QM 134, 142, 143) – homeless people often present at a later and more severe stage of an illness.
- Child immunisation rates are low in London for those families in insecure housing (QM 134).
- Cultural and language barriers hinder access to appropriate healthcare for refugees and asylum seekers (QM 147).

Use of other services

- Ethnic minorities are less likely to use traditional day centres or shelters for homeless people (Hinton in QM 134)

Impacts on health services

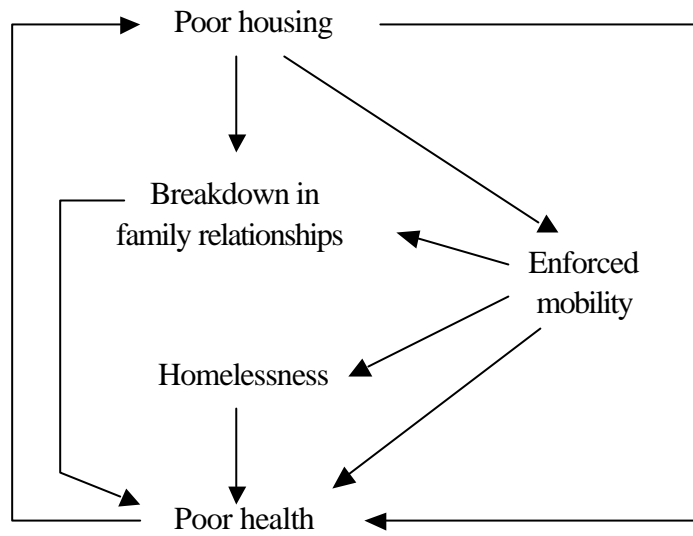
- Each ‘inappropriate’ visit to Accident & Emergency departments has been estimated to cost £28 over and above the average cost for an appropriate attendance (QM 141).

➤ **Inequalities in homelessness**

- Ethnic minorities form a large part of the homeless population (Hinton in QM 134).
- Black and ethnic minorities are the fastest growing group among the hostel population (Hinton in QM 140).
- There is very little information on the health needs of black and ethnic minority homeless people (often, they are not identified at the point of service use) – racism on the streets and within institutions means there are additional barriers and dangers for these homeless people (QM 138).
- Refugees have few resources and suffer considerable material deprivation while facing an uncertain future.
- The following groups are more likely to suffer mental illness than the general population and are associated with a risk of homelessness:
 - people who are socially disadvantaged (QM 145)
 - the unemployed (QM 145)
 - those living in overcrowded or poor housing (QM 145).

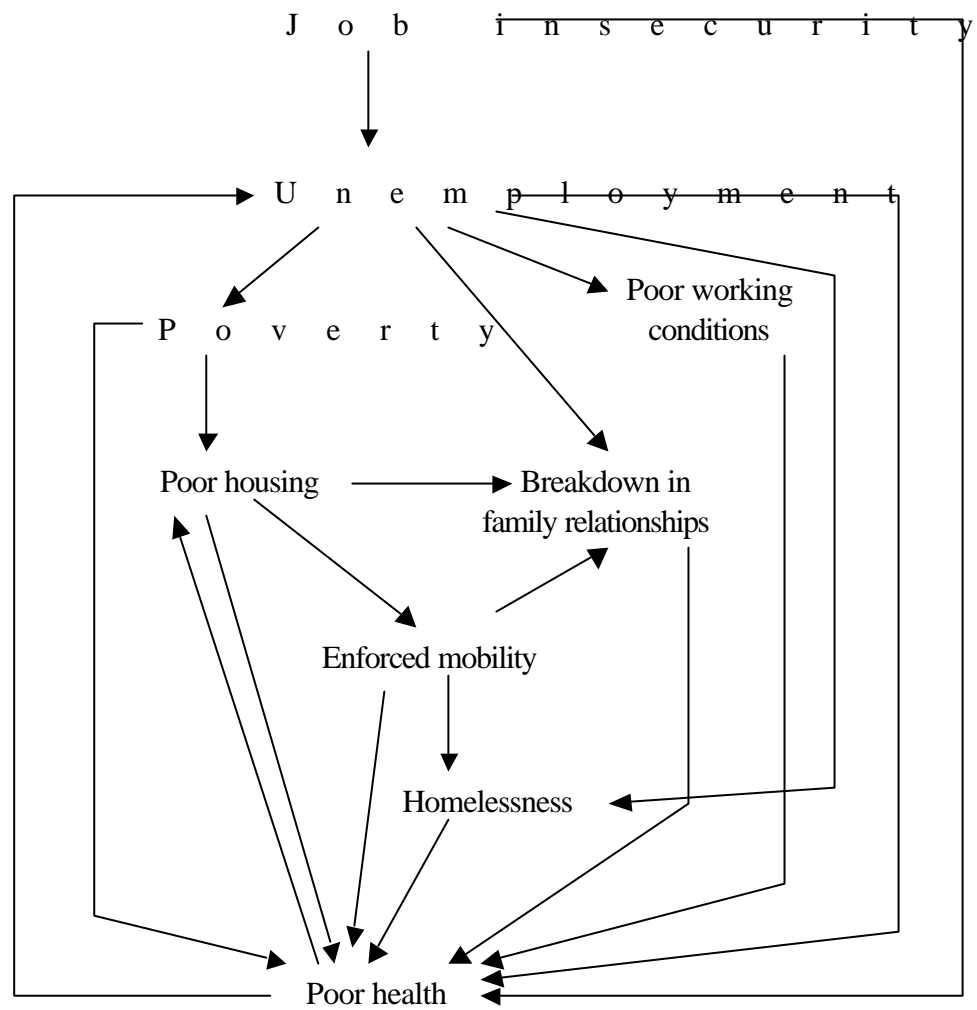
The relationship of some of the main factors leading to poor health as a result of the inter-relationship between unemployment and poor housing conditions and homelessness are shown in Figure 5.

F i g u r e 4



GLA/Figure4. ppt/ 9 . 1 . 0 1

Figure 5



Section 3

The effects on health of social capital

There are several definitions of social capital in the literature (see QM), although it is difficult to use a measure that captures adequately the subtlety of social interaction (QM 182); indeed, it may not be measurable, but instead apply as a concept in different ways in different contexts social, cultural, historical, economic (QM 176).

There is a synergy between economic development and social factors that affect health, but we need to understand the complexity of the relation between social capital and economic development and the ways in which social factors affect economic development (QM 182). Some authors question the practicality of applying the concept of social capital in the achievement of health gain (QM 189).

Mechanisms linking social capital to health may be different to those that link social network to health (QM 186).

1 Social contacts as a measure of social capital (QM 183)

- Mortality rates are lower in people who:
 - are married
 - have frequent contacts with relatives and friends
 - are members of a church and other social/community organisations.
- Mortality rates increase with each decrease in social connections, culminating in a significant increase in risk of death associated with the absence of any form of social contact.

2 Social networks as a measure of social capital (QM 187)

- Socially isolated men are:
 - more likely to smoke
 - more likely drink more
 - less likely to go for a health check-up (related to blood pressure, serum cholesterol, and physical examinations)
 - at risk of cardiovascular disease, accidents and suicides.
- Being unmarried was the strongest predictor of cardiovascular mortality
- Social networks reduce total mortality by lowering deaths from cardiovascular disease, accidents and suicides.

3 Social support and social networks as measures of social capital (QM O'Reilly & Thomas)

- Those people who maintained or lowered their risk status 3 years after the MRFI trial – ‘maintainers’ – received significantly more support

than ‘non-maintainers’, which included that specific to risk reduction efforts – information/advice, appraisal, emotional support, availability.

- Maintainers had larger support networks, which were more dense and family-oriented.
- Maintainers were more satisfied with the support they received.

4 Membership in voluntary groups and perceived social trust as measures of social capital (QM 188)

- There is a strong inverse correlation between age-adjusted all-cause mortality rates and each indicator of social capital.
- A 1% increment in the level of mistrust is associated with an increase in total mortality rate of 4.5 deaths per 100,000.
- Variations in the level of trust accounted for 58% of the variance in total mortality across States.
- Low levels of trust are associated with higher rates of major causes of death, including cardiovascular disease, malignant neoplasm, cerebrovascular disease, unintentional injury and infant mortality.
- The level of group membership is a predictor of coronary heart disease, malignant neoplasm, and infant mortality.

5 Civic participation and dimensions of trust as measures of social capital (QM 192)

- Civic participation was not related to health.
- Trust was not significantly related to self-rated health status.
- Willingness to turn to workmates in time of trouble was related to health overall.
- Commitment to personal happiness was important for predicting health status, and most relevant for the middle-aged and male populations.
- Attendance at religious services was more important in predicting health status for older people.
- Education was significantly related to health for the middle-aged (39–65 years).
- Education and income were significantly related to health in those who were older (>65 years).

6 Extent of civic trust and perception of reciprocity as measures of social capital (QM 186)

- In States that had low social capital, higher proportions of residents reported their health to be either fair or poor.
- There was a correlation between:
 - social mistrust and the percentage of residents in fair/poor health
 - perception of reciprocity and the percentage of residents in fair/poor health.

- Residing in a State with the lowest level of social capital was associated with a 45–73% increased odds of fair/poor health.
- Residing in areas with the lowest level of trust was associated with an odds ratio of 1.4 for fair/poor health.

7 Social integration as a measure of social capital (QM 191)

- Higher levels of social integration are associated with lower mortality rates and higher life-expectancy.
- A significant correlation was found between:
 - percentage of people living alone and mortality from heart disease, cancer, stroke, respiratory diseases, suicide, and all causes combined
 - divorce rate and mortality from traffic accidents and suicide
 - unemployment rate and mortality from heart disease, stroke, respiratory disease, suicide, all causes combined, and life-expectancy in men
 - proportion of discouraged job seekers with mortality from heart disease, respiratory disease, traffic accidents, suicide, all causes combined, and life-expectancy in men.
- High levels of unionisation are significantly associated with higher levels of mortality from heart disease, stroke, respiratory diseases, suicide, all causes combined, and life-expectancy in men; this is contrary to previous reports, which suggests it may be unwise to lump all group memberships together.
- People living alone is an important indicator of social integration, and reflects the degree of social isolation and atomisation in the community
 - it was the only indicator of social integration that was associated with all the mortality measures.
- Suicide rates are associated with the largest numbers of indicators of social integration.

8 Social integration, civic involvement, and religiosity as a measure of social capital (QM 184)

- Social capital may be more closely related to mental health than physical health.

9 Qualitative analysis used to measure social capital (QM 185)

- For people living in a high-health community, levels of the following were higher:
 - trust
 - perceived citizen-power
 - perceived civic engagement.

- For people living in a low-health community, dimensions of local identity and local facilities were stronger, but community-linked activist groupings and initiatives rarely referred to.
- A broader range of networks may be associated with better health outcomes.

➤ **Inequalities associated with social capital**

- There is a strong influence of socioeconomic status on community networks and relationships (QM 185).
- The largest effect of social capital on health is in people who have the lowest level of income (QM 186).
- The size of income inequality is powerfully and negatively related to the level of investment in social capital, and this lack of investment may be one of the pathways through which income inequality exerts its effects on the mortality of the population (QM 188).
- The growing gap between rich and poor affects the social organisation of communities; the resulting damage to social fabric may have implications for the public health (QM 188).