Health Policy Matters

HELPING DECISION MAKERS PUT HEALTH POLICY INTO PRACTICE

Social Policy Supplement

- Child poverty
- Youth policy
- Social services
- Social security policy
- Access to General Practice for people sleeping rough
- Environmental policy

SUPPLEMENT TO
ISSUE 1 JANUARY 2000

Introduction by Ken Jarrold

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It is not easy for chairs, non-executives, chief executives and senior managers to keep pace with the developing policy agenda. They need to be aware, to understand and to know what is expected of them.

This Social Policy Supplement accompanies the first issue of *Health Policy Matters*, on *Saving Lives*. It features policy initiatives aimed at the wider determinants of health. We hope that this and subsequent issues will help you to keep in touch with the developing policy agenda and that it will make a real contribution to your work in establishing the new NHS.

Background

In the last few years the Government has launched a range of initiatives, to tackle areas of policy which, though having distinct objectives relating to specific areas such as education, social services, employment, crime prevention and urban regeneration, will have an impact on the health of the population. A common theme throughout the many initiatives from government has been to address social exclusion and to promote social inclusion. (Social exclusion is a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health, poverty and family breakdown.)

This supplement to the first issue of *Health Policy Matters* summarises some of these policies. It aims to help people in the health service keep abreast of developments in public policy which are likely to have an impact on health and which may have implications for health service action. This supplement is also intended to stimulate policy makers, many of whom are now working in partnerships, to think about other areas relevant to health and do a bit more 'joined-up thinking'. Many of the approaches to dealing with social exclusion have not been evaluated. Therefore we cannot speculate with much confidence as to the likely impact on health and its distribution.

Child poverty

Child poverty (measured as the proportion of children living in households with incomes below half national average) increased more than threefold in the UK from 10% to 35% between 1979 and 1996/97 (Chart 1). The proportion of children living in families receiving Supplementary Benefits/Income Support increased from 7% in 1979 to 23% in 1998. A third of children are born to mothers receiving Income Support.

The Luxembourg Income Survey (LIS) reveals that in 1995 the UK had the third highest child poverty rate of the 25 countries included - only exceeded by Russia and the

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United States (Chart 2). These calculations reflect complex social trends (the rise in one parent families, for example, is a major factor in the growth of child poverty) and so some caution is needed when interpreting direct international comparisons. While most countries have managed to keep stable or even reduce their child poverty rates in the face of the economic and social changes of the last two decades or so, the UK has had one of the fastest growing child poverty rates.

The government has stated that its aim is to end child poverty within 20 years and that the policies already announced will lift 800,000 children out of poverty. The Chancellor has promised that measures to be announced in his next budget will lift another 200,000 out of poverty. An indication of the challenge facing the Government is that the latest Department of Social Security statistics indicate that in 1996/7 there were 4.5 million children living in households with income (from work or benefits) below half the average.

The Government is pursuing four strategies with respect to poverty: *redistribution*, *employment*, *prevention*, and *investment in human capital*. Among these, the policies of most relevance to children are:

Redistribution

- the minimum wage from April 1999
- Working Families Tax Credit and Childcare Tax Credit, October 1999
- increases in Child Benefit
- increases in the child scale rates of Income Support for families with children under 11
- a starting rate of income tax of 10%

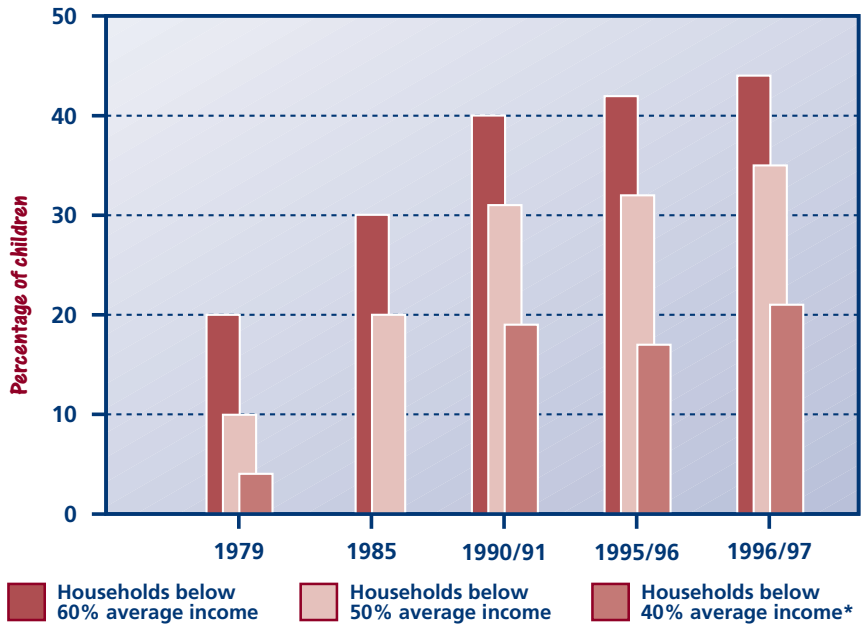

Chart 1: Percentage of children in poverty (after housing costs)

Employment

- the New Deals for the long term unemployed and lone parents (see section on Social security policy)

Prevention

- Childcare Strategy
- Sure Start

Investment in human capital

- investment in schools, training and the NHS

Implications for health service action

Of these, the Sure Start programme is probably the most relevant to health service managers see *http://www.dfee.gov.uk/sstart/* This aims to improve the life chances of younger children up to the age of four through better access to early education, health services, family support and advice on nurturing for parents and those expecting a baby. In each Sure Start area, locally-based programmes will try to ensure that the following core services are delivered in an integrated and coherent way:

- outreach services and home visiting
- support for families and parents
- services to support good quality play, learning and childcare for children
- primary and community healthcare and advice
- support for those with special needs.

Support will be community-based and involve a wide variety of local people and local professionals working together to provide an integrated service. It is important for health service decision makers to know whether and how Sure Start is operating in their area and that it is carrying out these activities in a way which research shows is likely to have an effect.[2,3]

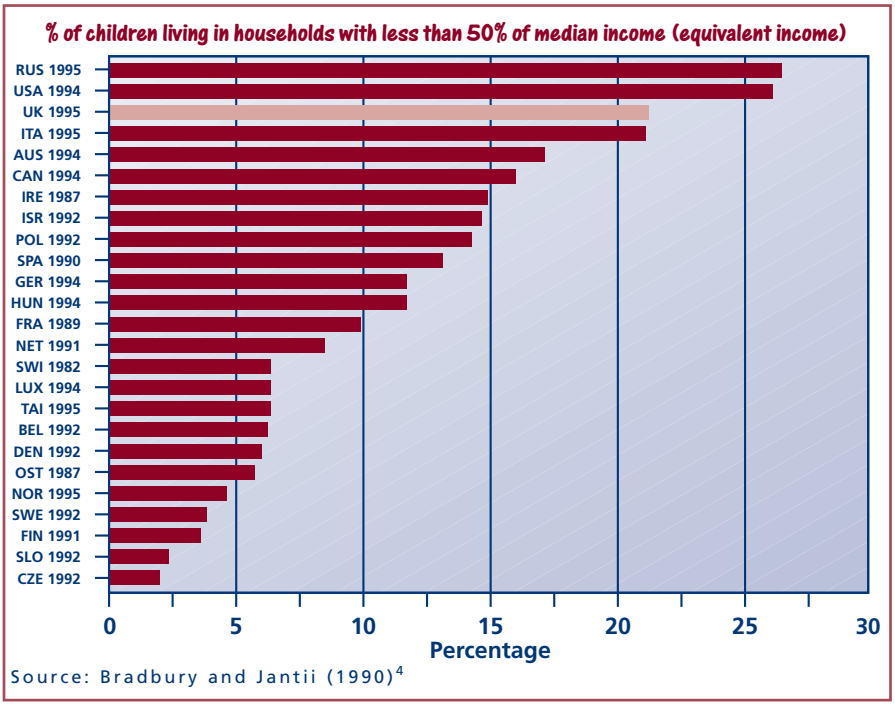

Chart 2: Child poverty rates LIS latest

Youth policy

Those excluded from school or not in any form of education, training or employment aged 16-18 are more likely to be involved in crime, drug and substance misuse, suffering from mental illness, unemployed, homeless, pregnant and have children while in their teens. Those 'looked after' by local authorities and those leaving the care system are at even higher risk of these problems. The geographical concentration of all these issues within poor communities has long been identified as one of the key sources of community dissatisfaction, stress, depression and ill-health.

Key policies in this area include new targets to arrest and reverse current trends, new partnership arrangements for local authorities and agencies, a reform of institutions dealing with young people and better systems of support. The Social Exclusion Unit, located within the Cabinet Office see *http://www.cabinet-office.gov.uk/seu*, has been at the forefront of a concerted attempt to promote 'joined-up solutions to joined-up problems'.[5-9] The Department for Education and Employment and other government departments and agencies have also been involved in a number of related policy interventions. Areas of policy or target groups for policies which affect youth include:

- Rough Sleepers (including youth homelessness)[5] (see section on Access to General Practice for people sleeping rough)
- Truancy and School Exclusions.[6] The DfEE has issued circulars on Social Inclusion aimed at reversing the upward trend in both school exclusions and truancy and for these to be reduced by a third by 2003.[10] In addition, all those excluded from school are to be provided with full-time education, and pregnancy is no longer grounds for school exclusion
- Poor Neighbourhoods[7]
- Teenage Pregnancy (see *Health Policy Matters* issue 1)[8]
- 16-18 year olds not in employment, education or training[9]
- Educational Action Zones see *http://www.dfee.gov.uk/eazlintro.htm*
- Strategies to address drug misuse by young people[11, 12]
- Initiatives in the Inner Cities (*Excellence in Cities*)[13]
- Special Educational Needs[14]
- Children 'looked after' by local authorities and those leaving the system (see section on Social services)[15, 16]

Implications for health service action

These initiatives are all likely to have an impact on people's health and several have implications for the NHS. For example, within the Social Exclusion Unit's report on teenage pregnancies, the 30-point action plan calls for the attention and involvement of a wide range of government departments and agencies. It is, therefore, important for local health service policy makers to know who has been appointed teenage pregnancy local co-ordinator for their area and what they are planning.

The new Drug Prevention Advisory Service (DPAS) which started in April 1999 is responsible for setting up a national network of 103 Drug Action Teams. These teams require co-operation and co-ordination of effort at a local level on the delivery of programmes in schools and in the community as well as work with vulnerable groups.[11, 12, 17]

The spatial concentrations of poverty and disadvantage also suggest opportunities for area-based multi-agency working. Many of the 18 areas for Policy Action Teams set up after the Social Exclusion Unit's report on poor communities[7] have implications for health care.

The social exclusion affecting young people, including educational disaffection, is often a symptom of a

more complex malaise including health and family-based issues which can also be addressed by Primary Care Groups. These initiatives offer an opportunity for the health service to join forces with others in tackling the complexities of poverty, disadvantage and social exclusion.

Social services

The White Paper, *Modernising Social Services,*[18] contains specific proposals for changes in services for adults and children, as well as general 'modernisation' proposals affecting all social services. These have been developed in the context of evidence of the abuse and neglect of children and vulnerable adults by carers in residential and day care settings; the lack of clear service objectives and the failure to co-ordinate services, especially health and personal social services; the geographical variation in the quality of services, and the failure to provide cost effective services. This marks a shift from a preoccupation with who provides the care to '*the quality of services experienced, and the outcomes achieved for individuals and their carers and families*'.[18]

Adult services

Changes have been proposed in response to problems such as restrictive eligibility criteria, service driven as distinct from needs led decisions, service dependency, and a lack of information. The aim is to help people to manage independently, provide more geographical consistency and develop more service user led provision. Specific actions proposed include:

- better preventive and rehabilitative services - especially through a joint health and social services approach as identified in the *National Priorities Guidance*[19] and facilitated by the Promoting Independence Partnership Grant '*...providing £650 million over three years, to foster partnership between health and social services in promoting independence as an objective of adult services.*'
- an extension of direct payment schemes
- better services for those who are able to work
- improved review and follow up
- better support for people with mental health problems.

Children's services

Three priority areas are identified in the White Paper: ensuring better protection from sexual, physical and emotional abuse and neglect, raising the quality of substitute care and improving the life chances of children in care and those in need - ' *...in particular through improving health and education and support after they leave care.*'

Specific actions identified include:

- strengthened regulation
- stopping dangerous people from working with children
- revised child protection guidance
- enhanced inter-agency working
- the introduction of the *National Priorities Guidance*[19] and the *Quality Protects Programme*.[20] This includes the proposal to reduce the number of care placements of those 'looked after' and new targets for their educational achievements.[15] *Quality Protects* is the government's three year programme for transforming the management and delivery of social services for children, supported by a £375 million children's services special grant. The government is also proposing new arrangements for 16 and 17 year olds who are 'looked after' or leaving care. The intended aims are to delay transitions until young people are ready for care, improve their preparation, encourage greater consistency in support for those leaving care, and improved arrangements for providing financial support to young people.[21]

Implications for health service action

Action to improve social services overall includes proposals for improving protection and regulation, raising workforce standards, developing partnerships, improving delivery and combating inefficiency.

Eight new Regional Commissions for Care Standards will be set up. These will carry out the independent regulation of residential, nursing home, domicilary, independent fostering agency, boarding school, and residential family centre care. They will be based upon boundaries of the NHS and Social Care regions and will include representatives from health, local authorities, plus user and provider representatives. A General Social Care Council will also be created to regulate training and set standards among the social care workforce. This will be linked to the related work of the new National Training Organisation for Personal Social Services.

Improving joint working between health and social services is identified as a top priority in the White Paper. Legislation is promised based upon the proposals in *Partnership in Action*.[22] This includes *pooled budgets* - where health and social services put a proportion of their funds into a mutually accessible joint budget to enable more integrated care; *lead commissioning* - where one

authority transfers funds to the other who will then take lead responsibility for purchasing both health and social care; and *integrated provision* - where one organisation provides both health and social care.

The specific links with health identified above in both the proposals for adult and children services, and in the joint working arrangements, are part of a wider reconfiguration of health and social services. The proposals contained within the White Paper, *The New NHS*[23] (e.g. social services participation in Primary Care Groups and Health Improvement Programmes and the provision of Joint Investment Plans), the White Paper: *Saving Lives*,[24] the joint *National Priorities Guidance*[19], *Better Services for Vulnerable People the Long-term Care Charter*,[25] and the development of *National Service Frameworks* covering both health and social care, are all evidence of this shift. This will have significant implications for the working methods of senior, middle and first line managers as well as a range of practitioners - beyond the current experiences of joint working. In the longer term it may also pose some searching questions about the existing organisational provider divisions between health and social service providers.

Social security policy

Changes to the social security system over the past two and a half years must be seen in the context of the wider policy agenda of welfare reform which has been a major goal of social and economic policy since the Labour government was elected in 1997. The new administration's diagnosis of the weaknesses of the welfare state were set out in the Green Paper *New ambitions for our country: A new contract for welfare*.[26] The principal policy responses fall into two distinct, though complementary, categories: policies in pursuance of the *welfare to work* strategy, and policies to combat *social exclusion*.

The thinking behind welfare to work is captured in the slogan of 'work for those who can, and security for those who cannot'. A distinctive feature of the government's approach to welfare reform is that policies have crossed traditional departmental boundaries, particularly the DSS, DfEE, Employment Service, and Inland Revenue. This 'joined-up' approach is evident also in the links between welfare reform and social exclusion. The government is clear in its conviction that the preferred way out of social exclusion for people of working age is for them to enter the labour market. Welfare to work is supported through a number of social security and employment policies:

- the programme of New Deals
- the introduction of the ONE initiative (a major initiative to provide claimants with a single point of entry to the benefit system and employment services)
- the introduction of tax credits for families and disabled people
- changes to sickness and incapacity benefits

The government's £5 billion New Deal programme is aimed at helping workless people to compete for jobs in the labour market. It includes six New Deals, for young people, long term unemployed people aged 25 and over, the over 50s, the partners of unemployed people, disabled people, and lone parents. The common element in all six New Deals is the provision of a Personal Adviser to benefit claimants to assist them in training or looking for work.

The ONE initiative (previously called the 'single work focused gateway') is also based on the Personal Adviser idea and requires nearly all new benefit claimants to take part in a compulsory interview to discuss how the claimant might return to the labour market. The two new tax credit schemes, administered by the Inland Revenue, replaced the old Family Credit and Disability Working Allowance from 5 October 1999 and now provide additional income for people with low incomes from work. The most important change to Incapacity Benefit is the replacement of the 'all work test' which measures what people *cannot* do by a new test based on a person's *capacity* to carry out physical and mental tasks.

Implications for health service action

The introduction of the New Deals and the associated changes to benefits have several possible implications for health services:

- There is likely to be an increase in the number of medical reports requested from GPs, hospital consultants and other health workers, in support of claims for benefit and to inform Personal Advisers in their decisions about helping people back to work. This overall increase may also be associated with a change in the type of claimants referred for medical reports. For instance, the New Deal for Disabled People is attracting more people with mental health problems than first expected.
- The replacement of the Incapacity Benefit 'all work test' will require medical practitioners to supply different types of information about their patients than previously, for which some form of training will presumably be necessary.
- The promotion of the welfare to work strategy (through both the New Deals and the ONE

initiative) might generate an enhanced role for health professionals in advising and informing people about the labour market opportunities that are available to them.

Access to General Practice for people sleeping rough

The *Rough Sleepers Report*, produced by the Social Exclusion Unit,[5] promoted a new policy approach to rough sleeping, based on joint working between agencies and the unification of existing rough sleeping programmes under the Rough Sleepers Unit.[27] As part of this approach, the Report included an undertaking to improve access to GP services for people sleeping rough. Severe mental illness, drug and alcohol dependency and a host of other health problems are highly prevalent among people sleeping rough. If these health problems are not addressed it will often be impossible to begin to reintegrate a former rough sleeper into society. GP services are essential, both for the care they provide and for the access to other services that GPs can arrange.

Research by the Centre for Housing Policy in York, found that access to GP services across England by rough sleepers was universally poor.[28] Some GPs and receptionists were anxious about taking on people sleeping rough as patients because of fears about their behaviour and an association between rough sleepers and drug use. People sleeping rough were themselves often apprehensive of visiting GPs because they expected to be poorly received or refused a service.

Implications for health service action

The key implications for the health service in areas with a rough sleeping problem are:

- a need for greater co-ordination between health services and those agencies providing services for the homeless. Access to a GP often depends on whether there is a sympathetic GP in an area. There is a general need for improved joint working between health authorities, PCGs, trusts and the homelessness sector. Some health authorities have employed GPs with a specific role in serving the homeless population
- a need for a mixture of services. The most marginalised people sleeping rough cannot be expected to use ordinary GP practices and ordinary practices cannot be expected to cater for people sleeping rough. Targeted services working from a fixed site, or on an outreach basis, are necessary to ensure that people sleeping rough have access to a GP. Such services should work with the homelessness sector as part of the resettlement process and, also as part of that process, enable and encourage people sleeping rough to re-engage with the mainstream health service. Services such as health visitors for homeless people can also encourage and enable use of the mainstream NHS.

Environmental policy

A wide range of health problems can be caused by environmental factors such as air pollution, the road and transport system, UV solar radiation and environmental lead. Pesticide residues on fruit and vegetables are known to exceed recommended levels and sewage pollution is also problematic. Also, many homes are insufficiently protected against high levels of radon gas, associated with increased risk of lung cancer.

Geoff Tompkinson/Science Photo Library

Sustainable development

Links between health and the environment are embodied in the principle of sustainable development that underpins UK environmental policy. The latest strategy document[29] explicitly includes health measures in its list of official sustainable development indicators. The Rio Summit in 1992 outlined guidelines for achieving sustainable development in an Agenda 21 document. The UK government has formulated its own Agenda 21 strategy and local authorities are formulating plans with local communities (local Agenda 21 groups). The Sustainable Development Unit, located in the Department of Environment, Transport and the Regions aims to pursue cross-Departmental initiatives. But even within a single policy area such as transport, policy development is proceeding slowly.

The case of transport

Shifting climate patterns, exacerbated by greenhouse gas emissions from vehicle exhausts, affect the range and distribution of insect vectors of numerous human pathogens, increasing the potential for outbreaks of infection in new geographical areas.

At a local level, atmospheric pollution from vehicle exhausts is associated with a range of deleterious effects on human health, especially among people who are already susceptible to respiratory or cardio-vascular problems. Road traffic accidents are a major cause of death and injury, particularly for children and young people. Increasing dangers from road traffic have been blamed for the growth in numbers of children who are driven to school, losing many of the positive health benefits of cycling and walking.

The 1998 UK White Paper on Transport[30] introduced policies designed to curb traffic growth, both for environmental and social reasons. It gives local authorities the power to levy charges on road users for workplace parking, with revenues to be ploughed back into better local transport. A new Strategic Rail Authority is to be established and measures taken to improve bus services. The government is also to promote safer travel to school through the School Travel Advisory Group.

The White Paper, however, fails to take account of the way policies will differentially affect people from different socially structured groups including those with health-related mobility problems. The extent to which it succeeds will largely depend on how local authorities discharge the responsibilities devolved to them to set and meet their own local targets for reducing traffic pollution and encouraging cycling, walking and the use of public transport.

Implications for health service action

The problem for health service managers and health professionals is to find ways of influencing environmental policy to protect public health and to foresee potential problems by keeping abreast of developments in a wide range of policy arenas. One route into the maze might be through the proposed regional sustainable development frameworks that are to be prepared for each of eight English regions by the end of 2000. A useful immediate point for liaison could be local Agenda 21 groups, responsible for promoting sustainable development principles at local level. In June 1997 the government set a target for all local communities to have such strategies in place by the year 2000.

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