

Response to the Marmot Review consultation

St Mungo's
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St Mungo's Response to the Marmot Review Consultation Paper June 2009

Introduction

We very much welcome the Marmot Review and this opportunity to comment on its work. As Southern England's largest homelessness agency, we experience the impact on our clients of the social determinants of health on a daily basis. The reality of health inequalities is borne out by our clients' levels of ill health, with multiple untreated physical health problems, several psychiatric/psychological conditions, and polysubstance dependency being a common occurrence; the average age of those who die in St Mungo's hostels is 41 (*St Mungo's Health Strategy, 2008*).

The Review is a major piece of work with a clear objective of reducing health inequalities and offering a wide range of proposals to tackle the social determinants behind them. We do not have either the capacity or the particular expertise to give detailed feedback across the whole Review, so our responses will inevitably be focused on our own client groups and our own areas of experience.

This does not mean we are not aware of the macro and micro contexts. On the former, for example, we recognise the link between redistribution of wealth and reduction in health inequalities, and the importance of tackling this; equally, we recognise the importance of equality of opportunity in education, and the need to reform the school system to achieve that. In the micro context, we appreciate that detailed reform of, for example, contract administration (avoiding the expensive and inefficient traps of over-monitoring, micromanagement, and of target-oriented delivery systems that, as the Review so neatly puts it, 'hit the target but miss the point') is very important. However, we cannot comment on all these processes or all the Review's proposals. Broadly, we welcome the direction the Review has taken and the concrete proposals suggested.

We will limit our comments to areas of 'headline' importance to our clients, and areas where we believe that our experience, expertise or evidence can add something new or useful.

However, although we will not answer all the questions fully, we will structure our response around the consultation questions posed.

Questions 1 -3 : Overview of evidence on health inequalities and their social determinants

Q1: Are the Principles and values of social justice the right approach to addressing the social determinants of health inequality?

This question is in a way tautologous: for many people, and certainly for St Mungo's, the desire to tackle health inequality arises from the principles and values of social justice that are central to our mission and our objects as a charity. That said, it is arguable that we do not live in a society in which the principles and values of social justice predominate – it could be said that the underlying principles and values of 21st century England are individualism and the acquisition of personal wealth.

The Marmot Review, if it is to carry the political argument through – which means active support from the Government and the media – needs to address both these sets of principles and values. It is possible to make the case for addressing the social determinants of health on other grounds than social justice: containment of disease and community safety are benefits which do not depend on social justice beliefs, and so is the reduction of cost to Government/society. It is evidenceable that tackling the social determinants of health and reducing health inequality would reduce the cost to

Government and society in criminal activity and criminal justice costs, direct medical and health costs, and employment costs.

There is also the a-principled (as opposed to unprincipled) value of pragmatism. If tackling health inequality is a good idea, then we need to do it in a way that works. There is plenty of evidence that tackling social determinants is the way that works, and that other relatively expensive ways don't work; this is a powerful argument.

So as well as the social justice approach, there is the 'this is the only thing that works, let's get on with it' approach, and the 'it'll enable you to knock 2p in the £ off income tax' approach. We suggest that, if the Marmot Review's proposals are to become reality, as we would hope they will, all three approaches need to be applied together.

Q2: Are there any significant gaps in the evidence presented in the task group reports?

Not that we are aware of. However, we would like to add two notes of caution.

The Review says that 'differences in health are progressive across the gradient' of social deprivation/advantage. While this may be broadly true, we believe that for the most marginalised groups, such as long term rough sleepers, there is more of a step than a gradient; in fact, it sometimes feels to us as if they have fallen off the edge of the scale altogether, both in terms of the level of their needs and the lack of access to treatment for them. It is important to note that, although differences in health 'are not simply attributes associated with extremes of advantage or disadvantage', extremes of disadvantage do bring with them an *acuity* of health inequality that translates directly into polymorbidity and early mortality. This acute disadvantage requires direct and immediate responses beyond addressing the social determinants underpinning it.

Secondly, we trust that the Review will remain aware that the social determinants of health are realised in individuals, and that individual factors will determine who lives and who dies; suicide rates may be roughly predictable at population level, but predicting who will kill themselves requires an individual approach. Lord Darzi said that homeless people could use the NHS just like anyone else; this is not true – the capacity of many individuals, including many of the chronically homeless, to use what is available is severely impaired. Individual responses (perhaps through personalised social or psychological interventions) are required to address health inequalities in these cases, as well as tackling the social determinants.

Thirdly, as mentioned in Q1 above, more use could be made of complex economic modelling of the budgetary impact of health inequalities not just in health costs, but across a wide range of cost bases.

Q3: Is there additional alternative evidence available which the review should be considering?

Carrying on with the theme above, there is considerable evidence of the impact of the quality of primary care given to babies and infants on their brain development and later social functioning (cf for example '*Affect Dysregulation and Disorders of the Self*', AN Schore, 2003; Norton Series on Interpersonal Neurobiology). The evidence of neurobiology is strongly supportive of the argument that a significant determinant of mental and social (relational) health in individuals is their early nurture; it is further arguable that mental and relational health determines much physical health. Incorporating the insights from this stream of evidence would enable the review to marry the individual to the social.

We have considerable evidence of the health needs of homeless people and rough sleepers, as do some other homelessness agencies. This does not just confirm the evidence of the social determinants of health. As stated above, it often seems to us that rough sleepers' health has fallen off the edge of the gradient rather than just being at the bottom. We would be very happy to share our evidence.

Questions 4 – 6: Key strategic themes.

Q4: Are these the most relevant themes?

We think they are. We particularly welcome the emphasis on devising specific proposals for vulnerable groups, the specific mention of homeless people as one of them, and the recognition that 'the role of work was seen as central'.

Q5: Do the themes provide a sufficiently comprehensive and appropriate framework in which to develop the Review's proposals?

Again, we think they do. However, the devil is as always in the detail, and some of the broad approaches outlined in the Consultation Paper raise more questions than they answer. We highlight what we see as some of the issues that need further deliberation.

3.1 'Reducing material inequalities' seems based on a redistributive economic model that has not been culturally dominant for thirty years or more; it therefore requires a cultural shift of major proportion, equivalent to the Reagan-Thatcher one towards 'greed is good', to enact.

However, again there is a cliff-edge point along the 'gradient' of material inequality: those in work are very much better off than those out of work. It may be that a pragmatic approach to material inequality will seek to tackle worklessness (which is broader than just unemployment), an approach that may command stronger support.

3.2 'Enhancing potential'. We welcome the recognition of the benefits of 'good work and continued education', and of civil participation.

We think that more emphasis needs to be placed on the child development aspect of this theme, which links the individual to the social. Child development is the arena in which intergenerational disadvantage is acted out: if we are to tackle health inequality, we must tackle the intergenerational transmission of mental ill health, worklessness, and antisocial behaviour. 'The importance of individuals having control over their everyday lives...was viewed as central to health outcomes' but a key aspect of this is to be able to have control over yourself, your impulses, and your social interactions. Enhancing potential therefore has a strong mental health/wellbeing aspect to it, which we think this underplays.

3.3 'Empowerment: enhancing social and community capital'. We strongly support this, but we do note the need for it to include marginalised groups. There is a danger that community empowerment can be a reinforcement of power structures within a community, which would be counterproductive: there has been some very good work done recently in Trinidad by communities themselves involving gangs within wider community activities, and thereby resolving the gang violence problem. Rough sleepers and homeless people (and other transients) need to be part of their communities, and this is a two-way thing – the communities need to reach out and say that these people, with all their sometimes quite challenging differences, 'belong to us'.

3.4 'Sustainability of neighbourhoods, transport and food systems'. We agree with the importance of environments, and have made considerable alterations to our own built environment with a view to enhancing the recovery of our clients.

Our experience is that environments that are open, fresh and enable a 'natural' flow of people around the functionality for which they were designed actually enhance the aspirations of the people that use them. More becomes possible in an improved environment, and people are more likely to look after their environment, making it more sustainable; in tandem, the improved environment stimulates positive change in the people within it.

3.5 'Quality and flexibility of work and security of employment'. As stated earlier, we are delighted to see the statement that 'the role of work was seen as central'. 96% of our hostel residents are unemployed, and we have no doubt that this is detrimental to their recovery and wellbeing. Many of those with poor mental health may never work again: we think this is wrong, both economically and morally.

There are many systemic tensions here. Flexibility means different things; to an employer, it might mean being able to take on and let go staff as business fluctuates, whereas to an employee it might mean being able to work different hours or days depending on other factors such as childcare arrangements. 'Productivity gains' often means getting more work from the same staff; this and improving work-life balance are often at odds. 'Efficiency' savings often simply means cutting staff to save money, but the workload continues and again staff have to do more. These processes are often instigated by local authorities and government, reducing contractual costs on one side whilst increasing unemployment and social costs on the other. Again, a cultural change is required.

Part of this cultural change might be towards tackling worklessness, and not just unemployment. For many of our clients, employment is a step too far at the moment. However, this does not mean that they should be excluded from the opportunity to work in ways they can manage. Many people with mental health problems could work; many might not be able to sustain employment, with its daily regularity, quite apart from the pressures of the modern workplace. We would like to see a shift towards valuing work, as opposed to valuing only employment and income; and towards a benefits and support system that enabled and supported people to play an active role in their communities through socially-valued work, rather than pushing them towards an unnecessary dichotomy between unemployment and employment. Such a system would value and support activities and work placements as much as getting a full-time job, and would enable many more of our clients to make the transition from excluded to included.

3.6 'Protecting vulnerable groups'. We very strongly welcome the idea of specific 'proposals focused on the most vulnerable in society including...homeless people'; within homeless people, rough sleepers are the most vulnerable of the most vulnerable, and, as we have said several times, are in danger of falling off the edge of the 'gradient of social disadvantage'.

We also applaud your statement that these vulnerable groups should have 'adequate support both financially and in terms of specialist services'. And we are delighted to read (elsewhere) that these specialist services would work better by commissioners giving 'greater professional autonomy and empowerment' to 'those working in the professions dealing with the care of the vulnerable'; there is something both absurd and perverse in local authorities contracting us for our expertise and then trying to micromanage our work.

We do have reservations however about the specific health measures you mention in the Consultation Paper. The health priorities such as cancer, diabetes and cardiovascular disease may be key targets for the NHS, but the most important health priorities for rough sleepers are mental health, respiratory problems and liver and kidney disease; it does not serve vulnerable groups well for assumptions to be made that national indicators of relevance to majority populations will retain the same relevance.

A key contributor to health inequalities for rough sleepers and other vulnerable homeless people is the inability of most statutory mental health services to work with clients who also are substance dependent; this is a systemic exclusion which needs to be tackled. There is a danger that when health professionals do not know how to do something – e.g. work with people with substance dependencies and mental health problems – they think it cannot be done, and so exclude the person from treatment; this is not acceptable if we are to tackle health inequalities for this group.

We also have some reservations about ‘contingency management’. We acknowledge that there is ample evidence that attendance improves through paying drug users to come, and so do completion rates if you pay people throughout. Whether this translates into positive outcomes for the individuals involved is much less well-evidenced. The majority of people who complete short treatment cycles continue to be substance dependent, and it is not clear that paying them to attend increases the percentage who ends their dependency: from a psychological perspective, the contrary is likely. ‘Contingency management’ may also impact negatively on take-up of other health interventions that do not offer financial incentives – screening, smears, vaccinations, etc – by populations accustomed to being paid to attend. We think more research needs to be done before any suggestion that the contingency management approach is rolled out any further. What we would prefer to see is new forms of treatment being piloted, as the current forms of treatment have very low success rates in terms of real outcomes (as opposed to outputs like the numbers who remain in treatment for x no. of weeks). We would also like to see the measure of success in drug and alcohol treatment changed to recovery rather than compliance with short treatments; currently a drinker who does three detoxes and rehabs in a row and is still drinking counts as three successful treatments for the treatment agency: this is manifest nonsense.

3.7 ‘Public sector performance and responsibility’. We have seen the value of concerted action on a particular problem with a simple focus on real outcomes, rather than inputs and outputs, in the success of the Rough Sleepers Unit. We would welcome this approach in other areas of our work (e.g. tackling mental health, reoffending, worklessness). We welcome your proposals in this direction, particularly your comments on strategies being ‘based on shared objectives’, and that ‘improving the morale, coherence, skills and autonomy of those on the front line is seen as essential’.

3.8 ‘Strengthening the approach to evidence based policy’. We welcome an evidence based approach, while agreeing with your comment that ‘there remain clear gaps in the evidence base’. What we would like to see is evidence derived from real life situations, rather than academic evidence derived from carefully constructed trials. The funding and creation of evidence is political, and is often about preserving the interests and power of the powerful rather than delivering something that really works best for ordinary people (never mind for vulnerable and excluded groups). The current over-reliance on the so-called ‘gold standard’ of RCTs and peer review distorts the evidence base. Evidence needs to be gathered, whether from pilot projects or ongoing services, from the experiences and practice of staff and clients in real situations. We would be happy to host research programmes ourselves.

3.9 'Strengthening universal preventive activity on health'. While our focus remains on the most vulnerable, we agree that universal health activity benefits our clients as well; the banning of smoking in public spaces is a case in point. We therefore support the proposal for broad population health improvement measures

Questions 7 – 11: Cross-Cutting Challenges for the Review

.Q7: What are your views on the challenges raised?

We agree with the challenges you raise, and are particularly pleased to see you support the idea of taking a wider approach to health inequalities than mortality rates ('being well' and 'well being'), and highlighting the importance of the 'role of resilience'. We think both of these are very important.

In terms of improving resilience and 'isolating factors...which weaken the relationship between adverse social and health outcomes', we would again note the advances in the fields of neurobiology, relational psychotherapy and attachment studies which offer significant suggestions in this direction.

In section 3.4 'Public services – creating the conditions that foster change' we think that one of your 'key aspects' of an approach 'shaping the hundreds of billions already spent' should be that clinicians need to take a broader view incorporating social, psychological and physical wellbeing when devising treatment plans, with a recognition that for many people these plans will be complex. As part of this working with complexity approach, it should no longer be permissible or acceptable for mental health services to refuse anyone treatment for their mental health because they are substance dependent.

Q8: Are there other significant challenges the review needs to address?

We think that possibly two other challenges could have been specified:

- involving the private sector, not just as a health providers, but as employers, constructors of our physical environment, co-creators of our economic environment, and highly influential purveyors of cultural concepts
- the role of the public themselves: a cross-cutting challenge must be to mobilise public opinion, and popular culture, behind the idea that health inequality needs to be tackled, and that social determinants are a key way to do this. Many of the Review's recommendations require culture or attitude change, and this in turn requires high levels of public engagement with the big themes. Alongside this wider public engagement is the need for vulnerable groups to be involved in both devising and implementing the proposals: much of inequality stems from the unequal distribution of power and influence, and so tackling it requires the involvement of the powerless and voiceless.

Q9: Are the current systems for delivering reductions in health inequalities the most appropriate? What would improve them?

We have given some of our ideas above, and agree that simple measures of mortality are inadequate, and result in inadequate targeting of resources.

The current systems are evidently inadequate as health inequality continues to increase, not decrease. The implementation of the proposals by the Marmot Review would improve them.

We believe that localism enhances health inequalities for minority populations within localities: commissioners ignore them because of their low numbers. Frequently, their needs do not even register on the Joint Strategic Needs assessment because the numbers are too small for statistical interpretation, and Health Observatories, for example, are staffed by statisticians. Localism also makes appropriate interventions seem expensive, and unjustifiable, so services are closed down because there is 'no demand for them'. There is a demand, only the people from the neighbouring boroughs are excluded from using them. For minority groups, and the socially excluded, and for transient populations like rough sleepers, there need to be regionally-funded and regionally commissioned responses to health inequalities.

On a smaller scale, what would improve health inequalities affecting our clients most of all would be greater cooperation and coproduction of treatment and support: neither St Mungo's nor the NHS nor our clients can resolve this on our own, and we need to develop partnerships based on mutual respect and shared objectives. Our clients are very straightforward in saying what they want – more accessible physical health services, more respect from health professionals, less 'what you need to do first is give up drinking/taking drugs' before they get any treatment, more specialist mental health workers in hostels, and better access to counselling. We are clear what we need to provide – accessible primary care, needle exchanges and substitute prescribing; staff committed to engagement and recovery; psychotherapists who are easily accessible or on-site, and who will work with any presenting issue that comes up; discharge management; palliative care; and support with wider social aspirations, including relationships, work and move-on. What would improve this is if health commissioners would recognise the health needs of our clients, recognise our expertise in working with them, and recognise that to design and deliver effective (including cost-effective) services we need to sit down together.

The logic of the social determination of health is that healthcare is an adjunct of social care, not vice versa; healthcare commissioning should be informed by this.

In a similar vein, the health profession has structured health treatment around clinical parameters. This may seem logical, but distinctly disadvantages people from minorities with different cultural paradigms of illness, and people with complex and overlapping conditions. At worst it means that services are structured around the discipline and convenience of clinicians – you can get your back treated here, but you'll have to go over there for your feet, and over there for your eyes, elsewhere for your teeth, and so on, without even mentioning mental health and substance use. This makes it difficult to impossible for many people to access health treatment. Treatment requires refocusing on health needs, not on clinical categorisation; the clinical paradigm of diagnosis and treatment may be useful for clinicians, but is often used as a system of exclusion. It is not person-centred. The logic of tackling health inequalities falls squarely within the personalisation agenda: treatment should be of the person, and should be based on their needs, not on fitting them into pre-determined categories.

This questions fundamental aspects of the way health services are organised. There are pathways for most conditions nowadays, and where there are not, they are busily being created. These pathways are designed for clinical convenience and as methods of distributing resources: they work reasonably well where a person has a clear-cut condition that fits within a pre-set category. They do not work for people whose condition is less clear-cut or who have multiple morbidities. On the contrary, they make treatment more difficult: it is not possible to go down four or five pathways at the same

time. Health treatment for many people has become a maze, and this in effect excludes precisely those with the greatest number of health problems, thereby directly increasing health inequalities.

Q10: Are the proposed interventions those most likely to impact on health inequalities?

There are some details, some of which we have alluded to in the text of this response, which we think need further thought, but broadly speaking we would say 'yes'.

There is a political difference between 'universal' and 'targeted' approaches, both of which the Review hopes will be implemented. Universal approaches, the evidence shows, would have a major impact, but their impact is often likely to be slow and for the future: as such, they are less popular with politicians or commissioners, and indeed many members of the public. There has been a cultural shift towards short-term gratification over the last fifty years or so, and long term initiatives are hard to instigate (or defend in a time of cuts). Targeted approaches offer quicker 'wins' and make it much easier for politicians to stand up and say they have solved the problem by hitting some target or other. It also seems unlikely in the extreme that any politician is going to fight the next election on a platform of income redistribution, or more steeply incremental taxation, or tackling disparity of educational opportunity (the quickest way of doing this would be to nationalise the private schools, but of course the 45% of MPs and 75% of judges who went to them wouldn't let that happen).

There is already a debate among many public health directors about health inequalities, and whether they can achieve any impact on them; many say they can achieve something in one area – say cardiovascular disease – and that that will be concrete and measurable and achievable within a relatively short timeframe (i.e. fit with SMART objectives). This approach is likely to satisfy most commissioners as well as the politicians.

There is therefore a danger that there will be a consensus on delivery of some high profile targets that affect a large population (again, eg cardiovascular disease), and the old argument that 'we can't do everything' and 'we can't afford to devise targets, and strategies for achieving them, for every group' (by implication excluding the numerically small such as vulnerable homeless people and rough sleepers). This is how it is now, and health inequalities remain stubbornly intact.

The great strength of the Review lies in its comprehensiveness, but that is also its weakness; it would require political vision to really implement it lock, stock and barrel, and there is no sign that there is any political vision available at the moment. If there is any political vision, it seems to be focused on surviving the economic downturn without tackling the financial services' corporate excess or questioning the ethos that gave rise to it. Perhaps the vision needs to come from, or be ignited by, someone else – the public, the faith groups (for example rabbis, imams and priests last week jointly delivered an open letter calling for a statutory limit on 'usury', fixing maximum interest rates at 8%), the media, or a case that becomes a cause celebre like 'Cathy Come Home' did. But without a jointly held vision, it is hard to see how the range of the Marmot Review's proposals will be implemented. And if the range is not acted upon, then it is hard to imagine that the actions that are taken will have a grand effect on health inequality.

From this rather pessimistic perspective, the targeted approach looks better than the universal. It would be possible to devise a targeted approach tackling the health inequalities of rough sleepers and the vulnerable homeless relatively inexpensively. Doing so would not only improve their outcomes and quality of life, but provide a model

for complexity and for working with so-called 'hard to reach' groups. Such a pilot could be branded as a step towards the wider implementation of the Marmot Review, so the politicians and commissioners would be seen to be doing something, and could achieve something.

The Review is excellent in describing ways to tackle health inequality, and we have little doubt that most of the proposed interventions are those most likely to impact on this inequality. In reality, whether this is done is a political decision, and the Review does not offer guidance on how creating the political will – not dissimilar to the will that created a universal healthcare service in the first place – is to be achieved in a far more fragmented society.

Q11: Are there examples of good practice and successful interventions which could be included and what evidence exists relating to their impact on the social determinants of health inequality?

We have mentioned some in the text.

In terms of targeted approaches for rough sleepers and vulnerable homeless people, we would cite several aspects of our own work:

- our Lifeworks psychotherapy service, one of the Cabinet Office funded Adults facing Chronic Exclusion (ACE) pilots, which increases resilience, facilitates and enhances processes of change, and increases the wellbeing of people affected by a range of complex health conditions
- our approach to delivering complex services within a recovery framework for people with complex problems, for example at our Clapham hostel or our dual diagnosis project in Brent
- our approach to supporting clients to make the transition to workers
- our autonomous client involvement organisation, Outside In, whose report on mental health and wellbeing, Happiness Matters, we attach with this response. They would be very happy to talk to the Review about participation in refining the proposals
- our Putting Down Roots work initiative, which provides socially useful work for clients and improves amenity in community spaces at the same time

In terms of broader community interventions, we already mentioned the community-organised work with gangs in Trinidad; there is Turning Point's community-based commissioning project, another of the ACE pilots; the DCLG's 'Places of Change' investment in improving the fabric of homelessness hostels and day centres; the mobile TB team in London.

Conclusion

We welcome the Marmot Review. We believe it is timely, and apposite; it tackles the right issues with the right values, and offers many constructive and practical ways forward. However, we have concerns over the political will to implement it, and believe this needs directly confronting as part of the Review itself. In a way, this is the biggest challenge facing the Review.

That said, we are deeply supportive and we would welcome further participation in developing aspects of it most relevant to our work. We look forward to the possibility of ongoing participation, and to helping make the Review's proposals happen in practice.

*Peter Cockersell
31 July 2009*

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