The Power of Place
Health Inequalities, Housing and Community in the West Midlands Conurbation – SUMMARY
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Foreword by Professor Sir Michael Marmot,
Director of the Institute of Health Equity

Introduction by Amanda Tomlinson,
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Foreword

Professor Sir Michael Marmot,
Director of the Institute of Health Equity

There is a rumour going around that poor people are unhealthy because they make unhealthy choices. This rumour is a myth. It has the causal connection backwards. More accurately, it is not mythical that the rumour exists but the evidence points the other way. It is not poor choices that lead to poverty, but poverty that leads to poor choices.

Change circumstances and people on low incomes are more likely to adopt the choices that are good for health. Having time to think about exercise is a luxury that people at the economic margins may not have, quite apart from lack of amenities; healthy food may be beyond a household budget; the stress of marginal employment would be happily forgone if better jobs were available.

This new report by the Human City Institute, covering the geography of the West Midlands conurbation, underscores where we live and work, our absolute and relative socio-economic circumstances, our housing and environment all combine to create inequalities in health and wellbeing. The report maps some important public health indicators and concludes that a wider range of public policy interventions – such as better housing for all and investment in the most deprived communities – is required alongside ongoing improvements to the NHS and its funding.

We urgently need healthier environments with an improved housing stock. Better working conditions, too. And we now have estimates for the millions of deaths globally caused by air pollution. Increasingly, environmental pollution is an equity issue. Employment and better working conditions are vital too; not just because work earns money that enables other things to happen, but conditions at work may influence stress pathways that change risk of early death, in addition to influencing healthy behaviour. Minimum income for healthy living is a must. Universal basic income is on the political agenda, and is supported by the Human City Institute’s report. Income is a health issue. Do we still need to make the case for why people need enough money to live healthy lives? In reality, the Chancellor of the Exchequer may have more influence on health equity than the Minister of Health.

Growth in poverty and inequality, in the wake of seven years of austerity policies that have seen the poorest hit hardest, need to be confronted for health inequities to narrow. I am, pleased, therefore, to write this foreword to the ‘Power of Place’ report since it adds to the weight of evidence that a fairer and more equitable approach to our economy and society are urgent if health inequities are not to widen and become embedded in our national fabric.
Introduction

Amanda Tomlinson,
Chief Executive,
the Black Country Housing Group

In this, the 70th anniversary of the founding of the National Health Service, healthcare and its costs are at the top of the domestic political agenda. Yet access to good quality healthcare is only one of the key factors in determining an individual’s health and wellbeing. While the NHS has been central to improving both the health and wellbeing of the nation, health inequalities persist that cannot be explained by differentials in access to healthcare. This new report by the Human City Institute, supported by the Black Country Housing Group, Coventry University, Family Kitchen, M-E-L Research, Nehemiah UCHA, People’s Health Trust and the West Midlands Combined Authority, seeks to provide an overview of how health inequalities are created and perpetuated by poor housing and deprived neighbourhoods.

The report, ‘The Power of Place: Health Inequalities, Housing and Community in the West Midlands Conurbation’, draws on Sir Michael Marmot’s work around the social determinants of health and the social gradient, whereby poverty, socio-economic status and inequality impact on mortality and morbidity rates. As HCI points out in its report, poor and overcrowded housing, concentrations of deprived households, ethnicity, gender and social class, environmental obsolescence, high levels of fuel poverty, and poor air quality correlate to lost years of life. The report illustrates, through a series of maps, charts and tables, how non-decent housing conditions, poverty and economic inequality are key factors in ensuring that poorer communities have less healthy and shorter lives. Males living in the most deprived areas of the West Midlands conurbation die, on average, 9.1 years before those living in the most affluent neighbourhoods. For women, life expectancy is 7.9 years lower between the ‘best’ and ‘worst’ areas.

It is no coincidence that we use the word ‘poorly’ as a commonplace for ‘ill’. Being poor kills; it shortens life, heightens morbidity, threatens wellbeing and lowers quality of life. The HCI report concludes that where we are born is still the major indicator of how we do in life and how healthy we are. ‘Place’ is very important in determining our health and wellbeing. And at the centre of ‘place’ is housing. What is needed is a recalibration of public policy to improve the health of all communities. We must acknowledge how inequalities are constructed and persist, with solutions going beyond NHS provision alone, as important as this remains. Rather, we need to tackle those factors, such as a lack of decent and affordable housing, poverty and wider inequalities, to ensure that the health and wellbeing of all are enhanced. HCI’s report makes an important contribution to this debate.
SUMMARY


About the Report

Report Aims ~ This new report by the Human City Institute (HCI) considers how ‘place’ is where health inequalities, deprivation, social status and household characteristics (such as ethnicity) intersect. Health inequities can be observed at all geographies – region, district, ward and neighbourhood, although the widest inequalities are at the smallest geographical levels due to ‘evening out’ at larger scale. The report seeks to illuminate how health inequalities play out within the West Midlands Regional Authority (WMCA), which is HCI’s home region, between the seven local authorities in the WMCA, and between the 1,681 designated neighbourhoods in the conurbation. The report, however, does not seek to review access to health services, nor biology and lifestyle, as drivers of health inequalities.

Neither does the report aim to be encyclopaedic, but provides an overview only of how health, housing and community overlap. Community is taken to be both geographically-defined and ‘communities of interest’ such as ethnic groups. There is also a focus on social housing and its increasing marginalisation in national housing priorities, and rising levels of precarity of social tenants. Finally, the report considers a series of case studies of initiatives to promote better health and wellbeing, arising from the local government, social housing and community sectors.

Research Approach ~ The report is largely based upon:

- A cursory review of key literature focusing on health inequalities, housing and community, and the social determinants of health was undertaken.
- Mapping of data from the Index of Multiple Deprivation (IMD) 2015, its domains and sub-domains, including those covering health deprivation and disability, housing, the living environment, income, employment, education, skills and training.
- Exploration of crucial public health and associated data published by Public Health England for various geographies.
- Deployment of relevant findings from HCI surveys and focus groups with social tenants.
- Case studies of health and wellbeing promotion by key local government, social housing and community organisations.

Health Inequalities and their Determinants

Overview ~ There is little doubt that health inequalities exist and persist in England today; nor that these inequities are a reflection of socio-economic inequalities embedded in the national fabric. The evidence points to access to health services (for example, primary care, accident and
emergency, screening and early detection of illness); heredity (such as gender, ethnicity, disability, inherited illness; lifestyle (especially smoking, alcohol or drug misuse, obesity and exercise/physical activities); and socio-economic status, class, relative poverty, and tenure being the key drivers. While there are intersections between these drivers, the report considers mainly the final set – the social determinants of health.

The Social Determinants ~ The social determinants of health are linked to the economic and social conditions, and their distribution among the population, which influence individual and group differences in health status. Chief among them are class and social status, relative wealth and poverty, neighbourhood characteristics, quality of environment, and increasingly, housing tenure. These determinants are arranged on a social gradient, running from top to bottom of the economy and society, with ‘high’ status individuals having better health than those of ‘low’ status, with increasing levels of poor health on every rung of the ladder between top and bottom. As an example, life expectancy between the fifth least deprived neighbourhoods in England and those at the top, is, today, almost a decade of life expectancy at birth.

The distribution of social determinants is shaped by a range of factors: prevailing economic and political ideologies, public policy-making, the universality of welfare and prevailing levels of inequality within countries. Unequal distributions of health status tend to cluster around a combination of unfair economic outcomes, poor or inadequate social policies, and a growing gap between rich and poor. The UK in 2017 is one of the most unequal of the group of industrialised countries, and has related, and seemingly entrenched, levels of health inequities.

The Social Gradient – The Role of ‘Place’ and Tenure ~ Intersecting the social gradient in the UK are questions of ‘place’ and tenure, since they are key markers of socio-economic and health status. There are clear neighbourhood effects on health. Alongside more deprived neighbourhoods being places of residence for more disadvantaged communities, there are also geographic effects, such as population density, relative air quality and concentrations of poor housing. Tenure too can broadly indicate socio-economic and health status – home ownership tends generally to be the tenure of higher status households while social renting is increasingly perceived as a tenure of last resort for those with little choice.

Health Inequalities in the West Midlands Conurbation

Health inequalities, as expressed through standardised mortality rates (SMRs), or as rates of illness in standardised populations, can be identified at different geographical levels. There are major differences between the countries and regions of the UK, between local authorities within regions and between neighbourhoods within local authorities. Life expectancy at birth in the West Midlands region is 78.7 years for men, which is 0.8 years lower than the national rate. Women in the region (at 82.7 years) have a greater life expectancy than men, but still lags behind the national life expectancy by 0.4 years. When contrasting male and female life expectancies between the seven local authorities in the WMCA core area and regional and national rates, wider disparities emerge, as chart (1) over the page illustrates. For example, the life expectancy of men in Birmingham and Sandwell is 1.6 years below that of the wider region, and 2.4 years under the national rate.
Health, Housing Need and Homelessness

Poor and overcrowded housing poses major risks to health, including poor mental health, respiratory disease, long-term health and disability and the delayed physical and cognitive development of children. Cold housing is especially damaging for health and causes an estimated fifth of excess winter deaths. In addition, insecure and short-term tenure housing is damaging for physical and mental health. Here are some key housing need and homelessness trends that contribute to health inequalities in the West Midlands conurbation:

- Statutory homelessness has increased by 94% in the last seven years to stand at over 6,500 households, compared with a 48% rise nationally and a 17% increase in the wider region.

- Rough sleeping rates have accelerated by 239% since 2010 – a greater rate than nationally and in most other regions outside London (although, at 132, still a relatively small number). Use of temporary accommodation (such as homeless hostels and bread and breakfast hotels) has risen by 183%, whereas for the wider West Midlands region recorded a 94% increase, and nationally it was 50%.

- The WMCA core local authorities have 56,000 households registered on their social waiting lists – a 3% increase over the last two years. However, this level of registration has fallen from the
highpoint of 2012 because of changes to registration criteria following introduction of the Localism Act 2011.

- Levels of poor, hazardous and overcrowded housing are on the rise. It is estimated that such housing costs the NHS £1.4bn annually. The prevalence of such housing is disproportionately located in the most deprived neighbourhoods across the WMCA core area, as the following maps on the following two pages illustrate.

- There are 3,500 fewer social homes in the conurbation than seven years ago. Housing need assessments in the West Midlands point to significant more investment in new and existing housing required in the coming decade; but especially in social and affordable housing.

**Health and Neighbourhood Deprivation**

There is also a strong relationship between deprived neighbourhoods and health inequalities. In the conurbation, men living in the bottom fifth most deprived neighbourhoods have a life expectancy at birth of nine years below that of men living in the most deprived fifth. For women, the life expectancy differential is almost eight years. There are very strong correlations between life expectancy and neighbourhood, income and employment deprivation, as the following maps illustrate. Those living in the most deprived neighbourhoods tend to have the lowest life expectancy and higher morbidity rates.

Mortality and morbidity rates are also correlated to ethnic group in the conurbation, and linked to neighbourhood deprivation, with some BAME communities having lower life expectancies.

**Health, Social Housing and Precarious Living**

Social housing is now a marginalised and minority tenure in England. As HCI surveys and focus groups with social tenants across the West Midlands show, a large segment can be considered a ‘precariat’ – characterised by precarious living and insecurity. Those seeking to enter social housing come mainly from marginalised groups, including the destitute, such as rough sleepers, those living in temporary accommodation, and others in extreme housing need.

The majority of social tenants face a precarious existence, existing on low incomes, dependent on welfare benefits and tax credits to survive, are more likely to be employed, sick or disabled, have little in the way of assets to fall back on in times of crisis, are reliant upon family and friends and high-cost lenders for loans for day-to-day living, and are less likely than other groups to have access to mainstream banking services or ICT.

Over two fifths (41%) of social tenants have total household incomes below £6,000 annually. Forty-five per cent are economically active, with 24% employed full-time, 14% employed part-time and 7% in education or training. Of working tenants, 35% are in short-term and sometimes zero hours contracts. Over one third (34%) say that their financial circumstances are poor or very poor. Sixty-nine per cent of tenants have no savings. In the last two years, 31% of tenants indicate that their standard of living has worsened with 49% saying it has stood still. Similar results were found when tenants were asked about their health and wellbeing, and their quality of life.
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**MAP (1) LOST YEARS OF LIFE INDICATOR (SMR)**

- Over 120 years
- 111 to 120 years
- 101 to 110 years
- 91 to 100 years
- 81 to 90 years
- 71 to 80 years
- 61 to 70 years
- 51 to 60 years
- Under 50 years

**MAP (2) INDEX OF MULTIPLE DEPRIVATION**

- Least deprived 1%
- 1% to 5% most deprived
- 6% to 10% most deprived
- 11% to 20% most deprived
- 21% to 30% most deprived
- 31% to 40% most deprived
- 41% to 50% most deprived
- 51% to 60% most deprived
- Least deprived 50%
Potential Local Government, Housing and Community-Led Solutions

The WMCA, social landlords in the West Midlands and third sector agencies have all developed a range of interventions in recent years to improve the health and wellbeing of local communities in the face of the consequences of austerity and retrenchment of local service provision:

WMCA ~ A recent Mayoral initiative to tackle the causes of rough sleeping across the WMCA and to organise solutions with local stakeholders.

Black County Housing Group ~ High levels of community investment activity to improve the financial circumstances, health and wellbeing of residents, while generating a high SROI.

Nehemiah UCHA ~ Nehemiah, a BME housing association, offers residents at its elderly schemes the opportunity of a range of activities to improve wellbeing and reduce loneliness.

Holiday Kitchen ~ Offers family wellbeing support and healthy communal meals for pre and primary aged children during school holidays.

People’s Health Trust ~ A ‘local conversation’ programme to confront health inequalities in Lozells ensuring that control is in the hands of local residents experiencing some of the highest levels of disadvantage in Birmingham to support improved pathways to health.

Coventry University ~ A Social Enterprise unit to assist students in establishing social enterprises.

M-E-L Research ~ Has undertaken a series of major research projects to evaluate initiatives related to health, housing and disadvantage.
About the Authors and the Human City Institute

**Professor Guy Daly** is Chair of HCI and Pro-Vice-Chancellor (Health and Life Sciences) at Coventry University. He is a member of various UK health groups - Council of Deans of Health Executive UK, West Midlands Clinical Senate and the West Midlands Combined Authority Wellbeing Board, the Coventry and Warwickshire Sustainability Transformation Partnership. He is a social policy academic with research interests in social care, housing policy, local government, and the governance of public services. He is an active member of the Social Services Research Group and is currently Joint Editor of its journal, Research, Policy and Planning.

**Dr Jill Jesson** is a retired public health academic, having worked in the School of Pharmacy and the Business School, at the University of Aston, Birmingham. She has also been an associate of M-E-L Research Ltd, a commercial research consultancy based in Birmingham, for over twenty years. Jill has published widely on topics such as literature reviews, qualitative research, community pharmacy and consumers, public health, housing and communities. She is currently a Director of the Centre for Community Research (CfCR), which is a non-profit research organisation based in Aston, Birmingham. Jill is HCI’s longest-serving Trustee.

**Kevin Gulliver** is Operational Director of the Human City Institute, former Chair of the Centre for Community Research, and a freelance housing and regeneration research consultant. Before this Kevin worked in senior positions in housing associations, community health services and the probation service. He is author of six books about the history of social housing and social housing organisations, and more than 100 reports on housing, mutualism, poverty, deprivation, welfare reform, austerity, debt and financial exclusion, equality and diversity. Kevin writes regularly for Inside Housing, 24Housing, the Guardian, New Start, LSE Politics and Policy blog.

About the Human City Institute

HCI is an independent, charitable ‘think tank’ based in Birmingham undertaking research into ‘human city’ issues, investigating exclusion, and promoting solutions to the problems of the most disadvantaged groups in today’s complex and diverse cities, towns and communities. HCI works around research themes that incorporate new visions for housing, mutualism and social value, health, wealth and life chances, no community left behind, and studies of age cohorts such as the young and older people.

HCI’s work in recent years has centred upon scoping the ingredients for ‘human’ cities; exploring the role of mutualism, community and resident-led action; equality & diversity; the widening inequality gap in health and wealth, the impact of austerity and welfare reform; and the role of innovative social and community investment approaches to alleviating poverty and disadvantage while boosting life chances.
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